agenda

Title of Meeting	157th Meeting of the Public Health Agency Board
Date	19 October 2023 at 1.00pm
Venue	Board Room, County Hall, Ballymena

standing items

1 1.00	Welcome and apologies		Chair
2 1.00	Declaration of Interests		Chair
3 1.00	Minutes of Previous Meeting held on 17 August 2023		Chair
4 1.05	Matters Arising		Chair
5 1.10	Chair's Business		Chair
6 1.15	Updates from Non-Executive Directors		Chair
7 1.20	Chief Executive's Business		Chief Executive
8 1.30	Update on Refresh and Reshape Programme		Chief Executive
9 1.40	Finance Report	**PHA/01/10/23**	Director of Finance

committee updates

10 1.50	Update from Chair of Remuneration Committee		Chair
11 1.55	Update from Chair of Planning, Performance and Resources Committee		Chair
12 2.05	Update from Chair of Governance and Audit Committee	**PHA/02/10/23**	Committee Chair

items for approval

13 2.15	Annual Quality Report	**PHA/03/10/23**	Ms Reid
14 2.30	Mid-Year Assurance Statement	**PHA/04/10/23**	Chief Executive
15 2.35	Updated Policies and Procedures: - Business Continuity Policy / Plan - Risk Management Strategy and Policy - Records Management Policy	**PHA/05/10/23**	Mr Wilson
16 2.50	Information Governance Strategy / Framework	**PHA/06/10/23**	Mr Wilson
17 3.00	Equality and Disability Action Plans 2023/28	**PHA/07/10/23**	Mr Wilson

closing items

18 Any Other Business
3.10

19 Details of next meeting:

Thursday 16 November 2023 at 1.30pm

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

HSC Public Health Agency

minutes

Title of Meeting	156th Meeting of the Public Health Agency Board
Date	17 August 2023 at 1.00pm
Venue	Board Room, Tower Hill, Armagh

Present

Mr Joseph Stewart	-	Interim Chair
Mr Aidan Dawson	-	Chief Executive
Dr Joanne McClean	-	Director of Public Health
Ms Heather Reid	-	Interim Director of Nursing, Midwifery and Allied Health Professionals
Mr Stephen Wilson	-	Interim Director of Operations
Mr Craig Blaney	-	Non-Executive Director
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director
Professor Nichola Rooney	-	Non-Executive Director

In Attendance

Dr Aideen Keaney	-	Director of Quality Improvement
Ms Tracey McCaig	-	Director of Finance and Corporate Governance, SPPG
Mr Robert Graham	-	Secretariat

Apologies

Mr John Patrick Clayton	-	Non-Executive Director
Mr Brendan Whittle	-	Director of Community Care, SPPG

93/23	**Item 1 – Welcome and Apologies**
93/23.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr John Patrick Clayton and Mr Brendan Whittle.
94/23	**Item 2 – Declaration of Interests**
94/23.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
95/23	**Item 3 – Minutes of previous meeting held on 22 June 2023**
95/23.1	The minutes of the Board meeting held on 22 June 2023 were

APPROVED as an accurate record of that meeting.

96/23 **Item 4 – Matters Arising**

96/23.1 For action 1 regarding the COVID Inquiry, the Chief Executive advised that an Inquiries Programme Board has been established within the PHA and that it held its first meeting on Wednesday afternoon. He explained that it will meet fortnightly prior to the Agency Management Team (AMT) meeting. He said that a number of additional staff have been employed to support ongoing Inquiry work.

96/23.2 The Chief Executive advised that there needs to be a discussion about getting Non-Executive Director (NED) input and for members to consider how they would like to be kept informed. He said that there is now a page on the PHA Intranet where Statements are uploaded. He noted that going forward there will be issues that pertain to the Board and added that the Inquiry has been requesting minutes of confidential sessions of PHA Board meetings and that PHA's legal representatives are discussing this with the Inquiry. The Chair said that the NEDs would need to have a discussion amongst themselves about how they can be involved.

96/23.2 A member said that the Board should see any Statements before they are submitted and agreed that there should be Board oversight. The member added that there is a lot of effort required to support these Inquiries and the staff involved need be looked after. It was agreed that the Chair would organise a Teams meeting with members to discuss NED involvement **(Action 1 – Chair)**.

97/23 **Item 5 – Chair's Business**

97/23.1 The Chair advised that he had circulated his Chair's Business in advance of the meeting and had no further matters to add.

98/23 **Item 6 – Updates from Non-Executive Directors**

98/23.1 Ms Henderson updated members on the recent meeting of the Planning, Performance and Resources (PPR) Committee where she advised that there had been a discussion on the financial planning process for 2024/25. She explained that a paper was presented outlining an approach for staff to identify areas of potential recurrent savings and that a draft Plan will be brought to the Board in October. She noted that this year savings will largely be funded from slippage.

98/23.2 Ms Henderson advised that the Committee had discussed the Substance Use Plan. She explained that the Committee had considered the Plan twice and that changes were made to it regarding which organisations were responsible for which parts, and that the Committee is happy to recommend the Plan to the Board today for approval.

98/23.3 Ms Henderson reported that the Committee had received an update on the work of the Strategic Planning Teams (SPTs) which members were impressed with.

At this point Ms Mann-Kler joined the meeting.

98/23.4 Ms Henderson advised that there will be a presentation on smoking cessation at a future meeting of the Committee.

98/23.5 The Chair said that he had attended the PPR Committee meeting and that it was an excellent meeting.

99/23 Item 7 – Chief Executive's Business

99/23.1 The Chief Executive reported that he had appeared before the COVID Inquiry on 12 July with regard to Module 1. He added that he also appeared in front of the Muckamore Inquiry in June with regard to Module 2. With regard to the Muckamore Inquiry, he said that the Inquiry was to write to PHA but correspondence has not yet been received. He added that he had also undertaken to forward additional information to the Inquiry. He advised that the Inquiries have taken a break but will shortly be re-established. He added that the Urology Inquiry will also be commencing.

99/23.2 The Chief Executive advised that a pilot Area Integrated Programme Board (AIPB) has been established in the Southern Trust area as part of the new Integrated Care System (ICS) and that Dr Diane Corrigan is PHA's representative on this. He said that the PHA has developed a dashboard which has been well received. He advised that in July PHA led a delegation of HSC and Local Council Chief Executives to Wigan for a fact-finding trip to meet their senior leaders to discuss ICS.

99/23.3 The Chief Executive said that at the request of the Chair a standing item on the Refresh and Reshape Programme has been added to the Board agenda, but there is no update today and that there is due to be a Board workshop on this Programme in September.

99/23.4 The Chief Executive informed members that the process for the appointment of a permanent Chair for PHA is ongoing and that the Department of Health has advised that interviews are due to take place in late August/September with an appointment being made by November. He noted that this will require the current interim arrangements to be extended by a further month.

99/23.5 The Chief Executive reported that PHA is engaged in a major of piece around hospital reconfiguration and that he is co-chairing one of the groups, which is looking at regional hospital services, with the PHA also being represented on other groups. He advised that this work will be completed by the end of September in order to inform the Department's blueprint on future hospital reconfiguration.

99/23.6 The Chief Executive advised that PHA has received confirmation of non-recurrent funding being made available for HSCQI for 2023/24. He added that a permanent funding arrangement needs to be put in place. The Chair said that his understanding was that PHA would receive 2 years of funding. Ms McCaig advised that she is hopeful PHA will receive the 2 years.

99/23.7 The Chair said that the hospital reconfiguration programme had come up at a recent Chairs' meeting. He added that while this is a significant and important piece of work, he was not clear why PHA is involved. The Chief Executive explained that PHA is putting forward the public heath view and is seeking to ensure that any reconfiguration takes cognisance of equality of access. He added that PHA has a role in service development and providing professional advice. The Chair asked why PHA is chairing a workstream and the Chief Executive explained that a number of Chief Executive are co-chairing different workstreams. The Chief Executive added that it is appropriate that PHA chairs this workstream as it has a regional focus.

99/23.8 The Chair asked what would happen if the outcome of this work is not welcomed by political representatives. The Chief Executive explained that PHA's role is only one aspect of this work, and that PHA is not writing the document, but at the same time the work should not be undertaken without PHA. He added that the document produced will be public facing and will be require to be signed off by a Minister and that part of this work is to ensure that all political parties are on board. Ms McCaig said that this work is part of the implementation of the Bengoa Report and that it is appropriate that PHA has a role and that the Chief Executive is chairing a workstream. The Chair said that he wished the Board to be clear on why PHA is involved in this and what its role is. He added that this links back to Public Inquiries and PHA answering questions about areas that are not part of its business. The Chief Executive said that this work is clearly defined in PHA's role.

99/23.9 A member said that while they understood why PHA is involved in this work, they remain unclear about PHA's role with regard to commissioning and would welcome a 2/3 page paper explaining what this configuration programme is and what PHA's role is. The Chief Executive explained that PHA has always had a co-joined role in commissioning and it would continue to have that role. The Chair said that he would like to see a paper so there is a record of PHA's involvement **(Action 2 – Chief Executive)**.

99/23.10 The Chair asked if PHA is clear in terms of its role within ICS. The Chief Executive replied that it is an evolving picture which is beginning to settle, but PHA's role is two-fold, inputting advice and preparing a population needs analysis. He explained that PHA is working in partnership with the Trust, primary care, local Councils and the community and voluntary sector. He added that what was originally envisaged for ICS has now changed and that it will likely continue to

evolve. He noted that in Wigan, public health sits within the Council so the set up will be different here. The Chair said that at the recent Chairs' meeting there seemed to be some concern as to where ICS in going and he wished to be assured that PHA is delivering what it is being asked to. The Chief Executive assured members that PHA is doing so, and is part of the decision making authority.

99/23.11 A member asked if carrying out the needs analysis is a big piece of work. The Chief Executive said that population health has always been part of PHA's remit and PHA is working on a more agile approach to produce data by developing a dashboard which focuses on the areas that ICS is seeking information on. The Chair asked if this information can be shared with the Board and the Chief Executive suggested that there could be a demonstration of the dashboard. A member asked if this dashboard can measure change and the Chief Executive replied that it could do in the long run.

99/23.12 Dr McClean advised that the 3 areas the AIPB is focusing on are frail elderly, mental health and children and the dashboard will contain in-depth information on those areas. She explained that PHA did not wish to develop a tome of information, but rather develop a dashboard which could be demonstrated for the Board. The Chair said that this type of baseline data has never seen by the Board before and that it should form the basis of PHA's strategic planning, and allow the Board to get a sense of where the public health inequalities are so that this information can be fed into the HSC system. The Chief Executive advised that part of PHA's strategic intention to have information at the heart of what it does, and that it should have timely information to enable it to be a more agile organisation. He added that PHA should be aiming to use technology to access a whole range of databases to obtain relevant information. He advised that the Department has already signed off on a number of outcomes it wishes to get from ICS.

99/23.13 A member asked if it is possible for the dashboard to look back at the data from 3 months ago. Dr McClean explained that the dashboard pulls together information from various sources and then data analytics staff can knit it together. She said that PHA uses data all the time. The Chair commented that he wish to see the data being more visible. A member said that it would be useful to compare present data with previous data, but added that there should always be a back up in place and not to be fully dependent on a dashboard. It was agreed that there would be a demonstration of the dashboard **(Action 3 – Dr McClean)**.

99/23.14 A member said that communication is important and that organisations outside the HSC need to be able to access this information. Dr McClean advised that PHA is aiming to carry out the needs assessment in a new way so that the information can be shared with the community and voluntary sector.

99/23.15 A member asked if information on health inequalities can be captured,

for example information on drugs overdoses. Dr McClean advised that the data are knitted together from various sources and information from the Self-Harm Registry could be included. She said that mental health is an area that is being looked at. The Chief Executive commented that each AIPB will have its own priority areas so PHA will have to provide them with the appropriate information. A member welcomed the dashboard saying that it sounded like a positive approach.

100/23 **Item 8 - Update on Refresh and Reshape Programme**

100/23.1 This was cover under Item 7 above.

101/23 **Item 9 – Finance Update**

101/23.1 Prior to presenting the Finance Report, Ms McCaig updated members on a matter discussed at the last Board meeting regarding outstanding monies from the Special EU Programmes Body (SEUPB). She said that almost 50% of the outstanding funding has now been paid.

101/23.2 Ms McCaig reported that as per PHA's Financial Plan, there is a projected year-end deficit of £650k, but this is now moving closer to a break-even position. She explained that funding has been secured for HSCQI, some monies have been refunded from the Bank following the fraud case and that there is a number of posts in Dr McClean's directorate which are coming vacant thus creating additional slippage in the management and administration budget. She noted that there is an issue with demand for Nicotine Replacement Therapy being higher than anticipated. She advised that the next Finance Report will show a projected year-end deficit of approximately £400k, but following a review of the current situation this may have reduced further to around £200k.

101/23.3 Ms McCaig advised that following the discussion earlier in the meeting regarding the savings proposals paper presented to the PPR meeting, she wished to clarify that the management and administration budget should not be protected, but and that all aspects of PHA funding need to be looked at in the round and that all impacts of plans need to be considered on relative merits including an Equality Impact Assessment. The Chief Executive agreed that all budgets need to be scrutinised in order to determine where savings can be made. He noted that PHA is in the middle of a restructure and this may generate savings.

101/23.4 A member said that it is unrealistic to expect that by next year all of the vacant posts will be filled and therefore the management and administration budget will continue to provide savings. Ms McCaig said that PHA needs to be agile and savings will likely come from both budgets. She added that there needs to be discussion about the impact of savings and whether some areas are being pushed harder than others. She advised that she would continue to keep the Department updated on behalf of PHA.

101/23.5 The Chair said that he appreciated that it is difficult to land on a break-even position. Ms McCaig reminded members that the Chief Executive, as Accounting Officer, has a responsibility to ensure that the organisation breaks even.

101/23.6 The Chair asked whether a decision has been made regarding the retraction of £3.2m of R&D funding for this year and if he should write to the Permanent Secretary regarding this. Ms McCaig advised that she had spoken to the Permanent Secretary about this and that she would ask him about it again next month as a decision needs to be made. The Chair said that if PHA feels that this funding is important, this should be reflected back to the Department. Ms McCaig suggested that the Chair should write to the Permanent Secretary **(Action 4 – Chair)**.

101/23.7 The Board noted the Finance Report.

102/23 Item 10 – Update from Chair of Planning, Performance and Resources Committee

102/23.1 This was covered under Item 6 above.

103/23 Item 11 – Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order (PHA/02/08/23)

Ms Karen Braithwaite joined the meeting for this item

103/23.1 Mr Wilson advised that the Annual Progress Report to the Equality Commission is structured with various chapters and that PHA has no license to alter this. He gave an overview of what is contained in each chapter.

103/23.2 The Chair agreed that the Report is long and felt that the template does not make it particularly meaningful.

103/23.3 A member asked for an assessment of how the outcomes in this Report are helping to reduce health inequalities and how meaningful a tool the Report is for the PHA. Ms Braithwaite said that the format of the Report is unhelpful, but PHA works with the Equality Unit in BSO to complete it. She commented that the Report ensures that PHA focuses on ensuring that PHA reports on all the work that it does in the area of equality and acts an *aide memoire* to address areas such as training and the completion of Equality Screenings. She added that a lot of PHA staff have undertaken equality training.

103/23.4 Ms Braithwaite advised that this Report represents Year 5 of a 5-year plan and that there are some actions which were not completed due to the pandemic so there has been a focus on developing new Equality and Disability Action Plans.

103/23.5 Ms Braithwaite noted that PHA does not receive feedback from the Equality Commission on this report and so there is a question to be asked about what the investment in for doing this Report, other than it being a statutory duty. A member said that everything PHA does falls within this Report, but there should be a look at the cost and benefit of compiling it. The member asked if there has been a high-level discussion with the Equality Commission. Ms Braithwaite said that PHA is good at doing work which has an impact on equality but is not good at recording it in such a way as it fits within the template of this Report.

103/23.6 A member commented that when thinking about PHA's role in terms of health inequalities, this Report does not look at inequalities in terms of poverty and asked how PHA measures this. The Chair said the format of this Report is around changes in organisational development vis-à-vis equality as opposed to societal development. He asked if PHA has had any discussion with the Equality Commission. The Chief Executive commented that this Report shows how PHA is being compliant with the law in terms of its equality obligations instead of how it deals with inequalities as a statutory obligation rather than how PHA conducts its business.

103/23.7 The Chair asked if it is worthwhile having a discussion with the Equality Commission. Mr Wilson suggested that it may be useful given PHA has now commenced on a new 5-year Equality Plan. He noted that Programme for Government (PfG) is the main document for driving how Northern Ireland creates a fairer society. A member said that there was formerly an initiative around targeting social need and asked how it has been replaced. Mr Wilson replied that PfG was to replace that. The Chief Executive said that he would be content to arrange a meeting with the Equality Commission and the Chair suggested that whoever is Interim Chair at that time should accompany him **(Action 5 – Chief Executive)**.

103/23.8 The Board **APPROVED** the Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order.

104/23 Item 12 – Draft Substance Use Strategic Commissioning and Implementation Plan (PHA/03/08/23)

Mr Kevin Bailey joined the meeting for this item

104/23.1 Mr Wilson said that this Plan has been presented to the PPR Committee and that Mr Bailey would give members an overview. He advised that the Plan has been modified to ensure that the PHA's role is clearly defined vis-à-vis that of SPPG. He added that following approval the Plan will go for public consultation in September.

104/23.2 Mr Bailey explained that this framework has been developed in response to the Departmental strategy and that over 150 organisations

have been involved in its development. At the first meeting of the PPR, he said that a number of challenges were highlighted which he has sought to address. He said that the targets that PHA is responsible for have been separated from those of SPPG, but added that there remains some overlap. He advised that following approval a public consultation will commence on 4 September and there will be a series of engagement workshops. Following the consultation, he said that the Plan will be redrafted and a final document brought to the Board which will outline PHA's priorities in this area for the next 4/5 years, and then procurement for regional services can commence.

104/23.3 A member said that there has been phenomenal work to produce this Plan and that it now clearly sets out the short, medium and long term objectives as well as those elements for which PHA is responsible. The member added that the Plan has also been considered at the Procurement Board.

104/23.4 A member asked what the biggest friction point has been developing this document. Mr Bailey replied that the document was compiled using a co-production approach but there is always a mismatch between what services want and what the service user actually needs. He added that there will be a challenge in terms of keeping a momentum on this work as well as getting additional funding from the Department. He said that PHA will have to reinvest money from one service into another.

104/23.5 A member acknowledged that this is a high level document, but asked what outcomes have been determined and how these will be monitored. The member noted that there are financial constraints and asked if the shortfall has been identified. The member said that within the document it indicates that PHA has to reprioritise and asked if there is a matrix for working that through. If no funding is available, the member asked if this means that full implementation will not be achieved and if PHA is prepared to live with that scenario.

104/23.6 In terms of outcomes, Mr Bailey responded that it is difficult to include those at a population level. He added that the Chief Medical Officer has asked for a framework to be developed but noted that PHA cannot go outside the statutory outcomes that are within the Department's Strategy and these will be monitored. With regard to the financial context, Mr Bailey said that it would be remiss to not set out that this is tough at present. He said that PHA is currently content with the services on the ground. He advised that this is a high level Plan and PHA will put in place an operational strategy and part of that will look at developing outcomes. He said that a risk matrix has not been developed, but he would take guidance on this. On what would happen if there was no funding, he pointed out that the overall Strategy is about saving lives.

104/23.7 The Chief Executive said that he wished to thank Mr Bailey for his work and added that PHA has to commit to this work acknowledging that it may have operational consequences. He explained that there may be

difficult conversations in terms of whether the actions in the Plan are in line with PHA's Strategy or if funding needs to be reinvested elsewhere. He noted that the Plan will also be signed off by SPPG as it relates to services being provided in Trusts.

104/23.8 A member commended the Plan saying that work is important as helping people early will have an impact in their later life. Another member said that this Plan repositions services that go together, thus de-stigmatising those services. Mr Bailey advised that this work links with PHA's Annual Business Plan. The Chair commented that if PHA is in a situation where funding is not available then it needs to have evidence to determine where its priorities lie.

104/23.9 The Chair thanked Mr Bailey for his work. Mr Bailey said that thanks should also go to staff in SPPG and PHA Operations.

104/23.10 The Board **APPROVED** the draft Substance Use Strategic Commissioning and Implementation Plan.

105/23 Item 13 – Performance Management Report (PHA/04/08/23)

105/23.1 Mr Wilson presented the Performance Management Report and said that members will be familiar with its format. He said that of the 37 actions against the 10 priorities in PHA's Business Plan for 2023/24, 1 action has been rated "red". He explained that this relates to HSCQI and represented the position as at the end of June, but that has now changed as per the discussion earlier in the meeting. He advised that of the remaining actions, 15 are rated "amber" and 21 are rated "green".

105/23.2 A member asked if there are any major issues to be reported in relation to the action plan targets. Mr Wilson explained that this relates to the Part B Business Plan and that no actions are currently rated as "red".

105/23.3 A member asked when the action rated "red" regarding HSCQI will move to "green". Dr Keaney said that she hoped that it would be rated "amber" by the time the next report is produced but there is a slight delay in implementing HSCQI's work plan.

105/23.4 A member asked whether the target of a 1% rise in vaccinations is an overall increase, or within each programme. Dr McClean explained that within the pre-school programme many of the vaccination programmes are joined up and that the World Health Organisation target is 95%. She advised that there is an issue with uptake in the Belfast area which is impacting on the figures. She added that there are also data issues as information is captured on different systems. She said that disadvantaged areas have lower uptakes.

105/23.5 The Chief Executive advised that he recently met with the Royal College of General Practitioners (RCGP) and the issue of vaccination was discussed at that meeting. He added that PHA will also meet with the

GP Federation in Belfast. A member asked if these meetings happen regularly, but the Chief Executive explained that it was the organisations themselves who initiated these meetings. The member noted that within the Substance Use Strategy, there appears to be better links with pharmacies than with GPs. The member asked if PHA has a role in managing this. Ms McCaig explained that this work would fall under the auspices of Mr Joe Brogan and Ms Mary O'Brien within SPPG. The Chief Executive said that at the next meeting there will be discussion on opioid use and antimicrobial prescribing. Dr Keaney advised that HSCQI has commenced 3 new work programmes, and there is a plan to establish a Medication Supply collaborative.

105/23.6 Members noted the Performance Management Report.

106/23 Item 14 – Any Other Business

106/23.1 A member advised of their recent attendance at a meeting with the Agri-Food and Biosciences Institute and asked if PHA would work with the Institute. Dr McClean said that PHA does have links with DAERA and the Chief Veterinary Officer and recently attended an all-Ireland exercise on Avian Influenza in Dundalk.

107/23 Item 15 – Details of Next Meeting

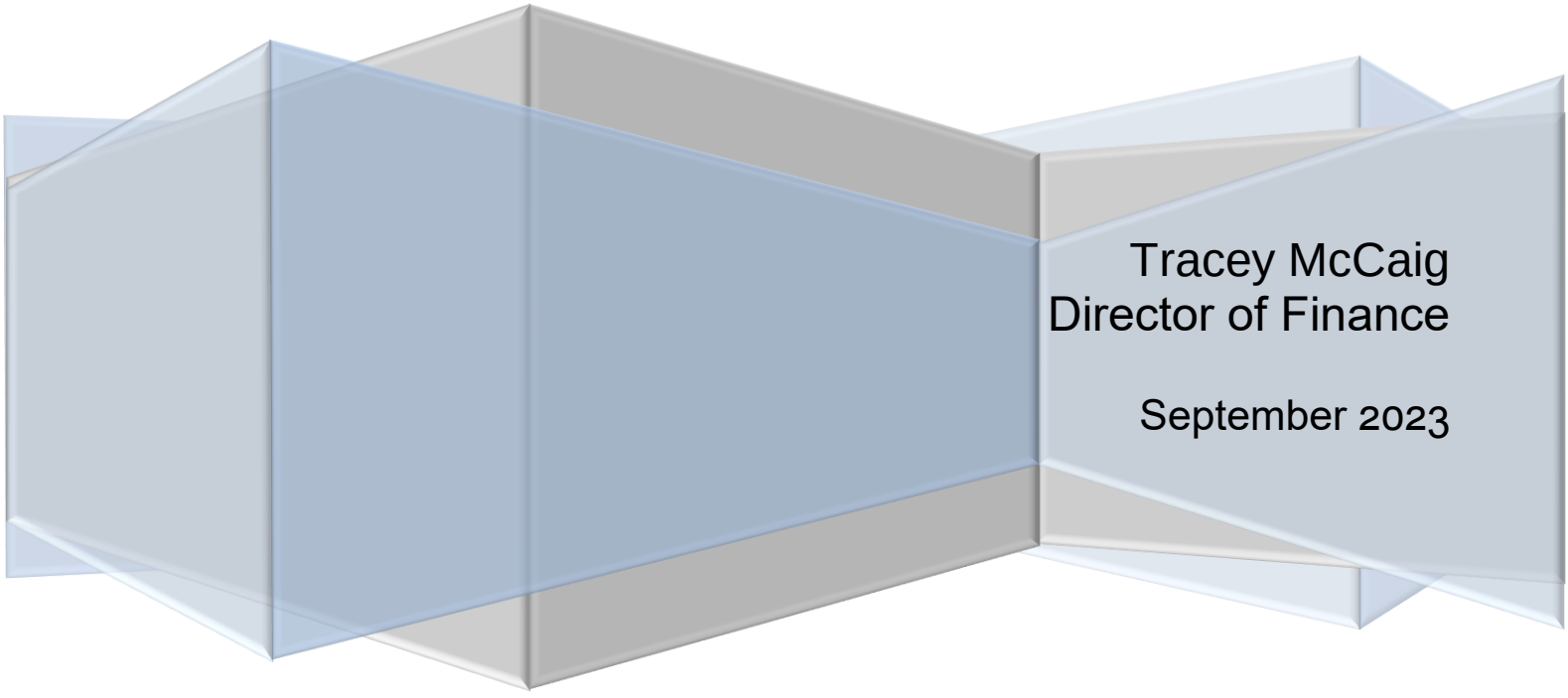
Thursday 19 October 2023 at 1.30pm

Board Room, County Hall, Ballymena

Signed by Chair:

Date:

Finance Report
August 2023



Tracey McCaig
Director of Finance

September 2023

Section A: Introduction/Background

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

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

3. This executive summary report reflects the draft year-end position as at the end of August 2023 (month 5). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

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

Table 1: Opening financial position 2023/24

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

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

5. The PHA has reported a surplus at August 2023 of £0.3m (July 2023, surplus of £0.2m) against the year to date budget position for 2023/24. The forecast year-end position is reported as breakeven (July 2023 forecast, £0.28m deficit), with the reduction primarily relating to a movement in the area of Management and Administration.

6. The month 5 position is summarised in Table 2 below.

Table 2: PHA Summary financial position - August 2023

	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Projected year end surplus / (deficit)
	£'000	£'000	£'000	£'000	£'000
Health Improvement	12,690	5,287	5,287	0	
Health Protection	9,541	3,975	3,975	0	
Service Development & Screening	14,689	6,120	6,120	0	
Nursing & AHP	7,188	2,995	2,995	0	
Centre for Connected Health	0	0	0	0	
Quality Improvement	24	10	10	0	
Other	0	0	0	0	
Programme expenditure - Trusts	**44,131**	**18,388**	**18,388**	**0**	**0**
Health Improvement	29,293	10,304	10,613	(309)	
Health Protection	15,262	5,694	5,812	(117)	
Service Development & Screening	3,148	907	1,000	(92)	
Research & Development	52	0	0	0	
Campaigns	867	118	179	(61)	
Nursing & AHP	1,192	98	124	(26)	
Quality Improvement	193	18	2	17	
Other	(187)	(90)	(14)	(76)	
Programme expenditure - PHA	**49,820**	**17,049**	**17,714**	**(665)**	**(2,421)**
Subtotal Programme expenditure	**93,952**	**35,437**	**36,102**	**(665)**	**(2,421)**
Public Health	16,691	6,955	6,364	591	
Nursing & AHP	5,089	2,125	1,935	190	
Operations	5,367	2,235	2,119	117	
Quality Improvement	717	274	279	(5)	
PHA Board	456	159	143	16	
Centre for Connected Health	458	204	173	31	
SBNI	840	349	303	46	
Subtotal Management & Admin	**29,618**	**12,301**	**11,315**	**986**	**2,421**
Trusts	272	91	91	0	
PHA Direct	0	0	0	0	
Subtotal Transformation	**272**	**91**	**91**	**0**	**0**
Trusts	147	0	0	0	
PHA Direct	3,444	624	634	(10)	
Other ringfenced	**3,591**	**624**	**634**	**(10)**	**0**
TOTAL	**127,432**	**48,453**	**48,142**	**311**	**0**

Note: Table may be subject to minor roundings.

Note: Table may be subject to minor roundings

7. In respect of the reported position:
   - **Programme – Trusts**: A total of £44.1m has been allocated to Trusts at this point, with full spend against budget shown.

- **Programme – PHA**: The remaining annual programme budget is currently £49.8m.
    - A cumulative overspend of £0.5m is shown to date (month 4, £0.5m) against the Programme budgets listed. This reflects some areas of spend ahead of current budget.
    - In line with the Financial Plan, the anticipated overspend for the year is c£2.4m with the overspend being met in 2023/24 by a forecast underspend in Administration budgets. Whilst work has completed to identify £3.6m of budget reductions in-year, work is ongoing to fully identify the remaining savings measures to meet the full financial target applied to PHA in 2023/24 and recurrently.
    - Savings plans will be closely monitored throughout the year and will be regularly reported to the AMT and PPR Committee.

- **Management & Administration**: Annual budget of £29.5m.
    - An underspend of £1.0m is reported to date (month 4, £0.8m), reflecting underspends in Public Health, Nursing & AHPs and Operations. The primary movement to date relates to the area of Public Health where staff costs have reduced due to role vacancies. Expenditure against funded budgets are reviewed with Directorate budget holders to understand any ongoing trends and incorporate these into the year-end forecast position.
    - The forecast full year underspend has been updated to £2.4m (month 4, £1.4m). The level of anticipated underspend has increased as initial forecasts are updated and these will be subject to further refinement based on ongoing updates from Directorate budget managers and the review of assumptions made in the Financial plan in respect of anticipated cost pressures. Information has been received on the reduction of senior medical posts, however some assumptions have been made regarding the timing of the replacement or recruitment of these posts, which may have to be updated to increase expenditure forecasts if necessary.
    - The anticipated underspend will offset, in-year, cash releasing savings applied fully to Programme budgets. The favourable movement has

therefore enabled a reduction in the Agency's forecast deficit to report breakeven.

- **Ringfenced**: There is annual budget of c£3.9m in ringfenced budgets, the largest element of which relates to a Covid funding allocation for the Vaccine Management System (£2.7m), along with other funding allocations such as Safe Staffing (£0.3m) and Suicide Prevention (£0.3m) and smaller allocations for NI Protocol and for SBNI. A breakeven position is assumed against these budgets for the year, however they will be closely monitored for any risk to breakeven throughout the year.

8. As noted above, the projected year end position is a reduction in the overall deficit to breakeven (month 4, £0.28m) and work will continue to identify measures to maintain this breakeven position.

Section C: Risks

9. The following significant assumptions, risks or uncertainties facing the organisation were outlined in the Financial Plan.

10. **Recurrent impact of savings made non-recurrently in-year**: The opening allocation letter has indicated that, whilst 2023/24 savings measures may be non-recurrent in nature, the funding reductions are recurrent and therefore PHA is expected to work to ensure savings are made recurrently going forward into 2024/25 where necessary. While PHA has identified a significant element of the £5.3m savings target applied (excluding the £3.2m reduction relating to PHA R&D), there remain challenges in delivering the full requirement in year and recurrently. PHA colleagues have identified savings / budget reductions for £3.6m in-year and are continuing to work on developing savings proposals to address the remaining gap. Savings targets will be monitored throughout the year with the identification of recurrent savings plans finalised well in advance of 2024/25.

11. **R&D revenue retraction:** A further £3.2m funding retraction has been applied in respect of the revenue Research & Development (R&D) budget, which eliminates this budget entirely. The formal allocation letter from DoH indicated that this funding

is being held pending a decision to proceed with this expenditure. If this funding is not allocated, PHA will be unable to participate in the National Institute for Health and Care Research scheme. This is a significant risk for Health & Social Care in Northern Ireland both now and in the future and the Interim Chair has written to the Permanent Secretary to set out the impacts for NI if not funded, with a decision pending.

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 report from EY will not be available until later in the year. There is a risk in implementing the outcomes of this review in a savings context, and careful management will be required at all stages of this process. In addition, there have been a number of material vacancies which are generating slippage and for which Directors are reviewing options for the remainder of the year.

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 not been receiving payments on a regular basis. At 31 March 2023, the value of funding due was c£4.3m however, PHA had an equal and opposite creditor listed for monies due to other organisations. Since year end a total of now c£2.1m has been received. R&D staff are continuing to work closely with colleagues in partner organisations and the relevant funding body to ensure the expected full reimbursement of all claims.

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, early initial indications are that there may be expenditure pressures in the area of smoking cessation / Nicotine Replacement Therapy (NRT). The financial position of these budgets are being carefully tracked. These budgets will be kept under close review throughout the year.

15. **Annual Leave:** PHA staff are still carrying a significant amount of annual leave, due to the demands of responding to the Covid-19 pandemic over the last two years. This balance of leave is being managed to a more normal level, and the assumption

that this is expected to be at pre-pandemic levels by the end of 2023/24 has been included in financial planning and will be kept under close review.

16. **Funding not yet allocated**: At the start of the financial year there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include Pay awards for the 2023/24 financial year. No expenditure will be progressed for any pay award payments to staff until such pay awards are approved by DoH and funding identified and secured.

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

Section D: Update - Capital position

18. The PHA has an opening capital allocation (CRL) of £13.1m. This currently all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at August 2023, is reflected in Table 3, being a forecast breakeven position on capital funding.

19. 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.

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

breakeven position. Further information on delays experienced in the reimbursement of costs is provided in Section C, above.

Table 3: PHA Summary capital position – August 2023

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	4,938	748	4,938	0
R&D - Trusts	8,136	0	8,136	0
R&D Capital Receipts	(1,074)	0	(1,074)	0
Subtotal HSC R&D	**12,000**	**748**	**12,000**	**0**
CHITIN Project:				
CHITIN - Other Bodies	1,040	0	1,040	0
CHITIN - Trusts	138	0	138	0
CHITIN - Capital Receipts	(1,178)	0	(1,178)	0
Subtotal CHITIN	**0**	**0**	**0**	**0**
Other:				
Congenital Heart Disease Network	683	0	683	0
iReach Project	405	0	405	0
Subtotal Other	**1,088**	**0**	**1,088**	**0**
Total HSCB Capital position	**13,088**	**748**	**13,088**	**0**

21. PHA has also received two other smaller capital allocations for the Congenital Heart Disease (CHD) Network (£0.7m) and iReach Project (£0.4m), both of which are managed through the PHA R&D team.

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

Recommendation

23. The PHA Board are asked to note the PHA financial update as at August 2023.

Public Health Agency

Annex 1 - Finance Report

2023/24

Month 5 - August 2023

PHA Financial Report - Executive Summary

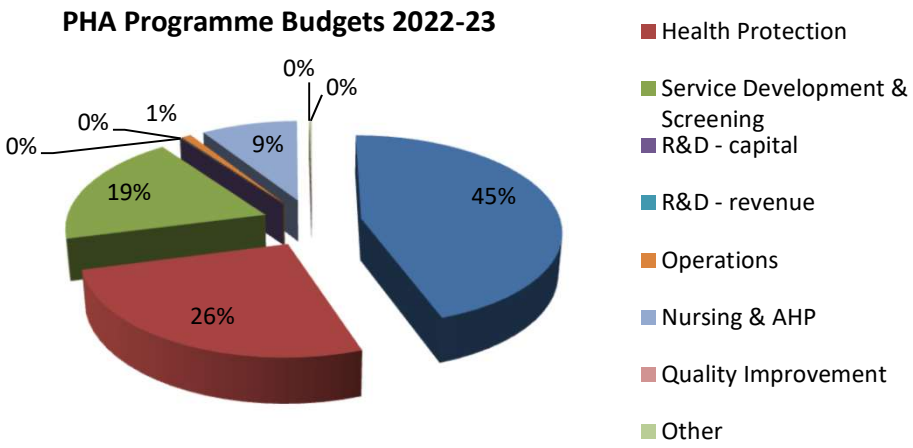
Year to Date Financial Position (page 2)

At the end of month 5, PHA is reporting an underspend of £0.3m against its profiled budget. This position is a result of PHA Direct programme budgets projected overspend for the financial year offset by underspends within Adminstration budgets (page 6).

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

Programme Budgets (pages 3&4)

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

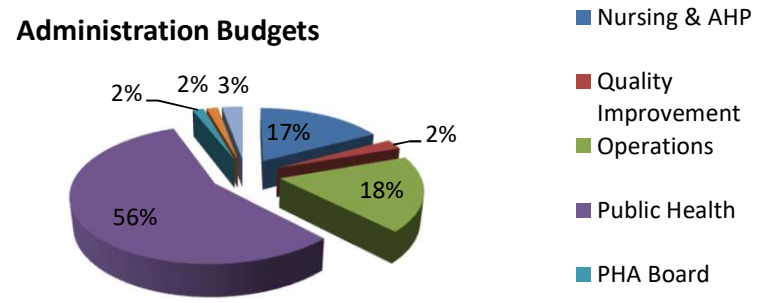


Administration Budgets (page 5)

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

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

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



Full Year Forecast Position & Risks (page 2)

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

This reflects the continued requirement to fully identify savings measures to meet the full cash releasing savings funding reductions applied to PHA in 2023/24.

Public Health Agency

2023/24 Summary Position - August 2023

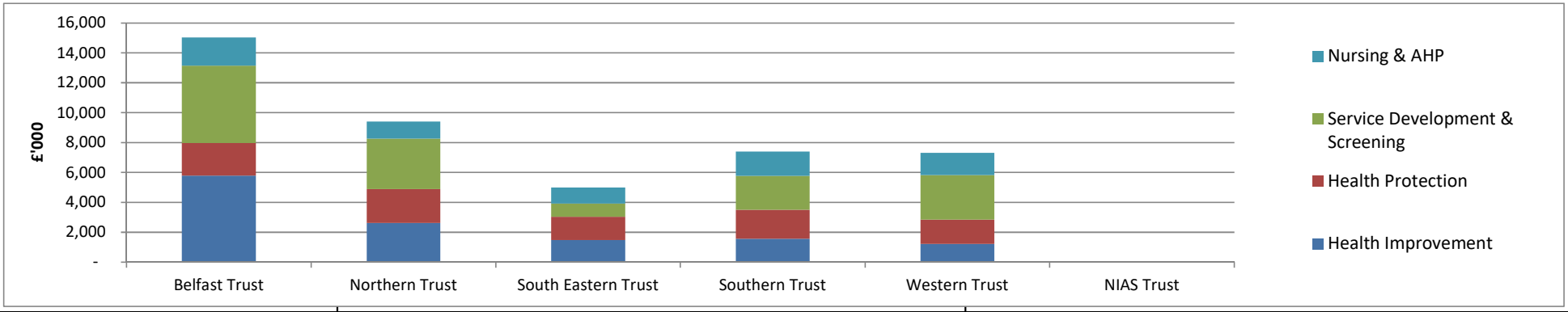
	Annual Budget					Year to Date				
	Programme		Ringfenced	Mgt &	Total	Programme		Ringfenced	Mgt &	Total
	Trust	PHA Direct	Trust & Direct	Admin		Trust	PHA Direct	Trust & Direct	Admin	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources										
Departmental Revenue Allocation	44,131	49,799	3,863	28,903	**126,696**	18,388	17,049	715	12,301	**48,453**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	21	-	715	**736**	-	-	-	-	**-**
Total Available Resources	44,131	49,820	3,863	29,618	**127,432**	18,388	17,049	715	12,301	**48,453**
Expenditure										
Trusts	44,131	-	359	-	**44,490**	18,388	-	152	-	**18,540**
PHA Direct Programme *	-	52,241	3,504	-	**55,744**	-	17,714	573	-	**18,287**
PHA Administration	-	-	-	27,197	**27,197**	-	-		11,315	**11,315**
Total Proposed Budgets	44,131	52,241	3,863	27,197	**127,432**	18,388	17,714	725	11,315	**48,142**
Surplus/(Deficit) - Revenue	-	(2,421)	-	2,421	**-**	-	(665)	(10)	986	311
Cumulative variance (%)						***0.00%***	***-3.90%***	***-1.44%***	***8.02%***	***0.64%***

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 an underspend £0.3m, which is a result of PHA Direct Programme expenditure being in an overspend position and being offset by an underspend within the area of Management & Admin.

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

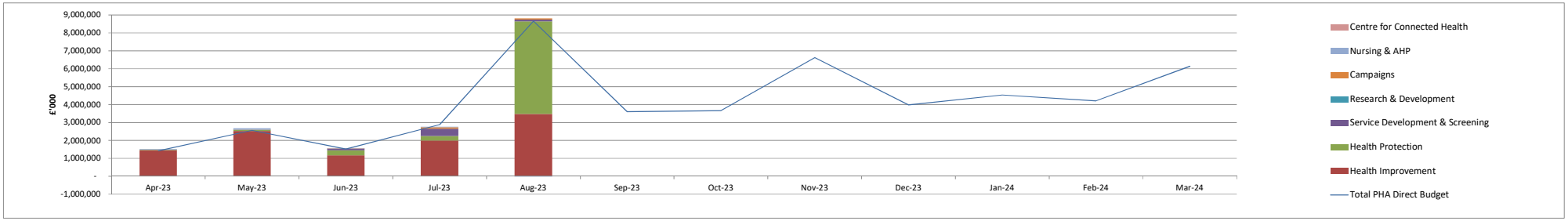
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,792	2,619	1,489	1,573	1,216	-	**12,690**	5,287	5,287	-
Health Protection	2,179	2,269	1,542	1,923	1,628	-	**9,541**	3,975	3,975	-
Service Development & Screening	5,164	3,372	889	2,278	2,985	-	**14,689**	6,120	6,120	-
Nursing & AHP	1,890	1,138	1,064	1,618	1,477	-	**7,188**	2,995	2,995	-
Quality Improvement	24	-	-	-	-	-	**24**	10	10	-
Other								-		
Total current RRLs	**15,051**	**9,399**	**4,984**	**7,392**	**7,306**	**-**	**44,131**	**18,388**	**18,388**	**-**
Cumulative variance (%)										***0.00%***

The above table shows the current Trust allocations split by budget area. A breakeven position is shown for the year to date as funds have been issued to Trusts in July 2023.

PHA Direct Programme Expenditure



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total	YTD Budget	YTD Spend	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
Profiled Budget																	
Health Improvement	1,318	2,228	1,356	1,920	3,482	1,225	2,414	4,215	1,770	3,460	3,327	2,578	**29,293**	10,304	10,613	(309)	*-3.0%*
Health Protection	42	204	184	122	5,143	2,217	1,132	1,668	1,521	632	234	2,164	**15,262**	5,694	5,812	- 117	*-2.1%*
Service Development & Screeni	29	73	219	493	93	105	21	609	517	269	436	283	**3,148**	907	1,000	(92)	*-10.2%*
Research & Development	-	-	-	-	-	-	-	-	-	-	-	52	**52**	-	-	-	*0.0%*
Campaigns	1	1	9	90	18	28	60	100	145	153	148	116	**867**	118	179	(61)	*-52.0%*
Nursing & AHP	32	53	- 33	21	26	26	35	37	30	24	70	871	**1,192**	98	124	(26)	*-26.1%*
Quality Improvement	-	-	-	-	18	-	-	-	-	-	-	175	**193**	18	2	17	*91.4%*
Other	-	-	(212)	245	- 122	-	-	-	0	0	0	(97)	**(187)**	(90)	-14	(76)	*100.0%*
Total PHA Direct Budget	**1,421**	**2,558**	**1,522**	**2,890**	**8,658**	**3,602**	**3,663**	**6,628**	**3,982**	**4,539**	**4,215**	**6,142**	**49,820**	**17,049**	**17,714**	**(665)**	
Cumulative variance (%)																***-3.90%***	
Actual Expenditure	**1,608**	**2,765**	**1,643**	**2,898**	**8,801**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**17,714**				
Variance	**(187)**	**(207)**	**(121)**	**(7)**	**(143)**								**(665)**				

The year-to-date position shows an overspend of approximately £0.7m against profile. A year end overspend of c£2.4m is anticipated with the overspend being met in 2023/24 by a forecast underspend in Administration budgets. Whilst work has completed to identify £3.6m of budget reductions in-year, work is ongoing to fully identify the remaining savings measures to meet the full financial target applied to PHA in 2023/24 and recurrently.

Public Health Agency
2023/24 Ringfenced Position

	Annual Budget				Year to Date			
	Covid	NDNA	Other ringfenced	Total	Covid	NDNA	Other ringfenced	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Available Resources								
DoH Allocation	2,854	272	563	**3,690**	350	91	274	**715**
Assumed Allocation/(Retraction)	-	-	173	173	-	-	-	**-**
Total	2,854	272	737	**3,863**	350	91	274	**715**
Expenditure								
Trusts	-	212	147	**359**	-	91	61	**152**
PHA Direct	2,854	60	590	**3,504**	350	-	222	**573**
Total	2,854	272	737	**3,863**	350	91	284	**725**
Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**	**(10)**	**(10)**

PHA has now received COVID allocation of £2.9m (£2.7m for Vaccine Management System & £0.2m for Vaccinators and Covid Vaccine Storage) for financial year 2023/24.

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

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

PHA Administration

2023/24 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	4,905	705	4,242	16,449	343	411	589	**27,644**
Goods & Services	184	12	1,125	242	113	47	251	**1,974**
Total Budget	**5,089**	**717**	**5,367**	**16,691**	**456**	**458**	**840**	**29,618**
Budget profiled to date								
Salaries	2,045	269	1,767	6,852	143	186	245	**11,507**
Goods & Services	80	5	469	103	16	18	104	**794**
Total	**2,125**	**274**	**2,235**	**6,955**	**159**	**204**	**349**	**12,301**
Actual expenditure to date								
Salaries	1,857	277	1,324	6,098	132	160	242	**10,091**
Goods & Services	78	1	794	266	11	12	61	**1,224**
Total	**1,935**	**279**	**2,119**	**6,364**	**143**	**173**	**303**	**11,315**
Surplus/(Deficit) to date								
Salaries	189	(8)	443	754	11	26	3	**1,417**
Goods & Services	1	4	(326)	(163)	5	5	43	**(431)**
Surplus/(Deficit)	**190**	**(5)**	**117**	**591**	**16**	**31**	**46**	**986**
Cumulative variance (%)	*8.95%*	*-1.74%*	*5.22%*	*8.49%*	*9.99%*	*15.35%*	*13.19%*	***8.02%***

PHA's administration budget is showing a year-to-date surplus of £1.0m, which is being generated by a number of vacancies, particularly within Public Health Directorate. 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£2.4m, which is contributing towards PHAs forecast deficit in Programme expenditure in the financial year'

PHA Prompt Payment

Prompt Payment Statistics

	Aug 2023 Value	Aug 2023 Volume	Cumulative position as at Aug 2023 Value	Cumulative position as at Aug 2023 Volume
Total bills paid (relating to Prompt Payment target)	£6,024,483	495	£22,145,131	2,347
Total bills paid on time (within 30 days or under other agreed terms)	£5,954,556	470	£21,568,054	2,240
Percentage of bills paid on time	**98.8%**	**94.9%**	**97.4%**	**95.4%**

Prompt Payment performance for August shows that PHA achieved its prompt payment target on value but narrowly missed it on volume. The year to date position shows that on both value and volume, PHA is achieving its 30 day target of 95.0%. Prompt payment targets will continue to be monitored closely over the 2023/24 financial year.

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

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	12 September 2023 at 10am
Venue	Meeting Rooms 2&3, 2nd Floor, 12/22 Linenhall Street, Belfast

Present

Mr Joseph Stewart	-	Chair
Mr John Patrick Clayton	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director (*via video link*)
Ms Deepa Mann-Kler	-	Non-Executive Director (*via video link*)

In Attendance

Mr Stephen Wilson	-	Interim Director of Operations
Mr Stephen Murray	-	Interim Assistant Director of Planning and Business Services
Ms Claire Devine	-	Assistant Director of Finance, SPPG
Ms Caren Crockett	-	Head Accountant, SPPG
Mrs Catherine McKeown	-	Internal Audit, BSO
Mr David Charles	-	Internal Audit, BSO (*via video link*)
Mr Roger McCance	-	NIAO
Mr Robert Graham	-	Secretariat

Apologies

Ms Tracey McCaig	-	Director of Finance, SPPG
Ms Colette Kane	-	NIAO

40/23	**Item 1 – Welcome and Apologies**
40/23.1	Mr Stewart welcomed everyone to the meeting. Apologies were noted from Ms Tracey McCaig and Ms Colette Kane.
41/23	**Item 2 - Declaration of Interests**
41/23.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda.
41/23.2	Mr Clayton noted that within the Corporate Risk Register, there are references to Public Inquiries, and how the PHA is responding to these, and therefore given Unison's involvement with Inquiries, he felt he should declare an interest.

42/23 **Item 3 – Minutes of previous meetings held on 8 June 2023**

42/23.1 The minutes of the previous meeting, held on 8 June 2023 were **approved** as an accurate record of that meeting.

43/23 **Item 4 – Matters Arising**

31/23.4 Corporate Risk Register

43/23.1 Mr Stewart advised that a risk around the Reshape and Refresh work remains under consideration by the Agency Management Team (AMT), and that he had discussed this yesterday at a pre-meeting with Mr Wilson. He noted that there a Risk Register for the Project Board, but this will be different to the one of the Agency.

43/23.2 For action 2 on the previous minutes regarding late receipt of payments from the Special EU Programmes Body (SEUPB), Mr Stewart noted that Ms McCaig had updated members on this at a previous Board meeting and he did not consider that any further action was required on his part.

44/23 **Item 5 – Chair's Business**

44/23.1 Mr Stewart advised that he had no Chair's Business.

45/23 **Item 6 – Internal Audit**

Internal Audit Progress Report [GAC/28/09/23]

45/23.1 Mr Charles advised that he was presenting two reports today, one following an audit of the management of community and voluntary sector contracts and a second around complaints and claims. He added that Internal Audit has delivered against 31% of its Service Level Agreement for this year and that all KPIs are on track.

45/23.2 Mr Charles reported that a limited level of assurance has been given to the audit of the management of voluntary organisation contracts. He explained that there was a specific focus on mental health and suicide prevention services.

45/23.3 Mr Charles advised that there were 2 significant findings, the first of which related to procurement. He highlighted that 291 contracts (104 of which were mental health and suicide prevention), with a value of £17.6m, have not been subject to a recent competitive award process and have been rolled forward. He added that because PHA had to refocus its resources during the pandemic, procurement timelines have been delayed. He noted that the rolling forward of contracts could mean that there may be similar contracts in different organisations, but at different rates. He said that current contracts are focused on measuring outputs rather than outcomes, but he acknowledged that work on outcomes measurement is at an early stage.

45/23.4 Mr Charles said that the second finding relates to contract validation as this process was stood down during the pandemic. He advised that there has been no sample validation of quarterly returns, something which was in place before the pandemic.

45/23.5 Mr Charles went through the key findings of the report. He noted that contract leads have not received training in how to complete Progress Monitoring Returns (PMRs), and that organisations have to manually input activity into a Word document rather than an Excel spreadsheet which could add up the data. He added that there are no KPIs in place and that there has been no formal reporting to AMT or the Board. He said that although contract leads have requested documents for review, these have not been reviewed appropriately.

45/23.6 Mr Charles advised that a total of 9 recommendations have been made, one of which is a Priority 1, and that management has accepted all of the recommendations.

45/23.7 Mr Clayton said that this was a very useful report as this has been an area of concern for the Committee and the Board for a long period. He added that the report gives the Committee a better sense of the issues regarding the current process and outlines what needs to be done going forward. He acknowledged that there has been difficulty for PHA in terms of being able to measure outcomes rather than outputs.

45/23.8 Mr Clayton outlined that his main concern was around the Priority 1 recommendation as PHA does not often receive many of those. He noted that there was an implementation date of this recommendation going back to 2015 and then has now been revised to 2026 and there is a significant amount of work to be done to achieve this. He asked if he could get a sense of why it will take this long and how the Committee will be kept updated on how the work is progressing. He acknowledged that there are issues around internal procurement capacity. Looking at the target to undertake 10 verification visits by March 2024, he asked how this number was determined.

45/23.9 Ms Mann-Kler said that she echoed many of Mr Clayton's comments and welcomed this report as it highlighted the concerns that the Committee has had. She asked how PHA intends to respond to the findings, acknowledging that management has accepted them. She queried if PHA is adequately resourced to take the recommendations forward and how progress will be communicated to the Committee and the Board.

45/23.10 Mr Stewart asked if the implementation date of 31 March 2026 for the Priority 1 recommendation is realistic adding that it is embarrassing having a recommendation that has been outstanding for 11 years.

45/23.11 Mr Wilson said that a number of the findings from the audit did not come as a surprise and reflected the operational issues that PHA is

experiencing. He added that PHA is not adequately resourced in this area and that as part of the Reshape and Refresh work, there is a need to look at where contract management sits and to bring it into the corporate side as this would be a more sensible approach. In terms of reviewing returns and completing validation visits, he conceded that there is a lack of capacity and that area at this time, but he added that the Procurement Board is well aware of these issues.

45/23.12 Mr Murray explained that there are legal requirements within procurement and it can take PALS a minimum of 12 months to process an individual tender, and that PHA may have up to 7/10 tenders, each of which will take time to process. He outlined that the one area that PHA is in control of is in relation to pre-procurement planning, but there are capacity issues in what is a complex and difficult area. He said that PHA's Procurement Plan requires many teams working in parallel, but the difficulty in then getting work delivered through PALS as it is working on a regional basis. He agreed that the Reshape and Refresh programme will be important in terms of pushing this work up PHA's agenda. However, he conceded that the timelines may slip and that although the implementation is possible, it is reliant on a number of factors.

45/23.13 Mr Stewart said that there is a serious issue if it can take 24 months to complete a procurement. Mr Murray explained that once a certain threshold is exceeded, there is a different process which looks at issues such as TUPE. He added that the nature of PHA's work makes it more open to political challenge. Mr Stewart suggested that there should be an external review of the process as he expressed concern that the deadline of March 2026 is not achievable.

45/23.14 Mr Wilson said that the timescale is ambitious, but that PHA does have a plan in place. He reiterated that this is a system-wide issue, not one solely for PHA and he agreed that perhaps having an external perspective may help with some of the internal issues.

45/23.15 Mr Clayton said that the recommendations around verification visits and KPIs will help give an oversight of how the system is currently operating. However, in terms of how long it takes for a procurement exercise to be completed, he asked if there is an appreciation about the amount of resource required at an HSC level. He noted that there is a considerable amount of money involved in these contracts for PHA, but across the HSC as a whole it would be much bigger.

45/23.16 Mr Murray agreed that procurement capacity is a huge issue across the HSC and that PHA has been raising this for a number of years. He said that a particular skillset is required to complete a procurement exercise. He added that this work is now becoming more complex as GDPR is causing delays of 6/7 months. He reiterated that resourcing is key and that the HSC system has not accepted the scale of resource that is required. He added that PHA is one of the organisations that is most

likely to get challenged with regard to its procurement.

45/23.17 Mr Stewart said that AMT needs to clarify what the requirements are so that if the PHA Chair were to write to BSO, PHA needs to be in a position where its own house is in order.

45/23.18 Mr Murray advised that PHA will be undertaking a review of assurance processes and that validation visits have been re-established. He explained that PHA cannot resource any more than 10 visits this year because it is an intense process, and that PHA is dealing with 70/90 providers per year.

45/23.19 Mrs McKeown noted that as the implementation date of the Priority 1 recommendation is not until 2026, Internal Audit will not be returning to review this area until then. Mr Murray said that the Procurement Board will be looking at this area and can provides updates to the PHA Board.

45/23.20 Mr Charles moved on to the second audit report which related to the management of complaints and claims and advised that a limited level of assurance was being given.

45/23.21 Mr Charles advised that there were 4 significant findings emanating from the audit, the first of which related to how information on complaints is stored in PHA. He said that the second finding is that there is no reporting on complaints at either Executive or Non-Executive Director level and that PHA does not produce a report on complaints in line with a Department of Health Circular from 2019. He advised that the third finding relates to the non-reporting on the status of claims at Executive or Non-Executive level. He said that the fourth finding is that staff have not completed training in respect of complaints management.

45/23.22 Mr Charles reported that there were 3 key findings, the first of which related to the timely completion of complaint investigations and informing complainants if there was going to be a delay. He added that the second finding was that PHA's Complaints Procedure has not been updated since 2012 and that the third finding was that PHA does not thank complainants for bringing issues to its attention or express sympathy around the complaint.

45/23.23 Mr Charles advised that the process for dealing with complaints has moved from the Nursing directorate to the Operations directorate. He added that a total of 10 recommendations have been made and these has been accepted by management.

45/23.24 Mr Wilson reiterated that the complaints function has now moved to the Operations directorate and he welcomed the timing of this audit. Going forward, he assured members that there will a more comprehensive approach to dealing with complaints and he was content to take on board all of the findings from the audit. He noted that prior to the pandemic, PHA did not receive many complaints, but the number has

increased.

45/23.25 Mr Stewart asked Mr Wilson if he anticipated that all of the recommendations would be completed by their due date and Mr Wilson replied that they would be. Mr Stewart noted that complaints is now a standing item of the agenda of PHA Board meetings.

45/23.26 Mr Clayton said that he hoped that the Priority 1 recommendation on complaints records can be rectified quickly. In terms of Board oversight, he noted that while there has been information on complaints in the PHA Annual Report, a separate report on complaints would be helpful. He acknowledged that the number of complaints has been low. With regard to the updating of the Complaints Policy and Procedure, he said that he assumed that this would be brought back to this Committee.

45/23.27 Ms Mann-Kler noted that while the discussion has focused on complaints, compliments are also important. She said that complaints are an important part of the assurance process. She added that she was pleased to see the changes being made to the complaints process and she sought clarity on when the Committee and the Board would receive reports on complaints. Mr Stewart noted that the Chief Executive had given an overview of extant complaints at the last Board meeting and will report on any new complaints at the next month and at the end of the year there will be a cumulative report.

45/23.28 Members noted the Internal Audit Progress Report.

46/23 Item 8 – SBNI Declaration of Assurance [GAC/35/09/23]

Ms Helen McKenzie joined the meeting for this item

46/23.1 Mr Stewart welcomed Ms McKenzie to the meeting. He noted that within the SBNI Declaration of Assurance there was an issue reported around illegal payments and he wished to be assured that the figure within the report is now accurate. Ms McKenzie advised that following a review the figure is now correct.

46/23.2 Mr Stewart sought assurance that there is now a process for closer scrutiny of payments within SBNI and Ms McKenzie confirmed that there are processes in place with HR, Finance and the Department.

46/23.3 Mr Stewart thanked Ms McKenzie for attending the meeting.

46/23.4 Members noted the SBNI Declaration of Assurance.

At this point Ms Mann-Kler left the meeting.

45/23	**Item 6 – Internal Audit (ctd.)**
	Internal Audit Annual HSC General Report 2022/23 [GAC/29/09/23]
45/23.29	Mrs McKeown presented the General Report and gave an overview of the main findings. She reported that 49% of reports received a satisfactory level of assurance, and that 58% of assurances were deemed to be "above the line". She said that a total of 31 Priority 1 recommendations were made, an increase from 19 the previous year. She advised that 82% of Priority 1 and 2 recommendations were fully implemented, the highest rate since these reports were produced.
45/23.30	Mrs McKeown advised that this was the first year where the percentage of audits that were wholly satisfactory was less than 50%. She said that it was difficult to pinpoint the reasons why, but she highlighted that in a number of areas, there were repeat "limited" assurances given. She added that in approximately 10 areas an area where a previous level of "satisfactory" was given had moved to "limited".
45/23.31	Mrs McKeown said that the number of audits carried out has reduced over time with a focus on more complex, risk-based audits. In terms of those audits where a limited/unacceptable level of assurance had been given, she advised that these audits are in areas such as people, procurement and contract management. She outlined the reasons for these levels of assurance being given, which included lack of compliance with processes and training.
45/23.32	Mrs McKeown commented that going forward, there is a need to reduce the volume of limited assurances and she outlined Internal Audit's advice. She said that there needs to be a continued focus on staff training and compliance, prompt implementation of audit recommendations, reduction in the number of outstanding recommendations and development of the 3 Lines Assurance Model. *At this point Mr Irvine left the meeting.*
45/23.33	Mr Stewart advised that a session for Committee members on the 3 Lines Assurance Model will be arranged and that an invite will be circulated for other Board members to join **(Action 1 – Mr Wilson)**.
45/23.34	Mr Clayton said that it would be useful to see how PHA compares to other organisations in terms of how many recommendations it has implemented. Mrs McKeown advised that in next year's report there could be a chart to compare implementation of recommendations year on year. Mr Clayton noted that when making a comparison, the complexity of the particular audits needs to be borne in mind.
45/23.34	Members noted the Internal Audit General Report.
45/23.35	Mr Stewart asked Mr McCance if he had any matters to update on from

an External Audit perspective.

45/23.36 Mr McCance advised that NIAO has completed around round of contracting and that Cavanagh Kelly will be completing PHA's audit, on behalf of NIAO, for the next three years.

Internal Audit Charter [GAC/30/09/23]

45/23.37 Mrs McKeown advised that the Internal Audit Charter is a standard document for all clients and outlines the activity of Internal Audit. She said that it has been approved by the Chief Executive and has been reviewed against a model Internal Audit Charter. She advised that there have not been any substantial changes made to the document, but she has extended the commentary in a number of areas.

45/23.38 Mr Clayton said that he had no comments on the Charter and that it was a useful document.

45/23.39 Members **APPROVED** the Internal Audit Charter.

47/23 Item 7 – Corporate Governance

Corporate Risk Register as at 30 June 2023 [GAC/31/09/23]

47/23.1 Mr Wilson advised that following a review of the Corporate Risk Register as at 30 June, a new risk has been added regarding Inquiries and a risk regarding financial break even has been removed. He explained that this update represents a further development in the implementation of the 3 Lines Assurance Model and that RAG ratings and risk scores have also been included.

At this point Mr Irvine re-joined the meeting.

47/23.2 Mr Wilson noted that many of the risks on the Register have been there for some time and the Register needs an extensive review and he hoped to come back to a future meeting with a more streamlined version. Mr Stewart agreed and said that some of the extensive commentary on the risks is not required. Mr Clayton commented that while some of the commentary is helpful, it could be reduced to give an overview of the most recent actions.

47/23.3 Mr Stewart reported that at his pre-brief with Mr Wilson yesterday, there was a discussion that the rating of the risk around staffing may be increased to severe. He agreed that there needs to a cleansing of the Register.

47/23.4 Mr Clayton asked about risk 55 and suggested that given Internal Audit have carried out an audit on recruitment, progress against recommendations in it should be referenced. He asked if there was any link between staffing issues and the financial position. Mr Wilson

explained that one of the main issues is that there is a dearth of public health consultants because individuals can avail of improved working terms and conditions in posts in UKHSA or in the Republic of Ireland. He added that there is also a number of staff on long term sick leave and then there is also the degree of uncertainty with the ongoing restructuring. Mr Clayton asked if the staff leaving to work in UKHSA can do more work remotely and Mr Wilson confirmed that this is the case.

47/23.5 Mr Stewart advised that it is Mr Wilson's intention to completely revise this risk and bring that forward to the next meeting.

47/23.6 Mr Stewart commented that with regard to risk 60, around the migration of HSCB to SPPG, there remains a fog in terms of the relationship between PHA and SPPG and this is an issue that may need to be raised with the Board given that it has been discussed at recent Public Inquiry hearings. He added that it was also an issue he had raised with the Permanent Secretary.

47/23.7 Mr Stewart advised that risk 61 relating to Lifeline should be removed by the next review as the issues outlined in the risk are close to being resolved.

47/23.8 Members **APPROVED** the Corporate Risk Register.

Operations Directorate Risk Register as at 30 June 2023 [GAC/32/09/23]

47/23.9 Mr Wilson presented the Operations Directorate Risk Register and noted that while it does not appear that there are many risks on it, this is because the nature of the business of this directorate would lead there to being a higher chance that any risks needed to be placed on this Risk Register would instead be on the Corporate Risk Register.

47/23.10 Mr Wilson advised that the first risk on the Register relates to capacity within the information governance team. He said that the second risk relates to website hosting, where it was thought that a solution had been found, but this has not yet been fully worked out so a new Direct Award Contract (DAC) is in place.

47/23.11 Mr Stewart commented that the risk on procurement may need to be elevated.

47/23.12 Mr Clayton said that the issue of capacity within the information governance team is an important one. He noted that Gartner had recently provided some support in this area in terms of updating paperwork within the health protection directorate, and suggested that there is a capacity issue for the organisation as a whole. He said that the Information Governance Steering Group will keep an eye on this issue.

47/23.13 Mr Murray agreed that there is a balance between corporate capacity and focused capacity, e.g. within the health protection directorate. He said that there is a large infrastructure piece that needs to be put in place as GDPR assessments have to be carried out as part of procurement.

47/23.14 Members noted the Operations Directorate Risk Register.

Update on Use of Direct Award Contracts [GAC/33/09/23]

47/23.15 Mr Wilson advised that the number of DACs is reducing and that this report is an analysis of those in place. Mr Stewart expressed concern about the number of DACs relating to SBNI and said that this flags up the uncomfortable nature of the relationship with SBNI. Mr Clayton asked if SBNI completes its own DACs, but Mr Wilson explained that they are signed off by the PHA Chief Executive. Mr Wilson added that there is sometimes an issue as the DACs are retrospective which he explained can be due to the specific nature of the DACs and the need to get the associated work completed quickly.

47/23.16 Members noted the update on the use of Direct Award Contracts.

PHA Business Continuity Plan and Policy [GAC/34/09/23]

47/23.17 Mr Murray advised that PHA is required to have a Business Continuity Plan which sets out the processes and leadership roles when responding to an incident. He said that the Plan has been revised and updated and that there was a test carried out recently, the report of which is contained within the papers. He reiterated that the Plan ensures that individuals are aware of their roles in the event of an incident. He advised that there was a recent water outage incident in Linenhall Street and while the Plan did not need to be implemented, the Health Protection team took the decision to relocate their emergency room to County Hall for a couple of days. Mr Murray said that work is taking place to update directorate operational plans which will support this overall Plan.

47/23.18 Mr Stewart said that he would like to see the PHA Board included in the structure diagram within the Plan. He also sought clarity on the point at which, during the operation of the Plan, the PHA Chair is advised of an incident. He asked noted the reference to telehealth within the Plan and asked if that should be in the Plan, but Mr Wilson said that it should be outside the Plan.

47/23.19 Mr Clayton asked if any learning from the pandemic has been applied to this Plan, or if the Plan worked well. Mr Wilson explained that work is being carried out at directorate level to look at the learning from the pandemic. Mr Murray said that there needs to be a shift in culture whereby staff have a different mindset in terms of knowing what their "first responder" roles are in an emergency. Mr Clayton sought clarity

	that this Plan also links to PHA's emergency preparedness work and Mr Stewart said that any emergency situation would see this Plan implemented.
47/23.20	Mr Clayton noted that some of the appendices have not been included, but Mr Wilson explained that this is for GDPR reasons.
47/23.21	Mr Stewart said that it was useful to read the report on the exercise, which he said was very worthwhile.
47/23.22	Mr Stewart asked why the MAO (Maximum Acceptable Outage) for screening programmes has been set at 10 weeks. Mr Wilson said that he would get clarity on this **(Action 2 – Mr Wilson)**.
47/23.23	Subject to minor amendments, members **APPROVED** the Business Continuity Plan and Policy.
48/23	**Item 9 – Any Other Business**
48/23.1	There was no other business.
49/23	**Item 10 – Details of Next Meeting** *Tuesday 10 October 2023 at 10am* *Fifth Floor Meeting Room (or via Zoom).* *12/22 Linenhall Street, Belfast, BT2 8BS* Signed by Chair: Joseph Stewart Date: 10 October 2023

HSC Public Health Agency

item 13

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Annual Quality Report
Reference	PHA/03/10/23
Prepared by	Denise Boulter
Lead Director	Heather Reid
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the 2022/23 Annual Quality Report.

2 Background Information

The PHA is required by the DoH to produce an Annual Quality Report in line with the implementation of the Q2020 Strategy.

This is the PHA's tenth Annual Quality Report, and the first independent report as previously these had been joint with HSCB. The aim of the report is to share information and demonstrate improvements both to those who use health and social care services and those who deliver them.

The DoH issued guidance on the content of the Annual Report and the expected timescales for completion. Following approval by the PHA Board this will be submitted to DoH for final approval and then formal publication on the PHA website on the 9th November 2023, 'World Quality Day' in conjunction with all HSC Trust and ALB Annual Quality reports.

3 Key Issues

The report has been written under the following 5 strategic goals:

- Transforming the Culture
- Strengthening the workforce
- Measuring the improvement
- Raising the standards

- Integrating the care

Feedback from previous reports highlighted the importance of ensuring articles had a focus on outcomes. With this in mind, each article has been written focused on ‘what we did’ and ‘what was the outcome’. The report is now completed with regards content and has had a final proof read.

4 Next Steps

Following approval by the PHA Board, the Annual Quality Report will be sent to the Department of Health for publication on World Quality Day on the 9th November 2023.

HSC Public Health Agency

Transforming the Culture

Strengthening the Workforce

Measuring Improvement

Raising the Standards

Integrating the Care

QUALITY 2020

ANNUAL QUALITY REPORT 2022/23

CONTENTS

Welcome to the Tenth Annual Quality Report of the Public Health Agency (PHA)

As Chief Executive of the Public Health Agency I am delighted to share this report outlining how the PHA has continued to improve the quality of health and social care services in line with our commitments set out in the Q2020 Strategy. This report covers the period 1st April 2022 to 31st March 2023, the first year since the dissolution of the Health and Social Care Board and the creation of the Strategic Planning and Partnership Group (SPPG). Moving forward, the SPPG has continued to carry out the roles and responsibilities previously undertaken by the HSCB, working closely with PHA in all elements of Safety, Quality and Experience to improve outcomes for residents of Northern Ireland, but will no longer contribute to this Annual Quality Report.

We continue in this report to outline the impact of the COVID-19 pandemic. Previous reports demonstrated our commitment to learning from our pandemic response, and as such provided examples of how we changed our ways of working, remodelled our service delivery and developed innovative ways to implement change; all of which have contributed to the regional rebuild agenda. This year we implemented updated COVID-19 testing guidance to support clinical pathways issued by the Chief Medical Officer.

This report has afforded the Agency the opportunity to reflect on our successes over the past year and demonstrate not only how far we have come, but also our continued collective drive to improve outcomes for residents of Northern Ireland; against a backdrop of an aging population, increased demand for services and unprecedented challenges across the Health and Social Care sector. Looking to the future we are committed to delivering the highest standard of services, designed and implemented in partnership with service users, our teams and the wider community of stakeholders.

Finally, we would like to thank all our staff for their efforts over the past year, we are proud of what we have achieved together through these challenging times. We will continue to strive for the highest quality standards in the care and services we provide and put the residents of Northern Ireland at the heart of everything we do.

Thank you

Aidan Dawson

Transforming the Culture

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

INTRODUCTION

The PHA recognises that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, and transparent and, in particular, patient and client focused.

Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1. TRANSFORMING THE CULTURE: PROMOTING PERSONAL AND PUBLIC INVOLVEMENT (PPI)

Personal and Public involvement (PPI) is the active and effective involvement of Service Users/Carers and the public in health and social care services. People have a right to be involved in and consulted on decisions that affect their health and social care. Under the Health and Social Care (HSC) Reform Act (NI) 2009, involvement is a legislative requirement and this is underpinned by the Co-Production Guide of 2018.

The involvement of Service Users/Carers and other key stakeholders is critical in the effective planning, commissioning, delivery and evaluation of HSC services. involvement helps to ensure that voices are heard, views are listened to, experiences are shared and expertise is valued, respected and utilised to achieve the best outcomes for the person-centred HSC that we continually aim to achieve.

The Public Health Agency (PHA) was assigned primary responsibility for leading the implementation of PPI across the HSC system by the then DHSSPS in the 2012 PPI Policy Circular. The PHA is required to provide the Department of Health (DoH) with assurances that HSC bodies, and in particular Trusts, meet their PPI statutory and policy responsibilities.

A core function of the PHA PPI team is the provision of professional advice, support and guidance on involvement, on strategic, high profile, sensitive, cross organisational issues/projects. The support provided varies, but in the main entails:

- The provision of professional involvement advice and guidance, stakeholder analysis and development of involvement plans
- Practical support in helping the project promoter to identify, secure and facilitate Service Users/Carers participation
- Development of monitoring arrangements

Outcomes

Leadership, Advice and Guidance

The PHA PPI team has provided professional advice and guidance on involvement, on strategic, high profile, sensitive, cross organisational issues/projects. Advice, guidance and support has been provided to our PHA colleagues across several divisions including:

- Health Improvement
- Research and Development
- HSCQI
- Learning Disability
- Patient Client Experience
- AAA Screening

The PHA PPI team have been able to keep a focus on ensuring the voice of Service Users/Carers has been heard. We have worked with HSC colleagues to formally build involvement into the infrastructure and management arrangements for these initiatives.

In addition, the contribution made by Service Users/Carers across these fields has added insight, authenticity and ownership to key areas of work and has the potential to improve quality, efficiency and safety of services.

Training

The PHA commissions, designs, delivers and promotes involvement, Co-Production and Partnership Working training opportunities for HSC staff, Service Users/Carers and Community and Voluntary Sector colleagues.

We continue to build a cohort (critical mass) of people in the region with knowledge, expertise and experience in involvement, Co-Production and Partnership Working. We have seen a significant rise in the number of staff, Divisions and Directorates looking for bespoke training in involvement and Co-Production.

Monitoring

The PHA PPI Team has led on the development of a Co-Produced, standardised, involvement data collection template with key stakeholders from HSC, PHA, DoH and Service Users/Carers, to develop this agreed approach and methodology.

This approach to monitoring will further support the HSC to:

- Evidence compliance with the Statutory Duty to Involve
- Demonstrate how policy commitments to PPI & Co-Production are being met
- Identify areas which could benefit from improvement

Leadership, Advice and Guidance

It is important to note, that while the below graphic provides some indicative figures, the PHA PPI team are currently developing a more comprehensive and robust data collection system that will better reflect the advice/guidance provided to the HSC system and crucially what impact this has made towards supporting the Public Health agenda.

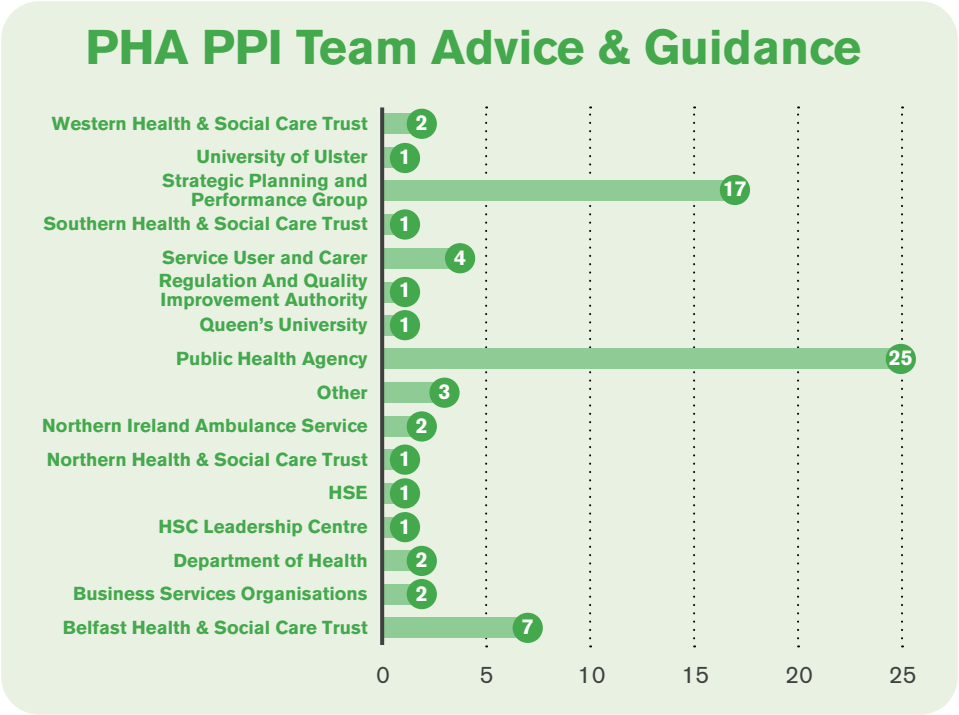


Figure 1: the above graphic shows some of the advice and guidance (71) the PHA PPI Team have provided to the HSC system from April 22 - June 2023.

With the information and evidence provided to the PHA PPI Team through our monitoring arrangements, the below graphics sets out the 6 HSC Trusts involvement high level achievements & deliverables.

Monitoring Involvement Activity:

Figure 2: How many Involvement activities have started and completed from January 2022 – March 2023

January 2022 - September 2022	October 2022 - March 2023	Total
115	**268**	**383**

Figure 2 demonstrates the total number of started and completed involvement activities have taken place from January 2022 to March 2023. From January 2022 to September 2022 there were 115 involvement activities reported and from October 2022 to March 2023 there were 268, giving a total of 383 involvement activities reported. It is recognised that the above number may not be a full reflection of all involvement activity taking place in the HCS Trusts, potentially due to under reporting in some services and the embedding of the new involvement Activity Data collection tool across the different Directorates and Divisions.

Figure 3: A breakdown in Service Users, Carers, Staff, Public and overall total participating in Involvement projects from January 2022 – March 2023

Number of public	Number of carers	Number of service user	Number of staffs	Total number of Involvement
494	8367	2034	1512	12407
211	275	728	332	1546
90	2	95	145	332
2524	1203	4736	448	8911
599	418	1571	291	2879
379	519	3360	1630	5888
4297	**10784**	**12524**	**4358**	**31963**

Figure 4: Overall Involvement Activity per Levels of Involvement January 2022 – March 2023

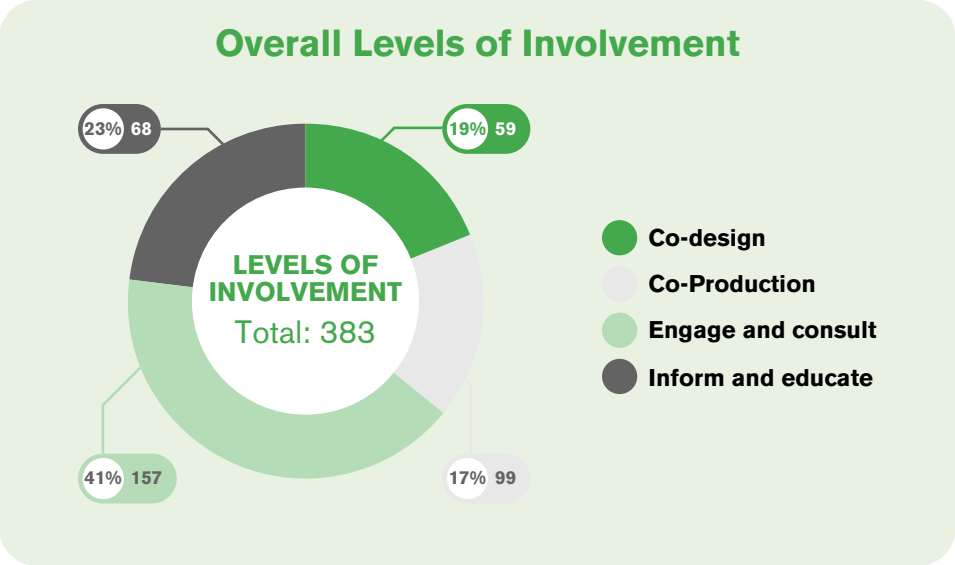


Figure 4, demonstrates the involvement activity per level of involvement across all HSC Trusts from January 2022 to March 2023. The majority of involvement activity fell into Engage and Consult, with a spread across the remaining levels of involvement.

Figure 5: Overall Involvement Activity per Programme of Care from January 2022 – March 2023

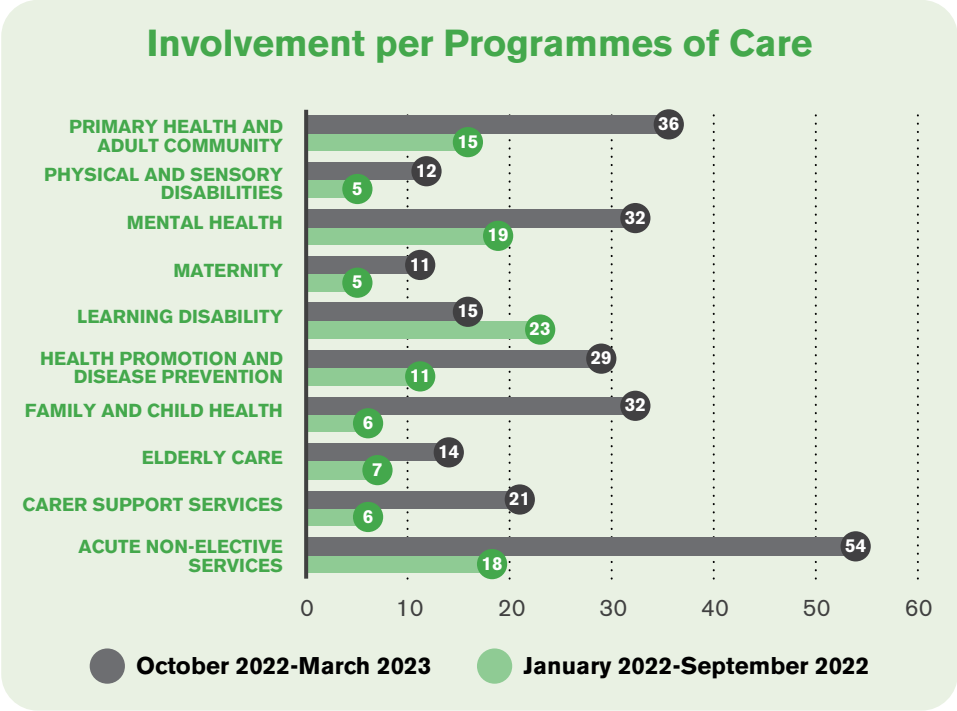


Figure 5, demonstrates the over-all number of involvement activities per Programme of Care across the different HSC Trusts. There is a spread of involvement across the different Programmes of Care, with Acute Non-Elective Services and Primary Health & Adult community showing the majority of involvement.

Figure 7: Overall Involvement Measurement Methods January 2022 – March 2023

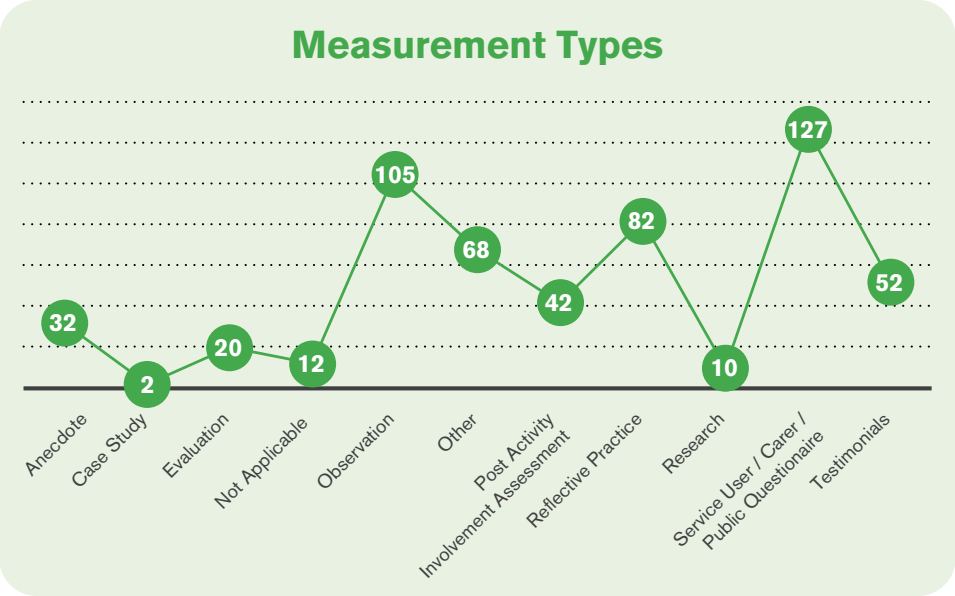


Figure 7, demonstrates the wide range of methods the HSC Trusts have utilised to help determine and measure the impact and outcomes for involvement from January 2022 – March 2023.

Figure 8: Overall Involvement Outcomes from HSC Trusts January 2022 – March 2023

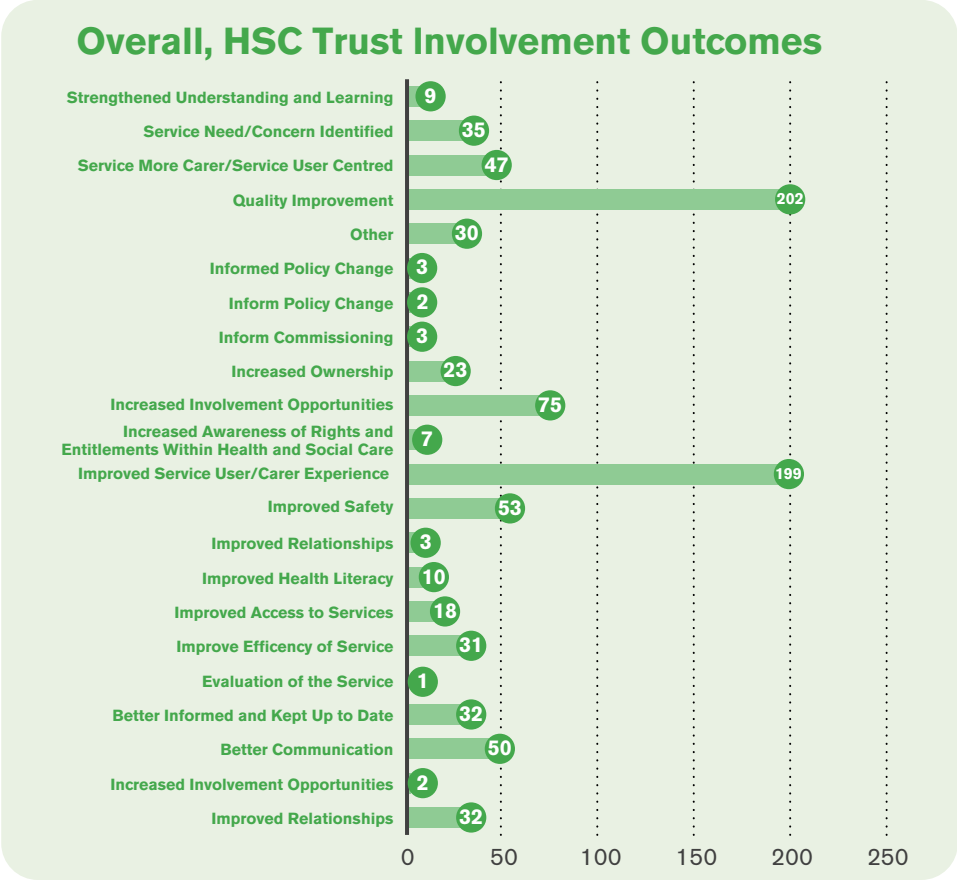


Figure 8, demonstrates the wide range of involvement outcomes and impacts that the 383 involvement activities have made across the HSC Trusts from January 2022 to March 2023.

Involvement Training:

The PHA commissions, designs, delivers and promotes involvement, Co-Production and Partnership Working training opportunities for HSC staff, Service Users/Carers and Community and Voluntary Sector colleagues.

A variety of training programmes have been delivered including:

- An 8th cohort of Leading in Partnership
- A 5th series of bespoke webinar broadcasts

involvement and Co-Production training delivered to:

- Health Improvement
- Commissioning leads
- Pharmacy undergraduates
- Senior Social Work Staff
- Procurement
- HSCQ

13 Service Users and Carers involved in PHA PPI training

72 Undergraduate/Post graduate students attended PPI training

65 HSC staff attended PPI training

49 Applicants for 8th cohort of Leaders in Partnership Programme

25 Participants begin 8th Cohort of Leadership in Partnership Programme

3 webinars commissioned for a 5th series of Tuesday Topics

2. TRANSFORMING THE CULTURE: SHARING LEARNING FROM HOSPITAL INPATIENT FALLS

HSC Trusts are no longer required to report inpatient falls that have resulted in moderate, major or catastrophic harm as a Serious Adverse Incident (SAI), unless serious care or service delivery issues are identified from the initial post fall review; instead inpatient falls are classed as **Adverse Incidents** and a timely Post Fall Review is completed internally. The aim of this is to allow for local learning resulting in a change in practice, to reduce the incidence of future falls.

A **Shared Learning Form** (SLF) following a Post Fall Review is then submitted to the PHA Falls Inbox falls.learning@hscni.net. This allows for a regional analysis of incidents where falls have occurred and for the sharing of this regional overview. The Safety Quality and Innovation Team between July and September 2022, carried out a detailed analysis of all the forms submitted to the PHA Falls Inbox in the period April 2021 to March 2022.

In addition, all Serious Adverse Incidents where analysed and patients' stories where included from Care Opinion.

A newsletter was created to share this information with HSC colleagues with the intention of improving future practice.

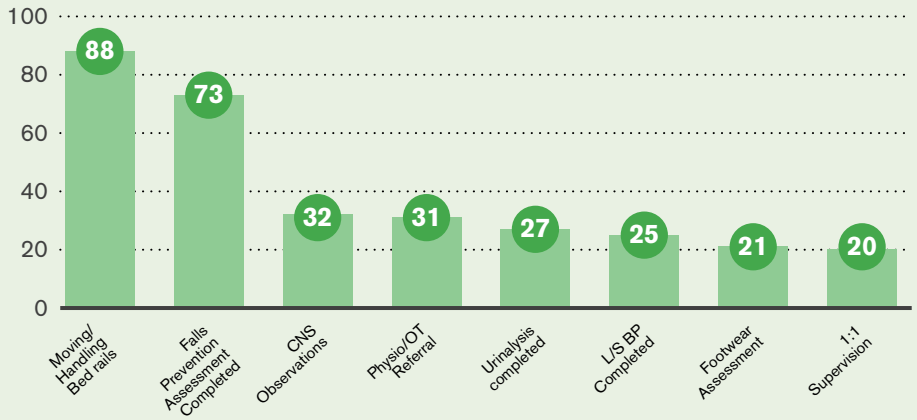
Outcomes

- A thematic analysis of 123 shared learning forms from incidents of inpatient falls resulting in moderate/major/catastrophic harm was completed. Four thematic headings were used, 'what happened to the patient', 'what went well', 'what we could improve' and 'what we learned'.
- 3 SAIs had been submitted in the period and these were reviewed individually with learning identified and shared from each SAI.
- 4 stories outlining patient experience were submitted from Care Opinion.
- A newsletter was produced and shared with HSC colleagues during Falls Week, in September 2022.

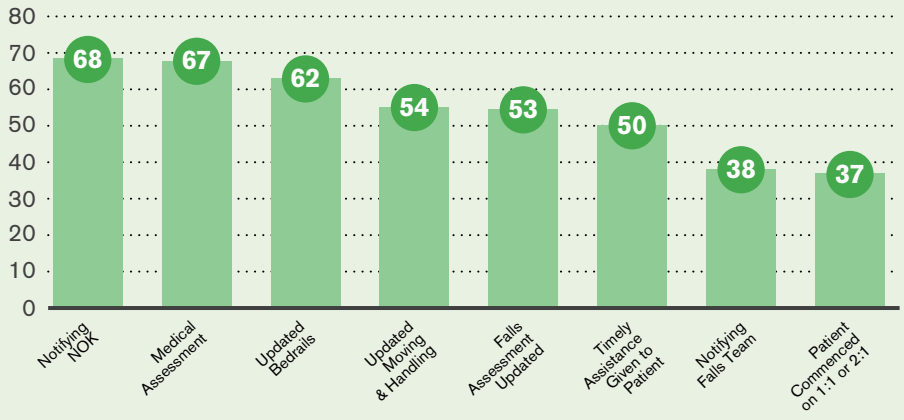
Table 1: Number of Shared Learning Forms (templates) Submitted per Trust April 2021 - March 2022

NHSCT	32
BHSCT	38
WHSCT	15
SHSCT	8
SEHSCT	30
Total	123

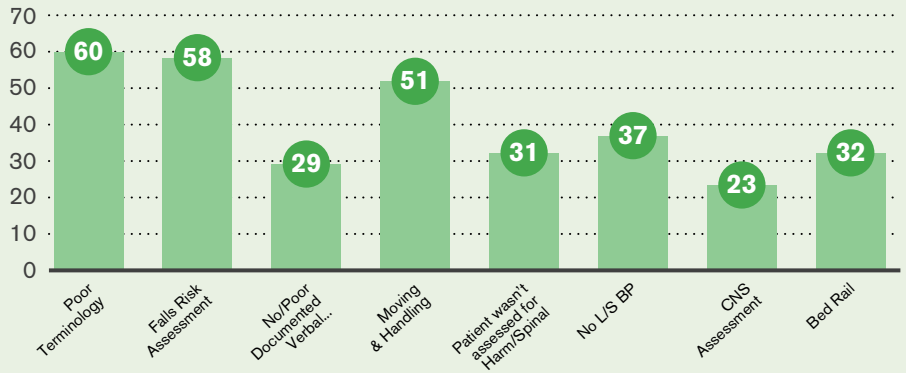
What went well? (Before fall) April 2021-March 2022



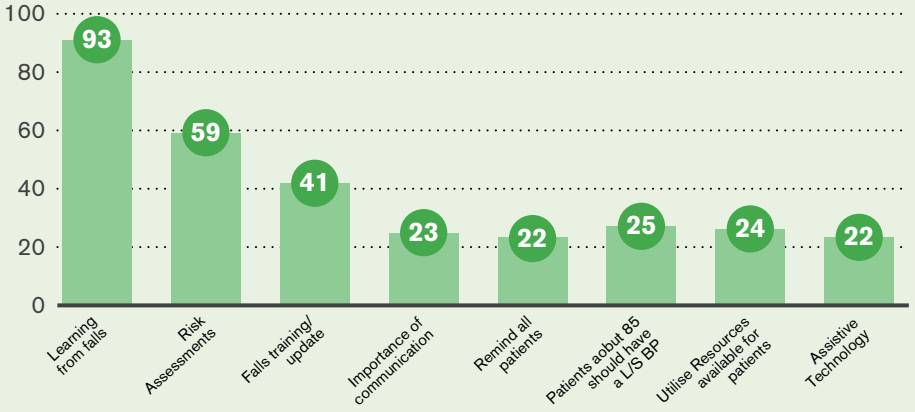
What went well? (After fall) April 2021-March 2022



What could we improve? April 2021-March 2022



What have we learnt? April 2021-March 2022



3. TRANSFORMING THE CULTURE: MEALTIMES MATTER – REGIONAL RESOURCES

The Regional Mealtimes Matter Group aims to maximise patient safety and ensure a high-quality patient experience **always** occurs at every meal, drink and snack time. Based on the feedback received from monitoring the patient and client experience, the area of meal and snack times was identified as a key area for improvement.

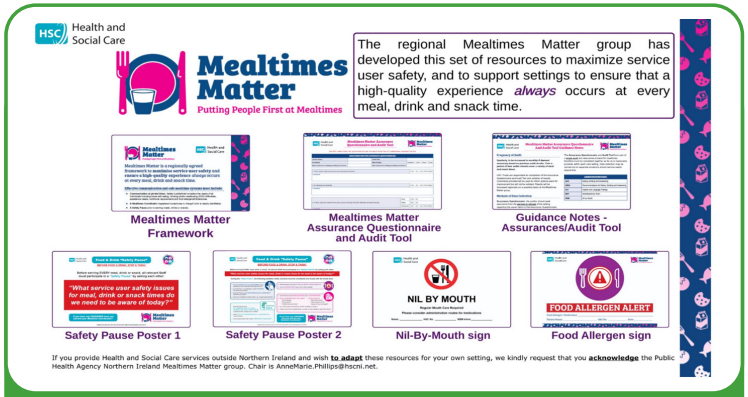
With choking related harm being a significant patient safety issue in Northern Ireland and a Safety and Quality Reminder (SQR) of Best Practice letter issued on in February 2021, the Mealtimes Matter Group chaired by the Public Health Agency co-produced and implemented a number of resources such as;

- **Regional Mealtimes Matter Framework**
- **Regional Mealtimes Matter Assurance Questionnaire and Audit Tool**
- **Guidance Notes on the Assurance and Audit Tool**
- **2 x Food and Drink Safety Pause Posters**
- **Regional Nil By Mouth Sign**
- **Regional Food Allergen Sign**
- **Regional 'Mealtimes Co-Ordinator' Badge**

We are still in the early stages of analysing impact of reduction of patient safety incidents but anecdotally it has supported prevention of incidents as per feedback from staff focus groups.

Outcomes

- Regionally agreed standardised resources embedded across all hospital and community settings in Northern Ireland.
- Audit data is in early stages but shows promise in delivering demonstrable and positive outcomes for patient safety both in hospital and community settings.
- Hugely positive feedback from patients/families, healthcare staff including support staff i.e. catering.
- Provides assurance to the NI Chief Medical Officer.
- Finalist for an HSJ Patient Safety Award 2023 – Category Early-Stage Patient Safety Innovation of The Year.



Mealtimes Matter Resources - 1

HSJ PATIENT SAFETY AWARDS 2023

WE ARE PROUD TO BE A FINALIST

EARLY-STAGE PATIENT SAFETY INNOVATION OF THE YEAR

Mealtimes Matter

Putting People First at Mealtimes

Our work in action

Mealtimes Matter

Mealtimes Coordinator

Mealtimes Matter

Strengthening the Workforce

Objective 3: We will provide the right education, training and support to deliver high quality service.

Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

INTRODUCTION

The PHA is determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution.

Health and Wellbeing 2026: Delivering Together asks HSC organisations to become exemplars of good practice in supporting staff health and wellbeing. The HSC Workforce Strategy 2026: delivering for our people also sets out ambitious goals for a workforce that will match the requirements of a transformed health and social care system.

The World Health Organisation (WHO) defines what is meant by workplace health:

"A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace..."

The PHA is committed to supporting staff health and wellbeing particularly over the last few years during the COVID-19 pandemic, and currently during the Reshape and Refresh programme of work. The PHA has introduced a number of initiatives to listen to and engage with staff and promote best practice through investing in training and education, and ensuring that the perspectives from all staff are heard and incorporated into the future of the Agency.

1. STRENGTHENING THE WORKFORCE: PROJECT ECHO: LEARNING FROM SERIOUS ADVERSE INCIDENTS RELATED TO THE DETERIORATING PATIENT

In March 2022, the Safety, Quality and Innovation Nursing Team in the PHA, led on the development of a new Project ECHO. Project ECHO (Extension of Community Healthcare Outcomes) is a worldwide movement providing an online learning and support methodology. It supports knowledge sharing between professionals from across health and social care, and facilitates the exchange of specialist knowledge and best practice. The theme of the ECHO was learning from Serious Adverse Incidents related to the Deteriorating Patient and the common patterns and trends that arose in various cases. The format of the ECHO was a short 30 minute teaching session followed by a short case study where participants were then placed into various breakout rooms to discuss key questions. Each session lasted 2 hours. The areas covered included:

- Recognition and Response to the Deteriorating Patient.
- Human Factors to include non-technical skills.
- Safety Culture: The Importance of Psychological Safety and Embedding a Just and Learning Culture.
- The Importance of Communication & Listening to Families in Relation to Patient Deterioration.
- Learning: How we Apply and Disseminate the Key Learning from SAIs – are we succeeding?
- Medication Safety and Systems Thinking.
- Learning relating to the newly adopted Patient Safety Incident Response Framework (PSIRF) within NHS England.
- Northern Ireland Ambulance Service – 'Thinking as a system to reduce harm from Ambulance delays'.

Outcomes

- From May 2022 to April 2023 there were six sessions of ECHO.
- The infographic below provides an overview of the End of Year Survey results.
- The ECHO was rated 'very high quality' by the majority of participants.
- It achieved a sense of community for all participants.
- Over 90% of participants, participating in ECHO Sessions increased their confidence in treating patients.
- 92% of participants reported the topics covered in the ECHO sessions were relevant to their role.
- 100% of participants reported that case-based learning as the focus for discussion is a highly impactful way of learning.
- 96% would recommend Project ECHO as a useful learning tool to others.
- Over 75% reported they have applied knowledge gained through the ECHO to their practice.

"I've thoroughly enjoyed all the different presenters as well as the opportunity to participate in break out rooms!"

"The importance of good communication between patients, relatives and staff and by taking the time to listen to concerns and think objectively can prevent SAIs."

Project ECHO® Northern Ireland

"It's a good systematic way of looking at things when they have gone wrong and getting the learning out."

"Some of the case studies shared have changed how I approach families."

"has allowed me to network with others and look at how we can implement learning and change."

"psychological safety was provided within the sessions."

Serious Adverse Incidents Deteriorating Patient ECHO Network End of Year Survey

Objective & Summary

A key theme emerging from SAIs in recent years is 'responding to the deteriorating patient'. Collectively between HSC Trusts, the HSCB and PHA we recognise that there is a lot of learning arising from recent SAIs on this broad area which could be shared with a focused audience.
We believe the ECHO model will provide the appropriate platform and technology in order to collectively discuss the themes, trends, causative factors around the deteriorating patient, share learning from both individual / team experiences, share best practice from experts in particular topic areas.

Networks Objectives - Particpants review of Objectives being met:

- **92%** To use an all teach/all learn method to improve safety across the region
- **83%** To collaborate across areas, professions and organisations to share learning and good practice
- **79%** To better understand and inform the SAI process
- **71%** To provide an opportunity for front line staff to input to SAI discussions
- **88%** To create a safe learning environment

Benefits

79% agreed that participating in ECHO sessions had '**increased their confidence in treating patients' r**anging from a 'moderate amount' to a "great deal'.

92% of participants surveyed would like to continue for another year.

92%

Outcomes

100% of participants surveyed agreed that a sense of community was achieved ranging from ' a moderate amount' to a 'great deal'.

100%

Attendance

42% of participants have attended 5+ ECHO sessions.

Quality

100% of participants surveyed rated the quality of the ECHO Sessions from **High to Very High Quality**

100%

Applied Learning

75% of participants learned something through ECHO that has been **applied to their practice.**

2. STRENGTHENING THE WORKFORCE: ADVANCED NURSING PRACTICE EDUCATION PROGRAMME

In Northern Ireland the first ANP education programme was commissioned from Ulster University in 2017. The programme initially offered three pathways: Children's, Emergency Care and Primary Care, and since its inception Mental Health and Adult Medicine & Older people have been added. The development of this programme is aligned with the Department of Health's strategic policy direction, Health and Wellbeing 2026 Delivering Together (DoH, 2016) and the Advanced Nursing Practice Framework (DHSSPS, 2016). The Nursing and Midwifery Task Group (NMTG) report and recommendations (NMTG 2020), provides a roadmap with direction towards achieving world class nursing and midwifery services in a reconfigured Health and Social Care (HSC) system over the next 10-15 years. This is set within the context of a population/public health approach and aims to maximise the contribution of nursing and midwifery to improve health and social care outcomes. However, while there is significant evaluation evidence of the clinical and care effectiveness of these roles with generally positive feedback from patients, these roles have not been evaluated within an integrated care system and have had limited evaluation within primary care. PHA nursing directorate assisted with data collection in the recent evaluation- led by Professor Alison Leary to understand the impact of the introduction of ANPs into the Northern Ireland health system.

Outcomes

- The introduction of ANPs into Northern Ireland has increased flexibility and service capacity, particularly in primary care.
- In common with other studies, ANPs in Northern Ireland have the characteristics of an agile, accessible workforce which can see and treat "whoever comes in the door".
- There was a distinct nursing contribution.
- Stakeholders (patients, colleagues, managers) valued the role and found it beneficial.
- Value drivers and enablers such as expert care, leadership, improved access, variety of service and access, enabling self-care and self-management and the development of specialist areas of practice all emerged from these data indicating that patterns of work compare well to other well evaluated/productive ANP workforces globally.
- There are some common challenges to practice, comparable to ANPs in other countries.

3. STRENGTHENING THE WORKFORCE: DEVELOPING AN ALLIED HEALTH PROFESSION POPULATION HEALTH STRATEGY FOR NORTHERN IRELAND

The 4 nations Allied Health Profession's Public Health Forum was established in 2019, to agree a 5-year UK population health strategic plan for AHPs. Subsequent to this, each jurisdiction developed and led on a localised framework aligned to UK goals that:

1. **Developed the workforce**
2. **Demonstrated impact**
3. **Increased profile**
4. **Developed strategic connections**
5. **Considered the health and wellbeing of the workforce**

In November 2022, AHP Consultants in the PHA and the Chief Allied Health Professions Officer agreed a Northern Ireland Population Health Strategy aligned to the UK plan and to meet requirements of a new Health and Care Professions Council standard being introduced in September 2023.

Outcomes

Northern Ireland's strategic framework developed in November 2022 has achieved the following outcomes:

- PHA developed and delivered online population health training for 200 of Northern Ireland AHPs. Outcome results indicated over 90% of staff rated their understanding or population health and the wider determinants of health as good/very good post training. An improvement of over 70%.
- PHA hosted a whole systems workshop in conjunction with NICON for AHP Leaders during which participants prioritised actions to develop the framework. Action teams are now rolling out agreed priorities across Northern Ireland.
- PHA supported AHPs from Northern Ireland to publish 5 case studies showcasing good practice on Royal Society for Public Health website.
- PHA develop and distribute AHP Population Health Newsletters online to share good practice and increase population health awareness across the region.
- PHA works closely with UK AHP partners and has developed strategic links internationally with USA and New Zealand to share learning on maximising the potential of AHPs in reducing health inequalities at a population level.

4. STRENGTHENING THE WORKFORCE - PHA IN-HOUSE OUTCOMES BASED ACCOUNTABILITY (OBA) AWARENESS TRAINING 22-23

Outcomes Based Accountability (OBA) methodology is an approach that is being actively promoted across Government Departments and Arm's-Length Bodies. It is a system for organising our efforts and resources towards achieving desirable end results or outcomes, and measuring how well we're doing. It is also known as Results Based Accountability (RBA). It focuses on:

- **Population outcomes** i.e. conditions of wellbeing for whole populations (such as those included in the draft Programme for Government and the Making Life Better strategy), and
- **Performance measurement** of our efforts and actions/what we do to achieve or contribute towards achieving those population outcomes (such as by delivering patient & service level outcomes).

From November 2022-January 2023, staff from the Planning and Business Services Team within Operations, delivered 7 x two-hour, interactive, online sessions, to 150 participants, with the aims of building OBA capacity and embedding OBA across the organisation.

The programme provided an introduction/refresher to OBA–what it is, where it came from and why we need to know about it, as well as what we need to do with it, when and how, and who can help. It provided staff with the opportunity to work through practical examples relevant to the organisation.

The desired outcome from the training was to increase participants' knowledge of OBA and their confidence in applying it in their work.

Outcomes

- **Usefulness of the session:** 85% of respondents rated the sessions as Extremely or Very Useful.
- **OBA Knowledge before and after the training:** The average level of OBA knowledge reported before the session was 'a little' (2.4 stars out of 5) and increased afterwards to 'a lot' (3.7 stars)
  - **Before** the OBA Sessions only a tenth (10%) of respondents rated their knowledge of OBA as a 4 or 5 out of 5 – i.e. felt they had a lot or a great deal of knowledge. Nearly half (47%) gave a rating of 1 or 2 out of 5 – i.e. only a little or very little.
  - **After** the sessions almost two thirds (64%) rated their knowledge as 4 or 5 out of 5, with another third (33%) rating it as 3 out of 5 (moderate).

- **Confidence in applying OBA before and after the training**: The average level of confidence reported before the session was 'slightly confident' (2.2 stars out of 5) and increased afterwards to 'moderately confident' (3.2 stars).
  - Before the OBA Sessions NO respondents rated their confidence in applying OBA as 5 out of 5 (extremely confident). Only 3% rated their confidence as 4 out of 5. A third (33%) rated moderate (3 out of 5). Just under half (49%) were slightly confident and 15% were not at all confident.
  - Afterwards 4% felt extremely confident (5 out of 5) and a quarter (25%) felt very confident (4 out of 5). A large proportion (62%) gave a 3 out of 5 rating – moderately confident – and only 9% felt slightly confident. NO respondents said they were not at all confident.
- **Likelihood of using OBA in work:** On average, respondents indicated they would be 'very likely' to apply OBA after attending the session.

"Thank you both for a really insightful session and clear training."

"I was told by my manager last week it was one of the most useful PHA training sessions she has attended."

"I attended the OBA workshop on 24th November and found it very useful for my role."

"That was a wonderful session, I thought I knew OBA but realise I still need to continue developing my knowledge."

Average Levels of OBA Knowledge

Before Training	After Training
★★☆☆☆	★★★★☆
(2.4 stars - a little)	(3.7 stars - a lot)

Average Levels of Confidence in applying OBA

Before Training	After Training
★★☆☆☆	★★★☆☆
(2.2 stars - slightly confident)	(3.2 stars - moderately confident)

5. STRENGTHENING THE WORKFORCE- PRIMARY CARE MULTI-DISCIPLINARY DIABETES EDUCATION PROGRAMME

Nationally and globally the incidence of diabetes diagnosis and prevalence continues to increase, posing challenges for all healthcare professionals involved in the management of diabetes. In Northern Ireland there were almost 112,000 GP patients aged 17+ recorded on the Diabetes Mellitus register at 31st March 2023. There have also been changes in the management of Type 2 diabetes as well as advances in diabetes treatment and technology. The majority of people living with Type 2 diabetes are managed mainly in primary care. General Practitioners (GPs), General Practice Nurses and Practice Based Pharmacists play a key role and it is essential that they have the required competencies.

It is recognised that a multi-disciplinary primary care team approach is needed to respond effectively to the health needs of people with diabetes. Formerly, primary care diabetes education programmes were commissioned from outside Northern Ireland but due to the increasing demand a local programme was deemed necessary.

In collaboration with representatives from the Public Health Agency, NI Diabetes Network, Ulster University, General Practitioners and GP Federation Clinical Pharmacists a bespoke course was developed. The focus of this blended learning education programme on diabetes management in primary care was to promote a consistent standard of care, develop supportive relationships and promote an environment that encourages shared learning.

Outcomes

- The PHA, in collaboration with key stakeholders, led the development of a Multi-Disciplinary Primary Care Diabetes education programme, which was approved in 2022.
- The first cohort of students commenced the programme in January 2023 (there were 23 students in total, 1 GP, 13 General Practice Nurses and 9 Practice Based Pharmacists).
- The post module review showed positive results with 95% of participants reporting an increase in knowledge and confidence.
- The blended learning approach included virtual sessions which reduced travel time for participants.
- Following the success of the first programme and wide interest from General Practice the DoH Education Commissioning Group has commissioned a second cohort to commence in January 2024.

Measuring Improvement

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Introduction

The PHA recognise the importance of measuring progress for safety, effectiveness and the patient/client experience in order to improve. The PHA promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

1. MEASURING IMPROVEMENT: COVID-19 TESTING - IMPLEMENTATION OF LATERAL FLOW DEVICE TESTING FOR HOSPITAL INPATIENTS IN NORTHERN IRELAND

- In May 2022, updated COVID-19 testing guidance to support clinical pathways was issued by the Chief Medical Officer, in the CMO letter HSS(MD) 22/2022 (1). This included a change in policy regarding testing in hospital inpatients, with a move to the use of lateral flow device (LFD) testing for many clinical pathways.
- A regional group was established to support the implementation of lateral flow testing in inpatient groups, as outlined in the CMO letter. Members included representatives from the PHA, the Department of Health, the Pathology Network Point of Care Testing Specialty Forum, HSC Trusts, BSO PaLS and digital health colleagues. The purpose was to implement the roll out of LFD testing to support clinical pathways for inpatients and to identify implementation issues, challenges and solutions.
- A number of issues and challenges were identified by the group and work was undertaken to resolve these.

(1) Addressee (health-ni.gov.uk)

Outcomes

Training

- The regional group agreed that the method of testing should be fully administered LFD tests, administered by trained and competent health care workers in accordance with Trusts' point of care testing (POCT) policy.
- A regional e-learning training package was developed, hosted by the Health and Social Care (NI) Learning Centre (hsclearning.com). Following discussions at the regional group, it was agreed that Trusts would be given flexibility in either availing of their own internal training methods (as agreed with their POCT team) or alternatively, utilising the specific inpatient e-learning training.

Recording of results and reporting

- It was agreed that Trusts should ensure that regional POCT guidance was followed with respect to the minimum data requirements for recording results. Various methods of recording results were discussed within the regional implementation group and, following discussions, Trusts were given flexibility in how this was taken forward for their organisation.

Procurement

- The method for ordering LFD tests was agreed between Trusts and the PaLS team.
- A management information template was developed for Trusts to utilise for their own internal stock management in relation to ordering and distribution of tests.

Standard operating procedure

A standard operating procedure document was developed to outline the procedures associated with the LFD testing. This was approved by the Northern Ireland Pathology Network's Point of Care Testing Specialty Forum.

2. MEASURING IMPROVEMENT: IMPROVING QUALITY FOR CHILDREN AND YOUNG PEOPLE WITH EATING, DRINKING AND SWALLOWING DIFFICULTIES (EDS) IN EDUCATION SETTINGS IN NORTHERN IRELAND

Eating, drinking and swallowing difficulties (dysphagia) affects 8.1%-11.15% of individuals with learning disabilities (Robertson,2017) and can cause aspiration, choking or death. There has been an 25% increase in demand for special school places over the past 5-years and increased level of complexity of presentation. This innovative partnership approach between PHA, HSC Trusts, Department of Education and Education Authority aimed to reduce risks and improve quality for children and young people in education settings by ensuring best use of resources and upskilling of education staff ensuring resources can be redirected for more specialist levels of support.

This project utilised knowledge and expertise from a range of AHPs including SLTs, OTs, Dietitians and Orthoptists to develop a comprehensive training programme whilst maximising digital solutions.

This multifaceted project has 3 strands:

1. **Training**
2. **Clear roles and responsibilities**
3. **Regional resources**

Regional eLearning awareness training developed by PHA in partnership with Trusts replaced ad-hoc training. The Education Authority has stipulated that training is mandatory for all staff working with and preparing food for children in education settings. This has had a subsequent impact on reducing risk and ensuring high quality care, feedback included “I didn’t know about the signs of difficulty but now I do”.

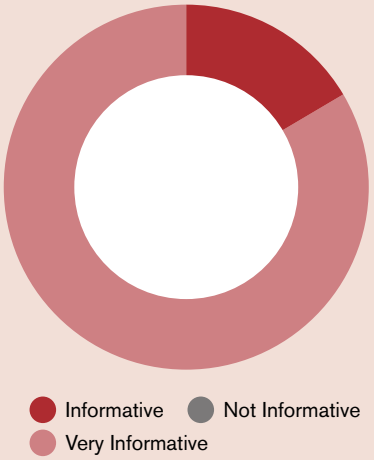
Roles and responsibilities were defined to ensure robust processes to support children effectively, ensure timely referrals to SLT and ensure care-plans were comprehensive, accessible and food/drinks were prepared correctly.

A regional safety alert poster was developed to summarise signs of Eating, Drinking and Swallowing Difficulties to reinforce the content of the eLearning.

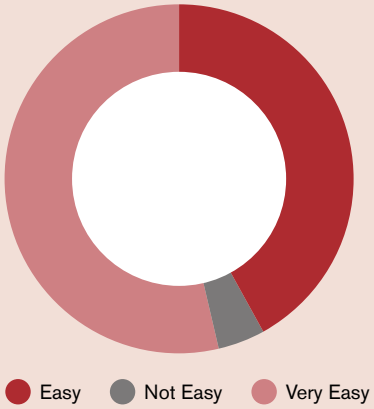
Outcomes

- Since going live in August 2022 1984 staff have completed the 90-minute awareness training, a 200% increase on numbers who had completed local training in the previous year.
- Feedback was very positive, 96% reported training was easy or very easy to access, 100% reported training was informative and 99% reported training met their needs.
- Training improved knowledge, skills and confidence so reducing risk and enhancing quality of care including timely referrals and understanding the risks and needs of children with eating, drinking and swallowing difficulties.
- Training was rolled out to all education settings at no additional cost and resources are available on Department of Education website for easy access. The training allows participants to review content anytime. The eLearning is always accessible addressing staff turnover issues.
- This work was a finalist in Advancing Healthcare Awards Northern Ireland in the category of Working in Public Health.

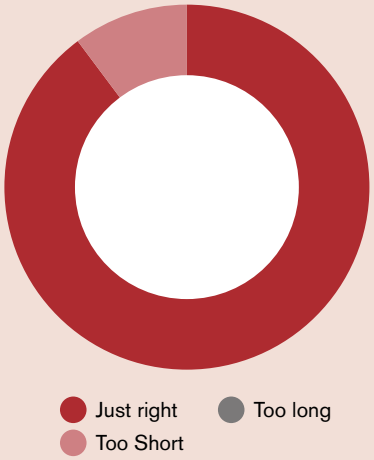
How informative was this awareness training?



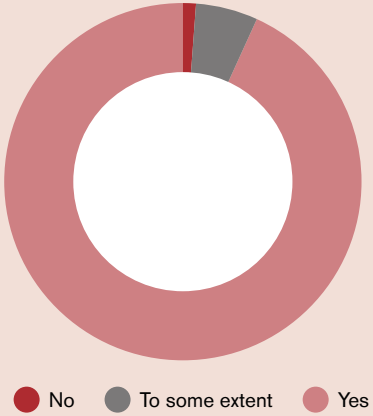
How easy was the training to access?



What did you think about the length of the training?



Did this training meet your needs?




AHA
2022 NORTHERN IRELAND
Allied health professionals
HSC Public Health Agency
Advancing Healthcare Awards
Northern Ireland 2022
AWARD FOR PARTNERSHIP WORKING IN PUBLIC HEALTH
FINALIST
Reducing Risk ... improving quality for children and young people with eating, drinking and swallowing difficulties in education settings in Northern Ireland
Alison Ferris,
AHP Consultant
Public Health Agency
Alison Dunn
Joint managing director
Chamberlain Dunn
Will Chamberlain Webber
Joint managing director
Chamberlain Dunn


HSC Public Health Agency
CHILD SAFETY ALERT
Signs of Eating and Drinking Difficulties
Swallow Aware
During or after eating and drinking watch me closely for the following:
COUGHING / CHOKING
Changes to my COLOUR
E.g. if my skin turns red or blue
Wet or "gurgly" VOICE
EYE-TEARING
Changes to my BREATHING
E.g. If I become "wheezy" or gasp for air; my breathing rate gets faster or slower
WEIGHT LOSS / DIFFICULTY PUTTING ON WEIGHT
Repeated or recurrent CHEST INFECTIONS:
Especially if I have no other symptoms of a cold!
If you have any concerns about my eating, drinking or swallowing
Please contact the Speech and Language Therapy Team
This work originated from the Speech and Language Therapy Team in South Eastern Trust

3. MEASURING IMPROVEMENT: DEVELOPING A CO DESIGNED, REGIONALISED APPROACH TO FALLS IN CARE HOMES IN NORTHERN IRELAND THROUGH SAFER MOBILITY, IMMEDIATE MANAGEMENT AND FOLLOW UP OF FALLS.

Why we did it:

NICE guidelines suggest that 30% of adults aged 65 years and older and 50% of adults aged over 80 years fall at least once per year (NICE, 2013). Globally, fall related death rates are the highest among adults aged over 60 years (World Health Organisation (WHO). Many residents find themselves admitted to a care home following a fall. Falls are one of the biggest problems reported within Care Homes in NI for their residents as they can have a major impact on residents quality of life, physically and mentally and can be catastrophic.

This Project was mandated by the Minister for Health through the Enhancing Clinical Care Framework.

What:

Using Quality Improvement methodology this MDT team (which includes care home staff, service users and relatives) engaged extensively with all key stakeholders (identified using Stakeholder Analysis) to co-produce, test and implement a regional falls pathway in care homes in NI that will reduce falls and harm from falls with the ultimate aim of improving resident experience and safety.

Co-production and engagement with residents and families was key- Resident interviews (PCE PHA) and Regional workshops via PCC.

We had 18 Partner Care homes across NI involved in this project, all Trusts were represented with equal numbers of Nursing Homes and Residential Homes. Also included were homes for people with Learning Disability and Dementia. Trust and Independent homes were included. The need for a pathway that would meet all needs of residents is a key priority so that equity and accessibility would be beneficial for all.

Project produced Regional documents for testing - Risk assessment and review document, Falls Calendar, long lives poster, Oral intake guidance and Post Falls Guideline (infographic below)

Collaborated with MOOP regarding medicine optimisation

Provided equipment for falls

Phase 1 testing - Dec-Feb 22

Phase 2 testing - May-July 22

Phase 3 Scale and Spread, meaningful activity, accessible communication. 23/24

Outcomes

How:

Outcome measures and process measures were used to demonstrate results across the quintuple aim (see diagram below). Whole system working resulted in whole system results.

Aim:

Resident wellbeing

Fear of falling was at **50%** pre-testing of new pathway, it is now **25%,** further testing and change ideas are needed.

Falls rate

Within 8 partner homes a reduction of falls was found by **33%**

Process Measures

Staff confidence - **82%** of staff felt confident in promoting safer mobility, and managing falls

NIAS call outs **reduced by 37%** This demonstrates savings and efficiencies across the system with less pressure also on Emergency Departments.

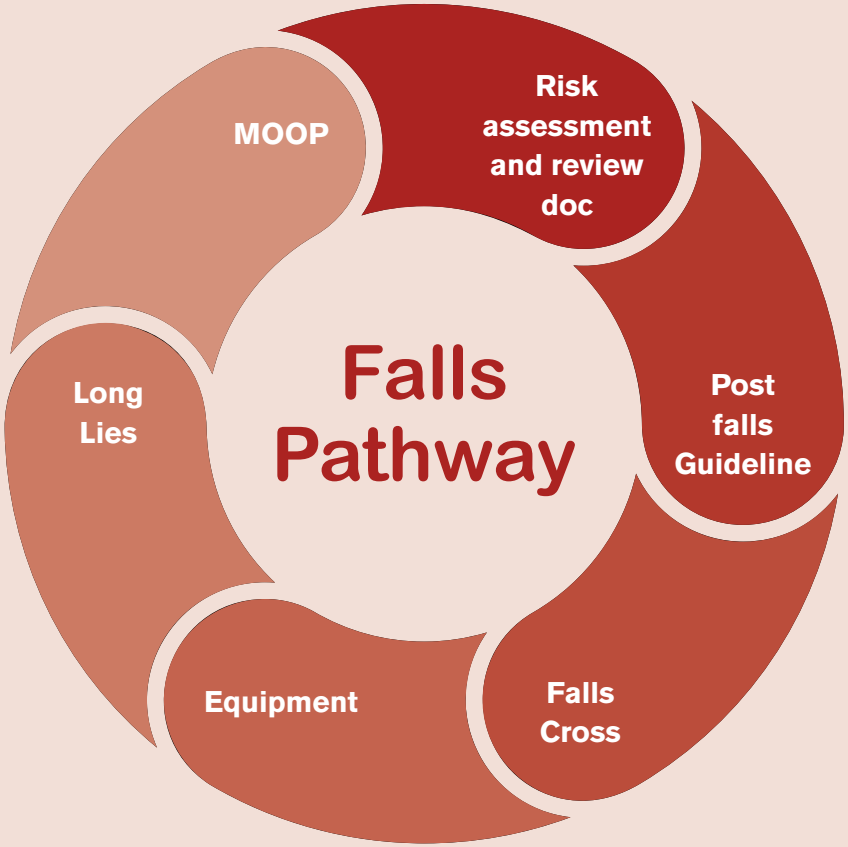
Other outcomes have been evident:

- Culture of falls-It's everyone's business-all staff involved.
- Home building on the pathway and creating their own innovative changes.
- Residents, from being involved in the surveys are becoming proactive about what keeps them safer from falls.
- Winner of the HSCQI Awards for Care Homes 2022.

> **"We can see by improving learning for staff and residents via the Safer Mobility learning materials, checklist, paper work and surveys, this has resulted in increased staff motivation, staff doing their own audits, assessments which is ideal as it is the Carers who are giving the care."**
>
> QUOTE FROM CARE HOME MANAGER

> **"Families came up with collaborative solutions. Reinforcing learning from falls with their loved one."**
>
> QUOTE FROM CARE HOME MANAGER

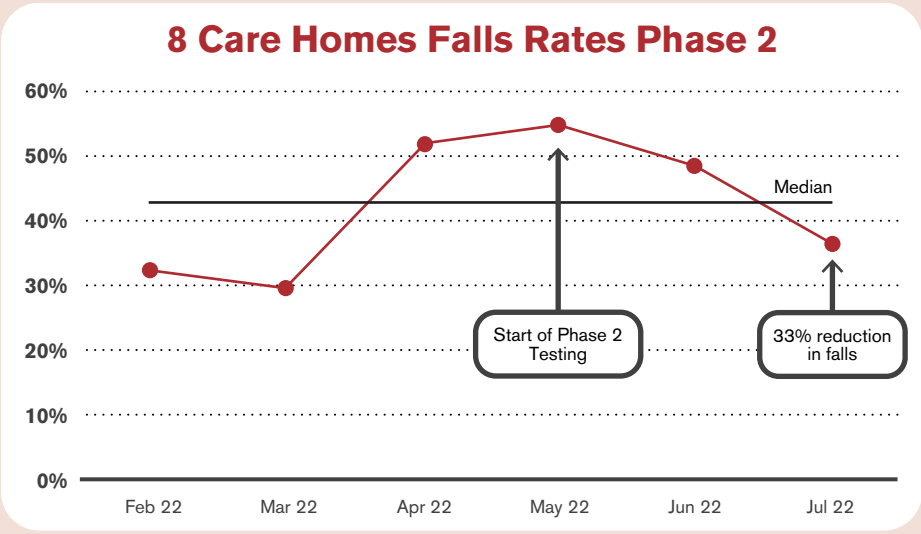
> **"...Residents got involved and started to self-manage their own safer mobility better."**
>
> QUOTE FROM CARE HOME



Falls rate run charts

33% reduction in falls in 8 Partner Homes

Aim Achieved

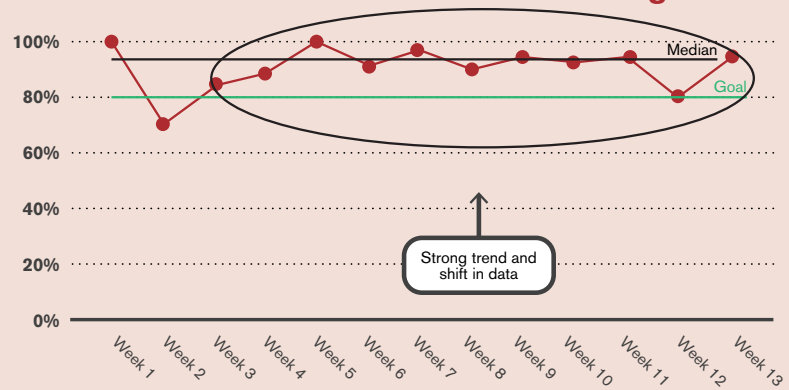


Resident Outcomes

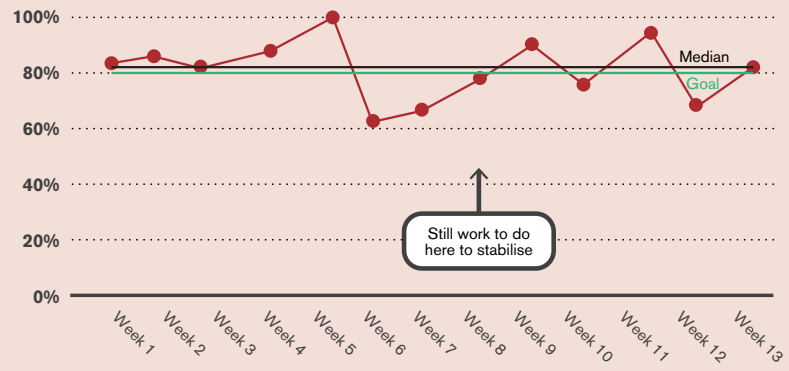
Aim:

- To improve resident experience and quality of life to 80%.
- Reduction in falls - decreases risk of long lies, better health and wellbeing.

Resident less fearful about falling



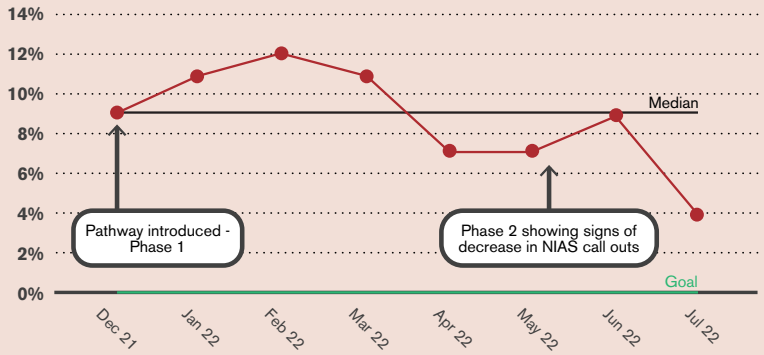
Resident feels safe and confident moving



NIAS Results

- **37%** reduction in NIAS Call Outs across the Partner Homes from Phase 1 to Phase 2 of project.

NIAS Falls Call Outs across the partner Care Homes



Evaluation of the Falls in Care Homes Project using the components of the quintuple aim

Improved resident experience of care

- **75%** of residents who report less fear of falling
- **82%** of residents who report they know how to move safely
- **82%** of residents who report they feel safe and confident moving around the home
- **93%** of residents who report they had equipment required to help them move safely
- **91%** of residents who report feeling less worry about tripping and falling

Better value for money

- **37%** reduction in NIAS call outs
- **33%** reduction in falls rates within partner care homes

Falls in Care Homes Project

Better staff engagement/exprience

- **82%** of staff reporting improved confidence promoting safer mobility in residents
- **82%** of staff reporting improved confidence in managing a resident fall

Better quity

- **100%** of Partner Care Homes using Regional Falls Pathway

Improved safety/health outcomes

- **131** changes made following medicines optimisation review
- **84%** increase in pharmacist knowledge

4. MEASURING IMPROVEMENT: FALLS: GAME CHANGING INNOVATION PROJECT

A consortium including Age NI, the Public Health Agency (PHA), the Southern Health and Social Care Trust, a UK-based technology firm and Taking Care, part of AXA Health, won a highly competitive UK innovation award aimed at delivering "game-changing innovations" to help people as they age, allowing them to remain active, independent and socially connected for as long as possible.

The funded project, *Move More Live More*, is aimed at tackling falls affecting the health and wellbeing of the older population. It uses wearable digital technology, combined with a unique data monitoring platform, which can predict an increased chance of a fall up to 32 days before a fall would occur. Through monitoring and early detection, the wearer can then be prompted with movement, actions and interventions aimed at preventing them from falling.

"The key message of the project is that falls are *not* always an inevitable part of growing older and there are actions and lifestyle changes which can help us all to stay stronger for longer."

Who's it for?

Move More Live More will deliver three tiers of support to people aged over 65 ranging from anyone interested in learning how to stay strong to prevent falls, to those who have experienced a fall and may be seeking health and wellbeing guidance to get more out of life, through to individuals experiencing slowing down and deemed as being at a higher risk of falling, who will trial innovative new remote monitoring technology.

Age NI deliver a new tailor-made six-week online course of expert sessions aimed at educating older people in health, wellbeing and movement to build all-important strength and balance to stay stronger for longer, all under the close guidance of physiotherapists.

The consortium's lead partner, **Taking Care**, part of AXA Health, is one of the UK's largest providers of personal alarms and monitoring services.

Working closely with the project's technology partner, **Technicare,** Taking Care will provide support and information to those users designated at higher risk of a fall.

How the technology works:

Technicare's ground-breaking remote monitoring platform captures data collected from wearable devices, including activity levels, sleep, heart rate and SpO2. The unique monitoring platform uses predictive analytics (computer learning) to detect changes which can indicate an increased risk of falling. Earlier research on the platform's predictive analytics indicates it can detect an increased risk of a fall up to 32 days before a fall occurs.

If a risk is flagged on any wearer's data, Taking Care's highly trained Prevention Team assess the individual and provide health and lifestyle information or intervention measures to avoid a fall. This can include guidance on exercise and movement, or may include prompts to self-refer for healthcare support (e.g. GP, pharmacist, falls clinic).

If risks are elevated and sustained, the wearer and their nominated advocate (family member or friend) will be alerted.

Age NI Chief Executive Linda Robinson said,

> **"It is brilliant to see an application of digital technology which is aimed specifically at supporting the older generation in such an impactful way. Move More Live More has the potential to alter the shape of later life for so many people, so it's really interesting and exciting."**

Also link to BBC Newsline article below:

New technology aims to prevent falls for elderly - BBC News

Raising the Standards

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Introduction

The PHA has established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The PHA is continuously striving for excellence and raising the standards of care and the quality of services delivered.

1. RAISING THE STANDARDS: NEW MODELS OF PRESCRIBING

New Models of Prescribing (NMOP) aims to make it easier for patients to get their urgent medicines without delay and from the most appropriate healthcare professional. Some prescribers working in Trusts can now write prescriptions for patients that can then be dispensed by community pharmacists rather than waiting for a GP to write the prescription following an outpatient appointment.

Prior to the NMOP project, Northern Ireland did not have a mechanism to allow prescribers working at interfaces between HSC Trusts and General Practice to prescribe a medication directly to the patient which can then be dispensed in the community. This means that there is often duplication of work, as the prescriber relies on the patient's GP to implement their recommendations and ensure that the required medicines are obtained.

In 2020/21, a number of small pilot projects were initiated to test what was needed to allow direct prescribing to the patient by a number of professionals. These included:

Outpatient and community physiotherapists writing prescriptions for respiratory symptoms, musculoskeletal problems and lymphoedema (long-term condition that causes swelling in the body's tissues) among other conditions.

Heart failure nurses prescribing at outpatient appointments to manage symptoms quickly.

Medical prescribers working in Belfast Trust's Home Treatment Team prescribing urgent medicines to prevent rapid deterioration of a patient's mental health.

The pilot projects have enabled longer-term funding to be secured under the Integrated Prescribing Programme. This will mean that we can build on the success of NMOP to benefit more patients across Northern Ireland and to consider other patient journeys that may need to access to prescriptions.

Outcomes

- NMOP reduces delays in accessing medication that should be started quickly, allowing the patient to access the right medicines, at the right time, from the right person.
- NMOP supports a reduction in unnecessary appointments and promotes a faster recovery, and a self-care approach to health needs.
- NMOP enhances the delivery of tailored interventions to patients, and maximises the use of the professionals' skills at the point of care.
- NMOP increases care that can be delivered by non-medical prescribers e.g. nurses, physiotherapists.
- NMOP reduces pressure on GPs.

2. RAISING THE STANDARDS: IMPLEMENTATION OF PURPOSE-T (PRESSURE ULCER RISK PRIMARY OR SECONDARY EVALUATION TOOL)

Purpose T is an evidence-based pressure ulcer risk assessment instrument that was developed using robust research methods.

The PHA, Safety, Quality and Innovation Team led a multidisciplinary and multiagency team, on the introduction of Purpose T, which was implemented to replace the previous Braden Scale, as PURPOSE T identifies more patients at risk of pressure ulcers.

In September 2022 the Public Health Agency Regional Pressure Ulcer Prevention Group members requested that CNO Business Meeting Attendees consider approving the safe implementation of PURPOSE T across all hospital and community care settings in N. Ireland.

In October 2022 a Task and Finish Group led by the PHA was formed.

Outcomes

Meeting of PHA and Clinical Education Centre (CEC): Senior Education Manager briefed on requirements for education sessions on Purpose T.

Meeting with Chief Nursing/Midwifery Information Officers (CNMIO) from 5 HSC Trusts and agreement to replace Braden with Purpose T within Person Centred Assessment Care documentation.

The e-learning programme amendments made by Leadership Centre.

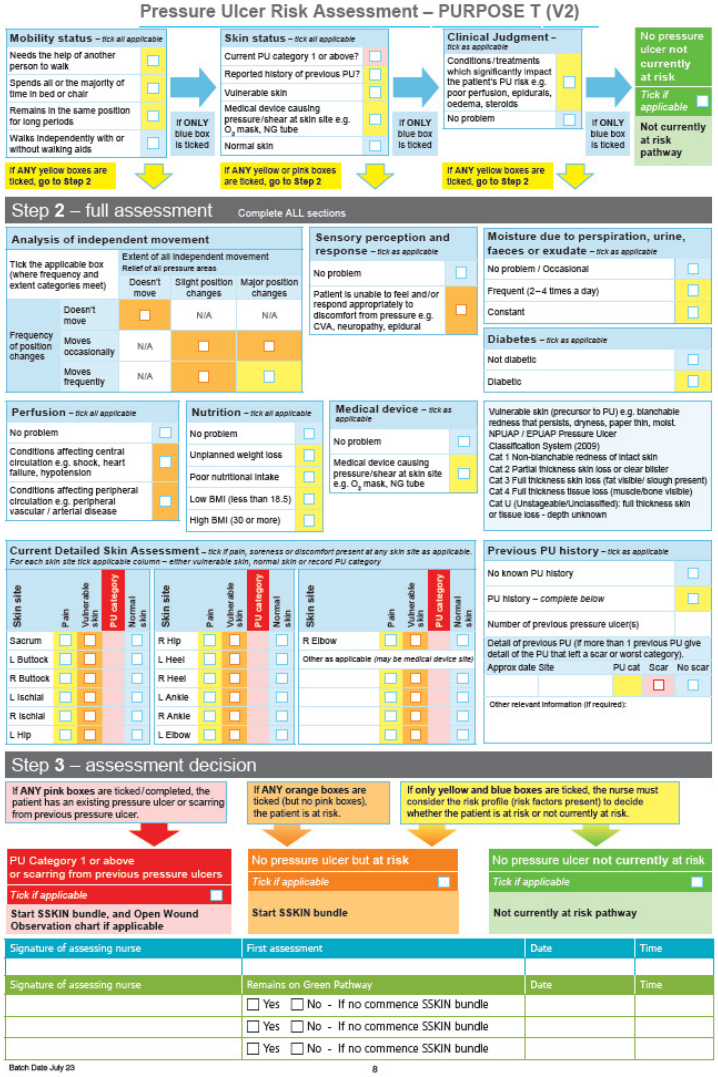
Agreed regional training date for Purpose T.

January 2023, a masterclass was provided to train the trainers, and a agree plan to ensure cascade of learning to all stakeholders.

February 2023 Person-Centred Assessment Care documentation testing completed and new documentation finalised for regional procurement. Regional Procurement of Person-Centred Assessment Care documentation commenced.

March 2023, ensured the project was in line for full roll out by June 2023.

Purpose T: Person Centred Assessment Care documentation



Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Mobility status – *tick all applicable*
- Needs the help of another person to walk
- Spends all or the majority of time in bed or chair
- Remains in the same position for long periods
- Walks independently with or without walking aids

If ONLY blue box is ticked

Skin status – *tick all applicable*
- Current PU category 1 or above?
- Reported history of previous PU?
- Vulnerable skin
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube
- Normal skin

If ONLY blue box is ticked

Clinical Judgment – *tick as applicable*
- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids
- No problem

If ONLY blue box is ticked

No pressure ulcer not currently at risk
Tick if applicable
Not currently at risk pathway

If ANY yellow boxes are ticked, go to Step 2

If ANY yellow or pink boxes are ticked, go to Step 2

If ANY yellow boxes are ticked, go to Step 2

Step 2 – full assessment
Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all Independent movement – Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*
- No problem
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*
- No problem / Occasional
- Frequent (2–4 times a day)
- Constant

Diabetes – *tick as applicable*
- Not diabetic
- Diabetic

Perfusion – *tick all applicable*
- No problem
- Conditions affecting central circulation e.g. shock, heart failure, hypotension
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease

Nutrition – *tick all applicable*
- No problem
- Unplanned weight loss
- Poor nutritional intake
- Low BMI (less than 18.5)
- High BMI (30 or more)

Medical device – *tick as applicable*
- No problem
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat 1 Non-blanchable redness of intact skin
Cat 2 Partial thickness skin loss or clear blister
Cat 3 Full thickness skin loss (fat visible/ slough present)
Cat 4 Full thickness tissue loss (muscle/bone visible)
Cat U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*
For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category

Skin site	Pain	Vulnerable skin	PU category	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category	Normal skin
R Elbow	☐	☐		☐
Other as applicable (may be medical device site)				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Previous PU history – *tick as applicable*
- No known PU history
- PU history – *complete below*
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked/completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

PU Category 1 or above or scarring from previous pressure ulcers
Tick if applicable ☐
Start SSKIN bundle, and Open Wound Observation chart if applicable

No pressure ulcer but **at risk**
Tick if applicable ☐
Start SSKIN bundle

No pressure ulcer **not currently at risk**
Tick if applicable ☐
Not currently at risk pathway

Signature of assessing nurse	First assessment	Date	Time
Signature of assessing nurse	**Remains on Green Pathway**	**Date**	**Time**
	☐ Yes ☐ No - If no commence SSKIN bundle		
	☐ Yes ☐ No - If no commence SSKIN bundle		
	☐ Yes ☐ No - If no commence SSKIN bundle		

Batch Date July 23

8

3. RAISING THE STANDARDS: UPDATED GUIDELINES ON THE USE OF INPATIENT FALLS ASSISTIVE TECHNOLOGY

Assistive technology has a role in enabling, maintaining and supporting the lifestyle of individuals. Advances in assistive technology have continued to develop within hospitals, given the pressures on inpatient services.

Assistive technology used correctly complements health provision, with the need for the health and social care professionals to select and justify the right kind of intervention to support the individual, while fully considering the needs, wishes, capacity and circumstances of the individual.

The role of Falls Assistive Technology in reducing falls on wards is growing. The following are common types of assistive technology that are often used within inpatient settings. Most companies will supply wired and wireless versions:

- Clip and cord
- Chair exit alarm
- Bed exit alarm
- Floor exit alarm
- Infra-red beams

To assist with the correct use of assistive technology, regional guidelines where developed. The guidelines on the use of Inpatient Falls Assistive Technology required amendment as a result of learning identified from a Serious Adverse Incident. The Regional Inpatient Falls Group, which incorporates multidisciplinary staff from all Trusts and is chaired by the PHA, Safety, Quality and Innovation Team, updated the guidance highlighting the importance of daily monitoring of any assistive technology that is in use.

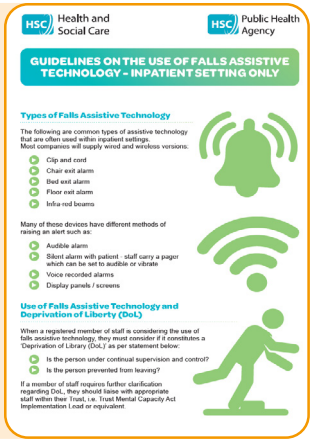
Outcome

As part of their programme of work, the Group have developed an amended version of the **Falls Assistive Technologies** guideline for inpatient settings, that was issued on the 19th August 2022.

The purpose of this document is to provide key information on Falls Assistive Technologies, which will support staff in ensuring safe and effective use of falls prevention equipment, which may be available in the inpatient setting.

A print ready copy and a PDF copy of the guidelines were shared with all Directors of Nursing to be disseminated to all relevant staff discussion at team meetings/ safety briefings. The document can be found at:

Guidelines on the Use of Falls Assistive Technology - Inpatient Setting Only



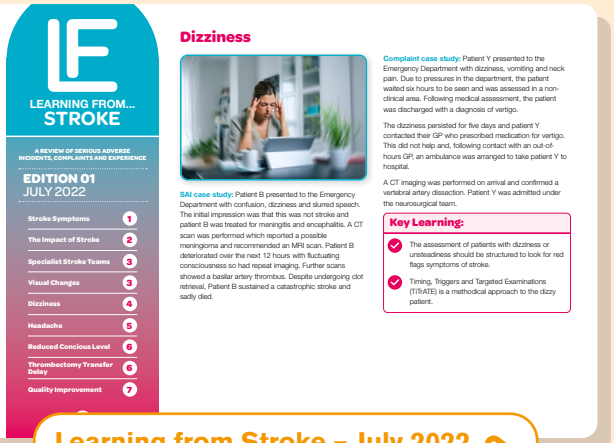
4. RAISING THE STANDARDS: REGIONAL LEARNING NEWSLETTERS

The Safety, Quality and Innovation Nursing Team in the PHA led on the development and design of several Regional 'Learning Matters'/'Learning From' Newsletters, which were issued to a wide range of key stakeholders, including all staff across the 5 Health and Social Care Trusts, Education providers for Healthcare and the private and independent health care sector. The various editions were distributed electronically and for the period of 22/23 **six editions** were issued:

- Learning from Falls – Sept 22 (launched on National Falls Awareness Week)
- Learning Matters Special Edition Sept 22 – Medication
- Learning from Stroke – July 2022
- Learning Matters Special Edition June 22 – Maternity
- Learning Matters Edition 21 June 22
- Learning Matters Edition 20 April 22

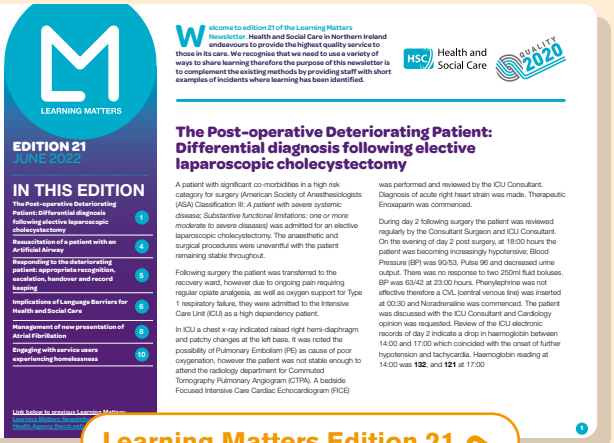
All editions are available on the public facing PHA website.

- Successful publication of 6 editions of a regional Learning Newsletter by the PHA Safety, Quality and Innovation Nursing Team, to share learning from the triangulation of data such as SAIs, Patient Experience and Complaints.
- Highly positive verbal and written feedback received from a selection of HSC staff.
- Raising the profile of the Learning Matters Newsletter which has meant additional engagement from frontline HSC staff who have asked for our Team to use Learning Matters to raise profile of certain patient safety issues i.e. ingestion of Caustic Soda in children.
- All editions cover a wide range of topics where key learning is identified and with each article the latest evidence-based practice is referenced.
- The Safety, Quality and Innovation Nursing Team co-produced various editions with frontline health and social care staff.
- In the coming year the Team plan to undertake a robust evaluation of Learning Matters to drive improvements in engagement and make any other suggested amendments to the format, which makes it easier for Health and Social Care staff to be aware of learning from incidents.



Learning from Stroke – July 2022

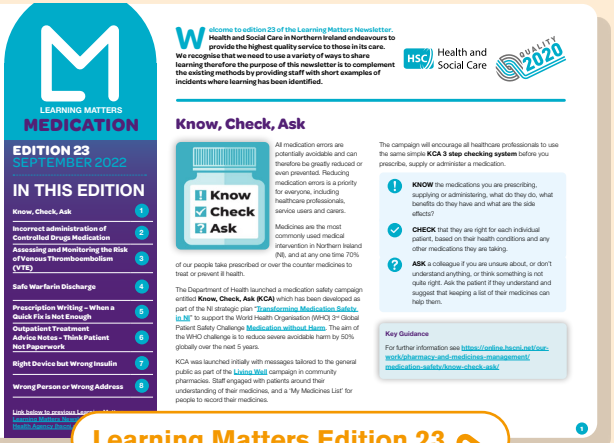
Learning Matters Edition 20



Learning Matters Edition 21

Learning from Falls – Sept 22

Learning Matters Edition 22



Learning Matters Edition 23

5. RAISING THE STANDARDS: DISTRICT NURSING CONFERENCE - SEPTEMBER 2022

The District Nursing Conference which took place in Belfast between 5th-7th Sept 2022 was successful in that it enabled the NI District Nursing family to come together face to face again after two years and review progress in a number of areas, re-energise and action plan regionally.

It was a chance to welcome all the DN teams regionally, thank them for their exceptionally hard work and versatility during Covid-19.

It was an opportunity to update the group on some of the policies and direction of travel including the implementation of the Nursing and Midwifery Task Group (2020) and the District Nursing Career Pathway (2022) whilst raising issues concerning the limited use of technology in District Nursing.

In addition, it provided an opportunity for district nurses, managers and neighbourhood district nursing coaches to collectively reflect on the challenges and opportunities for the further implementation of the Neighbourhood District Nursing model.

There were many presenters and workshops at this event and it was an effective mix of information sharing and staff having their own voices heard and documented. All of this work was themed and later informed the three new NMTG DN groups.

Furthermore, a conference scribe was commissioned to capture key points from this conference and this image below demonstrates the transformative journey that District Nursing continues to be on regionally.

Outcome

Integrating the Care

Objective 9: We will develop integrated pathways of care for individuals.

Objective 10: We will make better use of multidisciplinary team working and shared opportunities for learning and development in the HSC and with external partners.

Introduction

The PHA is committed to supporting an integrated HSC system in Northern Ireland, which will enable the seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the PHA last year which contributed to raising the quality of care and outcomes experienced by patients, clients and their families.

1. INTEGRATING THE CARE: COLLABORATING ACROSS ALL SECTORS TO OPTIMISE SAFE PRACTICE WITHIN PALLIATIVE CARE

The syringe pump is used extensively within palliative care to help manage symptoms. It can deliver a combination of drugs. Often a patient may have 2, and sometimes 3 syringe pumps at one time.

In May 2022 we brought together 37 stakeholders from across care settings, sectors, and professions including Nursing, Pharmacy, GPs and Clinical Engineers. The purpose of the focus group was to identify issues regarding the safe prescribing and management of syringe pumps and to share learning and insight.

Issues explored were

- The Syringe Pump Ability to Safely and Continuously Administer Medication
- One Syringe Pump for NI Position
- Scale of Need for additional devises and servicing
- Learning from SAIs
- Prescription and Administration Documentation for Syringe Pump
- Authorisation to Administer and Access to Medicines
- Training

Issues were addressed in order of urgency and priority. Assurance of devise safety and functionality was of priority as this was hindering investment by some HSC Trusts who were finding that they needed to urgently replenish their stock to meet the demand, but were faced with concerns raised by the clinical engineers.

A paper setting out the regulatory process and the salient points associated with the reported incidents, highlighting roles and responsibilities when escalating concerns regarding the performance of a device was developed. It included key points of learning established during meetings between Northern Ireland Adverse Incidents Centre (NIAIC), Trust clinical engineers, Trust managers and users of the device, the Becton Dickinson (BD) Manufacturers of the device and Rockford Healthcare (Medical Supplier).

Whilst the decision on the need to purchase a medical device is the sole responsibility of the individual organisations the process and learning undertaken during the meetings enabled individuals to make a more informed decisions about their future procurement.

Outcomes

HSCNI Trusts who were reluctant to purchase the new edition of the devise have now progressed procurement. This will ensure that people with complex symptoms, who are unable to take or absorb their oral medication can have their symptoms such as pain, nausea and vomiting well managed.

Resulting points of learning addressed practice and training and was shared across all sectors.

- Staff operators should attend syringe pump training in accordance with the Trust/Organisation policy.
- Training should highlight that, in accordance with manufacturer DFU
  - infusion should not be started if volume in syringe does not match volume on display, it should be removed from clinical use. Training will advise the user to check that the volume to be infused correlates with the volume in the syringe, the duration of the infusion is correct and that the rate is correct.
  - if a System Error occurs a pump should be removed from clinical use.
  - pumps removed from clinical use should be returned to the clinical engineers detailing error noted and requesting service check.
- To reduce the low risk of pre-load interruption due to the device being cold, the user should avoid leaving the syringe pump in an environment which is outside the temperature parameters recommended. This should be detailed in the Trust/Organisation policy.
- A regional Learning From communication has reviewed a number of SAIs relating to prescribing and will be published soon.
- Work is now being taken forward to develop a regional syringe pump guidance to standardise safe practice and inform training. A review of all prescribing and administration documentation is also being progressed.

2. INTEGRATING THE CARE: HEALTH & CRIMINAL JUSTICE

A major focus of SPPG/PHA Improving Health Within Criminal Justice Planning & Commissioning Team over the past year has been responding to the RQIA report 'Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons'. Six task and finish groups were established to take forward the recommendations from the RQIA review including:

- Benchmark prison health services with rest of the UK.
- Review the capacity & capability of prison addiction services.
- Develop an algorithm to assess the suitability of individuals placed in prison Care & Supervision Units.
- Review capacity & capability of prison psychology services and consider introduction of specialist psychology services for trauma and personality disorder.
- Align mental health appointments with the Quality Network for Prison Mental Health Standards including a reviewing the capacity and capability of mental health service.
- Plan, commission and implement a therapeutic approach to personality disorder.
- Identify options for expediting the transfer of acutely mentally unwell who require hospital admission.
- Identify a single point of entry to access PICU and acute mental health beds.
- Develop a regional service specification.
- Develop metrics to inform ongoing assessment of need including data collection for specific vulnerabilities and develop traffic light dashboard.

In the challenging financial context, the Planning & Commissioning team are endeavouring to identify potential funding sources to support investment in health care in prison.

Improving the health outcomes for those involved in the criminal justice system has a wider impact than just the men and women themselves, and affects their families and the wider society.

Outcomes

- Benchmarking identified lower resourcing in Northern Ireland compared with North East and South West regions of England. Subject to caveats as different commissioning arrangements and like for like comparison not possible.
- Investment in Administrative Support for the Transition pathway for Healthcare in Prison Addiction services, to free up clinical time from administration.
- In year funding for clinical addiction team to include nursing, medical and pharmacy.
- Recovery model for alcohol dependence being developed.
- Papers developed to improve prison psychological services including development of a personality disorder service and the development of an Enabling Environment approach across three prison sites.
- Improved collaborative working between SEHSCT, Northern Ireland Prison Service and Probation Services psychological service teams.
- Care and Supervision Algorithm is operational.
- Transfer Direction Order (TDO) process final stage of drafting, pending consultation.
- Care Plans in place for people with mental health concerns which do not meet the threshold for acute in-patient care.
- Telephone self-referral trial for people in the care of prison service experiencing mental health concerns initiated.
- Single point of access for mental health inpatient admission confirmed as Shannon Clinic.
- Revised interface with Regional Bed Management Protocol for acute Psychiatric Beds.
- Improvements to internal prison healthcare transition to community processes established between key stakeholders.
- Key metrics and KPIs developed but subject to further work by information specialists to ensure new regional patient information system (Encompass Epic) will be able to capture.
- Prison Health Needs Assessment at final draft.

3. HSC QUALITY IMPROVEMENT

Health and Social Care Quality Improvement (HSCQI)

Health and Social Care Quality Improvement (HSCQI) is a Network of Quality Improvement experts and enthusiasts which was established by the Department of Health in 2019 in order to support transformation of the Northern Ireland Health and Social Care system.

This HSCQI Annual Report 2022/23 highlights the range of work undertaken by the HSCQI Network during 2022/23. It is divided into four main sections, each section being aligned to one of the four key drivers stated within the HSCQI Strategy “Moving Forward, Shaping the Journey 2022 – 2024”. The four sections are: Developing Leadership for Improvement; Building a Learning System; Quality Improvement Methodologies and Building QI Capability; and, Partnership and Co-Production.

The link to the HSCQI Annual Report 2022/23 is
https://hscqi.hscni.net/about-hscqi/annual-report/

HSC Public Health Agency

item 14

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	PHA Mid-Year Assurance Statement
Reference	PHA/04/10/23
Prepared by	Janine Watterson
Lead Director	Aidan Dawson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the PHA Mid-Year Assurance Statement.

2 Background Information

All arm's length bodies are normally required to submit a Mid-year Assurance Statement to the Department of Health in a template that is set by the Department.

The Statement was approved by the Agency Management Team and by the Governance and Audit Committee.

3 Key Issues

The Mid-Year Assurance Statement provides assurance on the systems of internal control in line with Departmental guidance. It includes details of Internal Audit assignments for 2023/24 completed to date.

4 Next Steps

Following approval by the PHA Board, the Statement will be signed by the Chief Executive and forwarded to the Department of Health for information.

DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in the Public Health Agency as at 30 September 2023.

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 22 June 2023. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance Framework as described in the most recent Governance Statement continues in operation. The Audit Committee and the Remuneration Committee have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

An Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board. Minutes of board meetings are available to further attest to this.

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board and that risk management systems/processes are in place throughout the organisation.

As part of the board-led system of risk management, the Register is presented to the Governance and Audit Committee for discussion and approval and all significant risks are reported to the board – most recently on 12 September 2023.

In addition, I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set by out in the organisation's business plan as approved by the Department. The latest Performance Report to the Board advised that of the 37 actions across 10 Key Priorities, 1 action has been categorised as red (significantly behind target/will not be completed), 15 actions have been categorised as amber (will be completed, but with slight delay), 21 actions have been categorised as green (on target to be achieved/already completed).

The action categorised as red relates to a draft HSCQI workplan for 2023/24 which cannot be currently agreed as a programme budget for 2023/24 has not been allocated. This action has also been highlighted as internal control divergence at 12(b).

5. Finance

I confirm that proper financial controls are in place which if complied with enables me to ensure value for money, propriety, legality and regularity of expenditure and contracts under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance, with any exceptions noted in section, with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;

- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE).

6. Information Governance – UK General Data Protect Regulation (UK GDPR) & Data Protection Act (DPA) 2018

I can confirm that my organisation has taken appropriate steps and is carrying out the necessary actions to ensure ongoing compliance with UK GDPR and DPA 2018.

7. External Audit Report

There were three priority one recommendations identified by the Northern Ireland Audit Office (NIAO) in relation to their findings following the 2022/23 audit process.

It should be noted that these recommendations are contained within the NIAO's draft Report to Those Charged with Governance.

SBNI unlawful / illegal expenditure

This recommendation related to uplifts applied to the remuneration of three Panel Chairs within the Safeguarding Board for Northern Ireland (SBNI), which is 'hosted' within the PHA. These uplifts were applied without the appropriate approvals by the Department of Finance. NIAO recommended that PHA implemented additional accountability

arrangements to ensure the PHA Chief Executive receives all necessary assurances in relation to SBNI expenditure.

Actions were taken in 2022/23 to regularise the expenditure going forward and enhanced oversight arrangements have been put in place between SBNI and PHA. More detail is available in section 12a of this document.

PHA considers the resultant recommendation made by NIAO to be implemented.

Fraudulent payment

The PHA was subjected to a successful fraud during February 2023 where payments totalling £104,332 were made to a fraudulent bank account following a fraudulent request to change the bank details relating to a legitimate supplier.
The HSC Internal Audit service was asked by the Director of Finance to perform a rapid review of the circumstances pertaining to this matter and all resultant recommendations relating to PHA were confirmed by Internal Audit as implemented in the formal follow up exercise on audit recommendations as at March 2023.

In addition, engagement has continued with the PHA's banking provider to identify any steps which could be taken to recover any of these funds. In August 2023, PHA received notification from their banking provider that amounts totalling £56,008 had been recovered via the beneficiary bank, where these funds were initially deposited.

PHA considers the resultant recommendation made by NIAO to be implemented and investigations are ongoing with the PHA's banking provider and the beneficiary bank regarding the balance of funds.

Payroll controls

NIAO noted a number of weaknesses in controls relating to PHA's payroll control environment and recommended that internal audit recommendations, and the actions

identified by PHA management on enhancing controls, should be implemented and performance monitored accordingly.

PHA has performed a review of existing controls and put in place an action plan and a series of controls to improve performance in this area. Updates have been provided to the Agency Management Team and the Governance and Audit Committee regarding actions taken to enhance and improve processes and training to PHA managers.

PHA considers the resultant recommendation made by NIAO to be implemented.

8. Internal Audit

I confirm implementation of the accepted recommendations made by Internal Audit, with the following exceptions

Internal Audit carried out a full review of priority 1 and 2 accepted audit recommendations where the implementation date had now passed and provided a detailed progress report to the Governance and Audit Committee on 10 October 2023. The outcome of this report highlighted that 60 (79%) of the outstanding 76 recommendations examined were fully implemented, a further 16 (21%) were partially implemented. Action is currently being taken to ensure all recommendations are being fully implemented. A copy of this report is available if required.

As at 30 September 2023 the following internal audit reports have been finalised.

Title	**Level of Assurance**
Management of Voluntary and Community Organisation Contracts	Limited
Management of Complaints and Claims	Limited

The Priority one findings in the above internal audit reports were as follows:

Management of Voluntary and Community Organisation Contracts

There was one priority one finding in this report relating to the Procurement of Services and internal audit recommended that PHA should take action to ensure the delivery of a procurement plan in line with agreed schedule. Internal audit noted that they had identified similar findings in previous internal audits in this area. The PHA accepted this recommendation and highlighted that the PHA Procurement Board had reviewed all existing contracts and agreed revised timelines for individual tender awards and Operational Plans to be developed. It is anticipated that this recommendation will be implemented by 31 March 2026, subject to appropriate resources being available in PHA, BSO PaLS and Legal to deliver, as planned, on this complex programme of work.

Management of Complaints and Claims

There was one priority one finding in this report relating to the security of complaints records and internal audit recommended that PHA should ensure that all complaints information is saved appropriately with restricted access. The PHA accepted this recommendation and undertook to review and strengthen their processes by 30 September 2023.

9. RQIA and Other Reports

The PHA continues to work with SPPG colleagues to improve the reporting and assurance mechanism for RQIA and Governance Teams in SPPG. Following migration, these processes are under review and papers have been provided to AMT/ Group heads with a suggested way forward. PHA professional colleagues will still continue to be identified and work with governance colleagues to update with assurances regarding the implementation of any actions identified for PHA/SPPG.

10. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

11. Board Governance Self-Assessment Tool

I confirm progress has been made regarding the Board Governance Self-Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

12. Internal Control Divergences

I confirm that my organisation meets, and has in place controls to enable it to meet, the requirements of all extant statutory obligations; that it complies with all standards, policies and strategies set by the Department, the conditions and requirements set out in the MSFM, other Departmental guidance and guidelines and all applicable guidance set by other parts of Government. Any significant control divergences are reported below.

a) Update on prior year control issues which have now been resolved and are no longer considered to be control issues

SBNI – Unlawful expenditure

The Chair of the Safeguarding Board for Northern Ireland (SBNI) is accountable directly to the Department of Health through the relevant DoH Sponsor Branch arrangements. Due to the nature of the role of SBNI, formal Panels are in place in respect of Safeguarding and Case Management Reviews with appointed Panel Chairs.

The PHA is the corporate host of the SBNI, via arrangements which are governed by a Memorandum of Understanding (MoU). As such, SBNI expenditure is recorded within the accounts of the PHA and whilst the PHA Chief Executive has no day to day responsibility for the operations or expenditure of SBNI, he is the de facto Accounting Officer for SBNI. The SBNI has its own Board and the Chair of the SBNI provides an annual assurance statement to the PHA Chief Executive to attest to the effectiveness of internal control within SBNI.

On 17 April 2023 the PHA Chief Executive received communication from the DoH regarding an uplift which had been applied to SBNI Panel Chair's remuneration 91 which had been deemed unlawful, as being unapproved by the Department of Finance before being applied. The communication indicated that this was the second instance of an unapproved uplift of the rate paid to a Panel Chair within a five year period and also confirmed that the necessary approval for the uplift had been granted from 21 March 2023, which was later than the effective date of the uplift (earliest, November 2016).

Following a meeting of the SBNI Board on 19 April 2023, on 20 April 2023 the PHA Chief Executive received formal communication from the Chair of SBNI on this matter. This communication included the annual assurance statement, approved by the SBNI Board, and highlighted an error within the arrears paid to SBNI Panel Chairs. This error led to unlawful expenditure of £33.5k.

The PHA Chief Executive wrote to the Chair of SBNI on 2 May 2023, regarding the circumstances which led to the unlawful expenditure and also advising that more regular formal oversight arrangements be established going forward into 2023/24 and beyond. The first accountability meeting was held in June 2023.

Actions were taken in 2022/23 to regularise the expenditure going forward and formal regular oversight arrangements have now been put in place between the PHA Chief Executive, Director of Finance and the SBNI Chair and Senior Management.

COVID-19

The pandemic had an extensive impact on the health of the population, all health services and the way business was conducted across the public sector. Protecting the population, particularly the most vulnerable, ensuring that health and social care services were not overwhelmed, saving lives through mitigating the impact of the pandemic and patient and staff safety remained at the forefront throughout the emergency response.

This emergency response continued to be a focus and a challenge in 2022/23 and at the same time the organisation had transitioned back to core business delivery and was preparing to play a key role in helping to shape a new Integrated Care planning system.

During 2022/23 the PHA also took leadership of the COVID-19 Autumn and Spring Booster Vaccination programmes and, as part of Winter 2022 preparedness planning, developed a plan to provide an overview of arrangements for responding to a surge in public health incidents including SARSCoV2.

As the PHA has now appropriate operational procedures in place to manage the additional duties referred to above we no longer consider this issue to be an internal control divergence.

b) Update on prior year control issues which continue to be considered control issues

Financial Performance

The budget for Health and Social Care in Northern Ireland continues to be challenging. Funding reductions of £8.5m relating to recurrent cash releasing savings targets have been applied to PHA's 2023/24 opening baseline. £3.2m relates to a reduction to the

PHA's Research and Development budget, pending a decision by DOH on whether Northern Ireland should continue to participate in, and contribute to, the National Institute of Health and Care Research (NIHR). NIHR is the nation's largest funder of health and care research. Should a decision be made to continue with this annual expenditure, the planning assumption is that the associated funding will be returned to PHA.

Initial plans have been set in place to achieve the majority of the remaining target of £5.3m in 2023/24 on a mix of recurrent and non-recurrent measures. A plan has been developed to work through a process to identify options for management of this retraction recurrently.

The PHA approved a financial plan in June 2023 on its financial position and direct resources. The Financial Plan indicated an opening deficit of £0.65m, resultant primarily from the level of cash releasing savings removed from PHA's baseline funding versus the quantum of initial savings plans to achieve these targets. Continued efforts are being made to identify additional savings to address the remaining target and therefore also this forecast deficit.

Financial performance is monitored against this plan during the financial year alongside the identification of actions to address the quantum of the opening forecast deficit. The forecast deficit has been reduced in quarter 1 to c£0.45m and efforts will continue to work toward the aim of achieving a breakeven position for the financial year.

Management of Contracts with the Community and Voluntary Sector

Previous Internal Audit reports on the management of health and social wellbeing improvement contracts have provided satisfactory assurance on the system of internal controls over PHA's management of health and social wellbeing contracts reflecting the significant work that has been undertaken by the PHA. Service Level Agreements are in place, appropriate monitoring arrangements have been developed and payments are only released on approval of previous progress returns.

During 2023/24, we have continued to work with providers to review contract activity and agree revised performance measures, taking into account any changes in how services are targeted and delivered. A more detailed review of the current PMR process will also be undertaken to ensure that the measures of performance included in contracts are more focused on demonstrating the outcomes being achieved.

Work continues to fully address the partially implemented priority one weakness in control relating to the implementation of the PHA Social Care Procurement Plan. The PHA Procurement Plan continues to be regularly reviewed by the PHA Procurement Board and progress against agreed timescales for completing procurements closely monitored.

The PHA Procurement Plan contains all contracts that will be awarded under a formal tender process and need to be managed in line with the NI Public Contract Regulations 2015. A total of 62 contracts are currently included on the Plan with an annual value of £9.45m. One Procurement has been successfully completed to date during 2023/24. The Early Intervention Support Service was completed in August 2023 with 5 contracts successfully awarded with an annual value of £815k. The Youth Engagement Service is currently being advertised and this tender opportunity will close on the 29 Sept 2023.

The planned procurement of PHA Alcohol & Drug services will be guided by the Substance Use Strategic Commissioning and Implementation Plan which is now moving to public consultation in early September following approval by both PHA Board and SPPG. Procurement and onward tendering of PHA Alcohol & Drug services are planned to take place in a number of tranches the first being the Regional Service User Network tender, which is progressing well and will be advertised in Oct 2023.

Good progress has been made in the planning phase of the Self Harm Intervention Programme and pre-procurement work is underway, it is anticipated that this will be advertised in the near future.

Two further tenders at various stages are delayed due to the uncertainty around the PHA financial position for 23/24 and beyond. This includes the Shared Reading Service in the NI Criminal Justice Setting and Promoting Informed Choice in the Cancer Screening Programmes.

The PHA is continuing to build planning and procurement expertise in the organisation through supporting staff to attend the post graduate commissioning leadership programme that aims to build the knowledge and skills of senior staff across HSC in relation to planning, procurement and contract management processes. The PHA is also continuing to pilot multi-disciplinary strategic planning teams that will oversee the development of strategic plans for key business areas. These planning teams will help to ensure future procurements are progressed more efficiently, in line with required processes.

The PHA will continue to work closely with colleagues in SPPG (DOH), BSO (Directorate of Legal Services and Procurement and Logistics service), HSC Trusts and the DoH, to ensure that procurement processes continue to meet regional policy and guidance.

PHA Staffing Issues / Staff Resilience during COVID-19

During the 23/24 year the PHA has continued to consider the workforce requirements both in terms of recruitment and retention, supporting staff resilience.

PHA continues to face challenges in respect to consultant staffing. Consultant capacity is currently constrained due to a mixture of vacant posts and staff not being available for work due to sick or other leave. The use of retire and return allowing experienced consultants to return to provide a service has given us three consultants who work a total of 1.6WTE between them. In addition, locums are being used to ensure there is cover for the health protection service. Recruitment is ongoing for permanent and locum consultants. A range of other measures are in place to mitigate the impact of the reduction in consultant staffing. These include the development of senior programme

manager roles to deliver in a range of areas to ensure consultant expertise is applied where it is much needed. Arrangements have also been put in place with the UK Health Security Agency to provide advice and support on health protections matters in and out of hours should that be required. In addition, links have been formed with UKHSA teams which have allowed PHA staff to avail of training which previously was not available to our staff.

On the recruitment side the scrutiny process has been further refined to ensure robust information is available at the point of decision making and all activity processed through to the recruitment centre is monitored for timely actions. Reporting on recruitment performance is a key component of monthly reporting to AMT.

Temporary contract usage has been a particular focus in year commencing with a full review of all temporary appointments and a full report and revised process being presented via Scrutiny in May 2023. This incorporated an exit strategy for each existing temporary appointment and introduced a new process to ensure all future temporary appointments were entered into with a clear exit strategy. All of this is to ensure the use of temporary contracts is minimised to only being used where absolutely required.

In addition to the monitoring of temporary arrangements, the previously used Expression of Interest process has been stood down with a new process ‘Internal Talent Mobility’ being trialled. The purposes of this new process improves the flow of talent around the organisation to support business need as well improving the opportunities for staff generally and ensuring a robust process for use and management of such.

In the area of retention, the Organisation Development Engagement Forum (ODEF) is now established with a clear workplan split into 3 key workstream:

- Staff Experience - a number of products have been launched including a new Induction pack to support staff at point of entry to the organisation as well as an exit survey so that the Agency might gather information on the reasons for

leaving the organisation. A Health & Well being programme is also now being worked on for launch in the Autumn months.

- Workforce Development – with a key focus on the roll out of the new Learning Management System this workstream have also taken a lead in promoting and improving the uptake of mandatory training as well as appraisal. New policies have also been introduced including the Hybrid working model which is now due for evaluation to inform the future working arrangements across the Agency. A new skills framework is currently under consideration with development due to commence over the Autumn with a view to having a full framework and audit process ready for connecting to the 24/45 Appraisal round.

- Culture - supporting all of the above is the culture workstream who are developing mechanisms which will support the organisations communication systems with staff to ensure clarity, engagement and effectiveness. This workstream is also now working on approaches to recognition and celebration of the work our staff do which aims to ensure a culture which feels inclusive, rewarding and progressive.

Activity across these three workstreams is progressed through the engagement of a wide range of staff from across the Agency under the leadership of 2 sponsors per workstream with 3 underpinning targets being to ensure staff:

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

A People Plan is currently under development which aims to set out the Agency's goals for each of these areas.

HSCQI

The establishment of the HSCQI function, in April 2019, was a key action from 'Health and Wellbeing 2026: Delivering Together'. The DoH established HSCQI within the PHA, providing temporary funding through transformation monies for the Director of HSCQI and a number of additional posts. The Safety Forum, already within the PHA, also became part of the new HSCQI Directorate.

The budget allocation for 2021/22 included funding for some HSCQI posts, however it did not cover the totality of posts required. While the PHA welcomed the funding allocation, given the remaining ongoing gap in funding, it remains challenging for HSCQI to deliver on the design intent. During 2022/23 and 2023/24 no additional DoH funding was allocated to HSCQI. Therefore the HSCQI Hub, based within the PHA, remains fragile.

There is therefore a risk that HSCQI will be unable to fulfil its core function, service corporate requirements or undertake additional requests from the HSC system to support work and training. This risk was further exacerbated due to the redeployment of existing core HSCQI staff on occasions to support the PHA pandemic response.
The PHA Chief Executive and Director HSCQI will continue to work with the Department and the HSCQI Leadership Alliance to agree the priorities for HSCQI (in light of constrained resources) and to discuss funding for HSCQI.

During 2022/23 HSCQI was mandated by the HSCQI Leadership Alliance to align existing regional Quality Improvement resource and effort to leading improvement in relation to the Ministerial priority of Improving Timely Access to Safe Care. During 2023/24 HSCQI were further mandated by the HSCQI Leadership Alliance to continue this work on improving timely access to safe care and to also establish an additional regional scale and spread programme focused on delivering value. During 2023/24 HSCQI were also mandated to establish a regional medication safety programme and to establish a regional Level 3 QI Training programme. While in year money for these

programmes of work was identified in July 2023, that fact that no recurrent money has yet been identified means that all 4 programmes remain at high at risk of not delivering.

Previously, the PHA supported HSCQI programme work through an annual allocational of slippage. However, in order to realise the 2023/24 savings target required by the DoH, the PHA is no longer in a position to fund the HSCQI programme work. Without confirmed programme funding HSCQI will not be in a position to deliver its 2023/24 workplan. The HSCQI Director continues to discuss a way forward with the PHA Chief Executive, the PHA/SPPG Director of Finance and the HSCQI Alliance and DoH colleagues.

Public Inquiries

The Agency has continued to discharge its responsibilities in respect of ongoing Public Inquiries, namely; Muckamore Abbey Hospital Inquiry, , Urology Services Inquiry, Infected Blood Inquiry and the UK COVID-19 Inquiry. The requirements around detailed scoping/retrieval of information and records held by the PHA (in some cases extending to preceding organisations), and the sifting and analysis of relevance against the respective Terms of Reference is extremely comprehensive and resource intensive by nature across all Public Inquiries. These demands are expected to continue long term given the projected timeframe for the UK COVID-19 Inquiry in particular.

During the first 6 months of 2023/24 the PHA has presented evidence through written witness statements and in person to Muckamore Abbey Hospital Inquiry and the COVID-19 Inquiry. These undertakings have consumed significant time, resource and attention across the PHA and by AMT members in particular. In order to ensure good governance arrangements are in place the Agency has moved to establish and resource formal programme management arrangements to support this significant area of work. An inquiries project steering group with 4 wte staff members now underpins a new programme management board comprising Executive Directors, CEO, Directorate of Legal Services and Non-Executive Director representation. The Agency Management Team will continue to work to identify and secure additional resource to meet the legal

requirements in full including engaging with former colleagues to input into Inquiry proceedings where appropriate.

Accommodation

HSC(F) 30-2022 which was issued in January 2023 set out a requirement to submit business cases relating to the renewal of leases and licences 12 months prior to the existing lease / licence expiry date. As the PHA licence for additional offices in County hall expires in September 2023, along with the HSCB/SPPG licence that relates in the main office accommodation in County Hall, non-compliance with that timeline was automatic.

Officers from the PHA and SPPG worked with the Department of Finance, as the landlord for County Hall, to complete separate business cases in regard to the distinct office requirements of both organisations. This separation of the business case process was required due to changed organisational structures and accounting arrangements. The development of the new business cases also required the completion of new surveys to determine the size of the areas occupied by each organisation. The PHA business case for the renewal of a new single licence was submitted to the Department of Health for approval on 21st August.

c) Identification of new issues in the current year (including issues identified in the mid-year assurance statement) and anticipated future issues

Pause on Campaign Programme

As a result of current pressures on the HSC budget the DoH has moved to introduce a pause on campaign related mass advertising by its ALB's during 2023/24. Public health campaigns play a significant role and are deployed regularly by Governments and Public Health Authorities worldwide in raising awareness and influencing attitudes and behaviours around a range of key public health issues. As one of its key functions, the PHA has significant experience and expertise in developing successful population wide campaign programmes which have proven to be very effective when delivered as part of

a wider programme of measures including legislative change and other programme interventions. Awareness raising campaigns are recommended within a number of current NI health strategies eg. Tobacco control, Mental Health and suicide prevention, Fitter Futures and Organ Donation and the PHA is responsible for taking this work forward. Whilst other communication channels can be deployed the evidence base demonstrates that they are less effective in reaching population wide audiences. The agency therefore recognises that the pause in its campaign programme is likely to have a detrimental impact on its ability to meet strategic commitments and annual business plan targets.

13. Mid-Year Assurance Report from Chief Internal Auditor

I confirm that I have referred to the mid-year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations.

I confirm that I remain fit to carry out the role of Accounting Officer in accordance with MPMNI Chapter 3 and that any issues arising which question my ability to carry out the role (e.g. bankruptcy, disqualification, serious conflicts of interest, etc.) are notified immediately to the Departmental Accounting Officer.

Signed: *Date:*

CHIEF EXECUTIVE & ACCOUNTING OFFICER

HSC Public Health Agency

item 15

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Updated Policies and Procedures
Reference	PHA/05/10/23
Prepared by	Operations Directorate Staff
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the following updated Policies and Procedures:

- Business Continuity Policy / Plan
- Risk Management Strategy and Policy
- Records Management Policy

2.1 Business Continuity Policy / Plan

PHA Corporate Business Continuity Plan Exercise Report

On 13 March 2023, senior staff participated in an exercise to test the PHA Corporate Business Continuity Plan.

The aim was to test the Plan and ensure it is as up-to-date and robust as possible to help the organisation recover its key services during or after a Business Continuity incident. Particular consideration was given to issues faced by the organisation in response to a cyber security incident and also the likely impact on staffing as a result of industrial action.

Updated PHA Corporate Business Continuity Plan

The PHA Corporate Business Continuity Plan was updated following the exercise outlined above and was circulated to Directors on 22 March 2023 to ensure the Services, Strategies and Resources sections of the Plan were up-to-date.

The revised PHA Corporate Business Continuity Plan was approved by the Agency Management Team on 2 August and by the Governance and Audit Committee on 12 September.

2.2 Risk Management Strategy and Policy

The PHA Risk Management Strategy and Policy has been updated and includes the following changes:

- Reference to the adoption of the 3-line model of assurance for the PHA Corporate Risk Register following an internal audit recommendation (made regionally)
- Other presentational changes or updates as required

The revised Risk Management Strategy and Policy was approved by the Agency Management Team on 6 September and by the Governance and Audit Committee on 10 October.

2.3 Record Management Policy

Following a review, minimal changes have been made to the Records Management Policy. These consist mainly of formatting changes and an update to Section 7.1 (Statutory Responsibility). All suggested changes are highlighted in red throughout.

The revised Records Management Policy was approved by the Agency Management Team on 20 September and by the Governance and Audit Committee on 10 October.

3 Next Steps

Following approval by the PHA Board, these policies will be shared as appropriate with PHA staff.

PUBLIC HEALTH AGENCY

Corporate Business Continuity Plan

Version	9.0
Issue Date	

CONTENTS

TERMS AND DEFINITIONS

IMT	Incident Management Team
IMAT	Incident Management Action Team
BCM	Business Continuity Management
RTO	Recovery Time Objective: the target time for resuming the delivery of a product or service to an acceptable level following disruption (full service or phased return).
AST	Administration Support Team
BCP	Business Continuity Plan
MAO	Maximum Acceptable Outage: the maximum amount of time that the organization can continue to function without its key products or services before the impact is deemed unacceptable and viability is threatened (the “point of no return”).
MBCO	Minimum Business Continuity Objective (minimum level of service acceptable during an interruption)
RPO	Recovery Point Objective (Point to which information should be restored to enable the activity to operate on resumption)
BCMS	Business Continuity Management System
SOP	Standard Operating Procedure

1.0 DOCUMENT CONTROL

1.1 Revision History

This Business Continuity Plan (BCP) is a controlled document, owned by Mr Stephen Wilson, Director of Operations (Interim) and is held centrally by those listed in Section 1.2.

Any amendments should be forwarded to the Plan Administrator/Operations Manager via email to: Mark.Johnston@hscni.net

Any changes must be recorded using the table below: -

Table 1: Version Control

Version	Issue Date	Changed by	Designation	Reason for and Details of Changes made	Date Approved by AMT
1.0	13.08.12	n/a	n/a	Original Version	10.10.11
2.0	02.01.14	C Hermin	Operations Manager	Following exercise	07.11.13
3.0	08.06.15	Project Team	n/a	ISO 22301 requirements	31.03.15
4.0	08.02.16	Project Team	n/a	Review following power outage on 30/4/15 and exercise	27.10.15
5.0	24.04.17	C Hermin	Operations Manager	Following exercise and relocation of staff	21.03.17
6.0	20.04.18	C Hermin	Operations Manager	Following exercise and review of cyber security	13.03.18
7.0	12.03.19	C Hermin	Operations Manager	Following exercise	29.01.19
8.0	16.10.19	C Hermin	Operations Manager	Review following AMT walkthrough in light of EU Exit and potential industrial Action	11.11.19
9.0		C Hermin M Johnston	Asst Info Governance Manager Operations Manager	Post Covid working arrangements included. Staff details updated. Updated following test exercise	

1.2 Distribution List

The following table records the distribution of each version of the Business Continuity Plan (BCP).

Those using the BCP must check that they have received the most recent version and have disposed appropriately of any previous versions.

As the BCP contains personal contact details, its distribution must be controlled and confidentiality maintained at all times.

Table 2: Distribution Control

Name	Designation	Version	Date
TBC	Chair	9	
A Dawson	Chief Executive	9	
S Wilson	Deputy Chief Executive, Director of Operations (Interim) and Assistant Director, Communications and Knowledge Management	9	
J McClean	Director of Public Health	9	
H Reid	Director of Nursing and Allied Health Professions	9	
I Young	Director, Research and Development	9	
A Keaney	Director, HSC Quality Improvement	9	
TBC	Assistant Director, Health Protection	9	
TBC	Assistant Director, Health and Social Wellbeing Improvement	9	
T Owen	Assistant Director, Public Health (Screening and Professional Standards)	9	
B Farrell	Assistant Director, Public Health (Service Development, Safety and Quality)	9	
J Bailie	Assistant Director, Research and Development	9	
M Tennyson	Assistant Director, Allied Health Professions and Public Involvement	9	
D Boulter	Assistant Director, Nursing	9	
D Webb	Assistant Director, Nursing	9	
C Buchner	Assistant Director, Nursing	9	
S Donald	Assistant Director, Nursing	9	
S Aitcheson	Assistant Director, Nursing	9	
S Rogan	Assistant Director, Nursing	9	
S Murray	Assistant Director, Planning and Business Services (Interim)	9	

Distribution to Tower Hill, Gransha Park and County Hall facilitated via Local/Office Managers.

1.3 Location and Access

When version changes are made at subsequent reviews of this document, as recorded in Table 1, all existing or outdated plans must be returned to the Plan Administrator for destruction (as at Section 1.1). The Plan Administrator will circulate revised copies as necessary.

The most up-to-date copies of the BCP will be held securely in each of the following PHA locations: -

- 12-22 Linenhall Street, Belfast
- Tower Hill, Armagh
- Gransha Park, Derry/Londonderry
- County Hall, Ballymena.

2.0 ORGANISATION AND CONTEXT

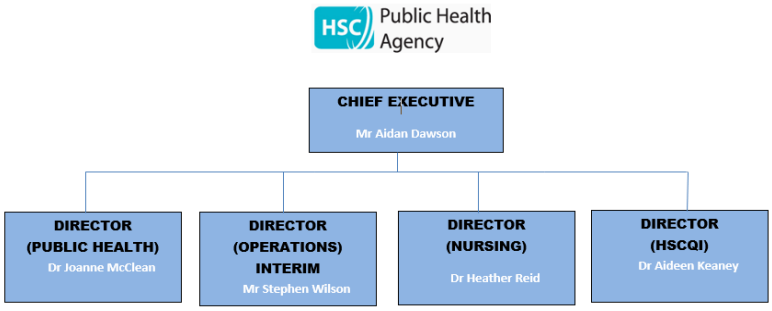
The Public Health Agency (PHA) is a multi-disciplinary, multi-professional body with a strong regional and local presence, established to provide a renewed, enhanced focus on Public Health and Wellbeing. It receives guidance and instruction from the Department of Health (DOH) and works with Local Government, the Public and the Voluntary and Community Sectors to tackle the underlying causes in poor health and health inequalities.

The PHA works closely with the Strategic Planning and Performance Group (SPPG) in terms of commissioning and shared premises and with the Business Services Organisation (BSO) for provision of Information Technology Services, Human Resources and Finance. It also liaises with the small Agencies and Health and Social Care Trusts.

As a Public Body, the PHA must meet certain external legal and regulatory requirements, such as Information Governance, Risk Management, Health and Safety and Corporate Governance. Operations Directorate staff monitor organisational compliance across the organisation.

The Corporate Structure of the PHA is summarized in the following diagram.

Figure 1) Corporate Structure



2.1 Business Continuity Management - Policy

As part of Business Continuity Management preparations, the PHA Business Continuity Policy was developed in 2011 and approved by the PHA Board in February 2012. The Policy was amended slightly in January 2015 in order to reflect requirements in the new International Standard (ISO 22301) and was reviewed again in February 2018. The aim of the Policy is to detail a comprehensive framework for Business Continuity Management so PHA can continue to function during an operational interruption.

It sets out general principles and processes for the development, maintenance and review of PHA Business Continuity Plans and is separate to but complements the PHA Risk Management Policy. The Policy is available on the PHA Intranet for all Staff and has been placed on the PHA Website for the attention of interested parties.

2.2 Business Impact Analysis (BIA)

As part of Business Continuity planning, a Business Impact Analysis (BIA) was carried out by the Project Team in 2011 and is kept under review. During the BIA, the Project Team considered internal and external resources, dependencies and processes, as well as the environment in which PHA operates before prioritising, in order of time criticality, the key services and functions which must be maintained or restored during an incident in order to maintain an acceptable level of business.

2.3 Key Services - Assessment of Priority

PHA services have been prioritised based on the following information: -

- Assistant Director/Senior Manager knowledge and experience of their areas of work and the potential to stand down/postpone service provision
- Awareness of issues in Emergency and Business Continuity Planning, acquired through numerous real-life events and training exercises
- PHA statutory responsibility to provide certain services/functions
- The risk and severity of harm coming to individuals or members of the Public if business functions are not maintained i.e. impact on individual patient outcomes and potential impact on population health/loss of health gain
- Likely impact on business recovery
- Impact on overall PHA aims and objectives
- Risk of impact on public confidence/reputation/Media reporting
- Impact on other interested parties/business partners of standing down business functions
- Corporate and financial governance requirements
- Impact on achieving Programme for Government (PfG) Targets
- Impact and dependency on other organisations, such as the Business Services Organisation, Strategic Planning and Performance Group and HSC Trusts
- Ability to escalate or reduce services and the ability to modify current processes which would delay business functions or cause serious disruption if not stood down

A full list of key services is included at **Appendices 1 and 4.** These should enable IMT **to determine how and when these should be managed and reintroduced.** This may depend on the time of year and the nature and severity of each incident.

2.4 Purpose and Scope of the Business Continuity Plan (BCP)

This **BCP** has been compiled under the auspices of the Agency Management Team (AMT) by the PHA Business Continuity Project Team and is in line with the requirements of ISO 22301.

The Plan is designed to assist the PHA Incident Management Team, at a Corporate Level, through the necessary steps from an incident's occurrence to the resumption of business as usual. It is kept 'live' by regular testing, consideration of business process planning and monitoring by Senior Managers and the Project Team on an ongoing basis.

This BCP focuses on two elements, the first being immediate incident response to prevent further injury, damage, loss, tending to the injured and evidence gathering. The second element concerns addressing the damage, restoring service continuity to normal and providing information to staff, the public and Media.

Whereas **Emergency Planning*** deals with providing a response to a major external incident, this BCP seeks to establish an incident management structure which supports the provision of key PHA internal services, focusing on maintaining and recovering these to normal working.

NB: Should a business continuity incident escalate towards emergency planning*, copies of the **Emergency Preparedness Plan** can be obtained via the PHA Emergency Planner (Ms Mary Carey) or members of the **Emergency Planning Team as outlined in Appendix 12** (Contact Details).

This BCP has the following objectives: -

1. to ensure arrangements are in place to identify and maintain critical services during the incident period;

2. to allow threats to be identified and managed throughout the period of disruption and recovery;

3. to enable normal business to be resumed as soon as possible and;

4. to ensure processes are in place to test and keep under review the PHA plans for Business Continuity.

In keeping with good practice, this document focuses specifically on a limited number of key services which, because of their nature, could cause loss of life; tangible, adverse impact on health and/or well-being or significant damage to the reputation and functioning of the PHA.

The BCP concentrates on Business Continuity and restorative activities within the first 7 days following a Business Continuity incident and, in particular, the following aspects: -

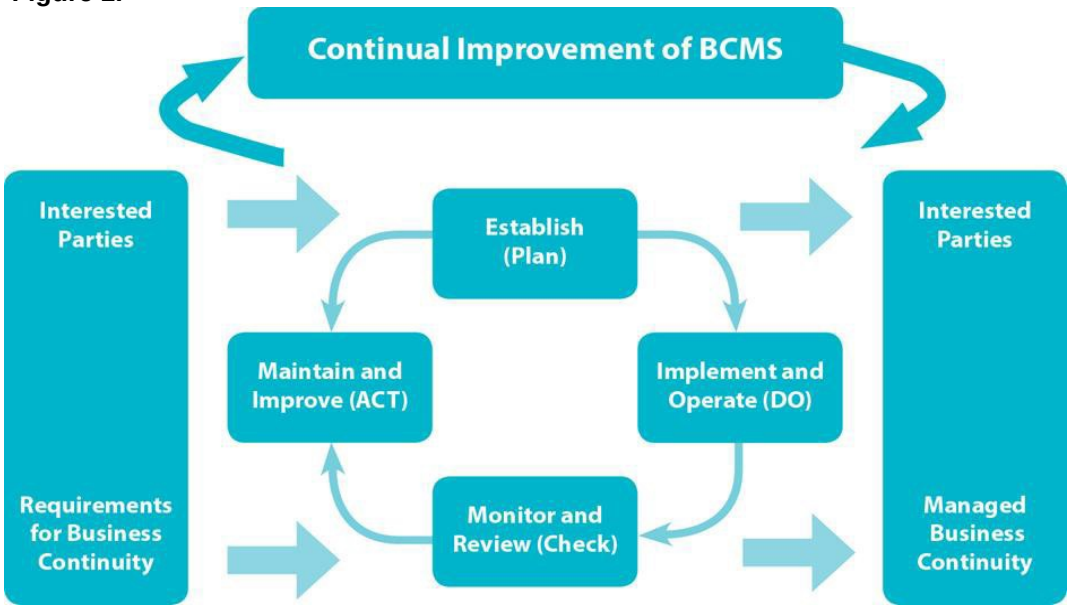
1. Programme – proactively managing the process;
2. People – roles and responsibilities, awareness and education;
3. Processes – all organisational data and processes, including ICT;
4. Premises – buildings, facilities and equipment;
5. Providers – supply chain, including outsourcing and utilities;
6. Profile – brand, image and reputation;
7. Performance – benchmarking, evaluation and internal audit.

2.5 The Plan-Do-Check-Act (PDCA) Model

This BCP takes into account the needs and expectations of interested parties, legal and regulatory obligations, corporate and information governance specifications and the required scope of BCMS as identified by ISO 22301.

The Plan incorporates aspects of the Business Continuity Plan, Do, Check and Act Model (illustrated overleaf in Figure 1) - planning, establishing, implementing, operating, monitoring, reviewing, maintaining and continually improving the effectiveness of an organisation's Business Continuity Management System (BCMS).

Figure 1.



Plan (Establish)	Establish business continuity policy, objectives, controls, processes and procedures relevant to improving business continuity in order to deliver results that align with the organisation's overall policies and objectives.
Do (Implement and operate)	Implement and operate the business continuity policy, controls, processes and procedures.
Check (Monitor and review)	Monitor and review performance against business continuity objectives and policy, report the results to management for review, and determine and authorize actions for remediation and improvement.
Act (Maintain and improve)	Maintain and improve the BCMS by taking corrective actions, based on the results of management review and re-appraising the scope of the BCMS, BCP and objectives.

2.6 Planning the Business Continuity Management System

The following assumptions underpin this BCP: -

- All relevant data and information was provided at the time of BCP development.
- Line management arrangements support implementation of Business Continuity.
- Any amendments required are brought to the attention of the Plan Administrator.
- Key services have been identified and these have been categorised in order of priority according to the potential impact of the service being compromised.
- Various actions in the event of a range of crises have been proposed. These actions were developed from suggested handling strategies as agreed by AMT and Assistant Directors in each area.
- This BCP is separate to the Emergency Preparedness Plan developed jointly by the PHA, SPPG and BSO and may be activated should it become necessary to support Emergency Planning preparations where internal working or capacity is challenged.
- All staff and Project Team members involved in Business Continuity Management within the PHA have been appropriately selected from Directorates across the PHA, with training provided where relevant and any certification retained.

2.7 Overarching Principles of PHA Business Continuity Management

Although every business continuity incident will require a unique response, the PHA will apply the following overarching guidance principles: -

- Hold the welfare of staff and wider interested parties/colleagues/neighbours uppermost in all considerations, including how plans and actions are co-ordinated, in order to respond sensitively and appropriately to the incident and with those directly involved in or connected with the incident.
- Establish an Incident Management Team (IMT) and Incident Management Action Team (IMAT) with key roles and named deputies to provide a firm foundation upon which sound incident management will be based.
- Keep under review any incident not initially deemed substantial enough to invoke the BCP and ensure a Director or the Director of Operations is notified accordingly.
- Ensure that any outbreaks or non-Business Continuity related incidents are managed by Deputies pre-designated in each Directorate, maintaining communication with IMT throughout the course of the event.
- Consider the needs of any Section 75 groups during the decision-making process, to minimise or avoid any adverse impact.

2.8 Risk Management

Risk Management is concerned with ensuring that the PHA has the necessary systems, processes, policies and procedures in place for managing risk. It is an integral part of good practice and part of the organisation's culture and plays an important role in Business Continuity Management.

Every organisation faces risks of varying degrees – it is an inevitable part of conducting everyday business. One of the ways the PHA manages those risks is to record them on a risk register (there is a Corporate Risk Register and 5 individual Directorate Risk Registers) and keep them under regular review. This ensures measures are implemented to address adverse impacts, thereby reducing risk to the organisation.

Members of the Agency Management Team and Business Continuity Project Team regularly consider risks which might impact on the organisation and this Business Continuity Plan contains steps to help mitigate against such risks and suggests strategies to implement when an incident occurs. Learning will follow any review, incident or exercise to allow appropriate action to be taken to reduce likelihood of such risks in future.

2.9 Risk Appetite

Risk appetite can be described as the risks which the organisation has determined to be 'acceptable to bear' and those which it has determined cannot be tolerated (unacceptable) in agreed circumstances.

The PHA carefully considers the risk appetite – in other words the extent of exposure to risk that is judged tolerable and justifiable. There will be times when it is necessary to accept a level of risk in order to progress with business. Risk appetite is built into the organisation's risk assessment process.

The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, Interested Parties and the organisation alike.

Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA's business viability or reputation is significantly high and may outweigh any benefits to be gained.

The level of the risk appetite reflects the PHA's willingness to take opportunity from risks and is an indicator of how well risk culture is embedded into management processes.

An acceptable (or residual) risk is when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable and/or to reach the level of risk appetite of the PHA for that risk.

2.10 Acceptable/Residual Risk

- The PHA acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, service users and others. The PHA will therefore make all efforts to reduce risk or ensure that risks are contained and controlled so that they are as low as reasonably practicable.

- It is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. A balance needs to be struck between the costs of managing a risk and the benefits to be gained.

- Where a risk has been reduced to the point where the cost of further controls to reduce the risk outweigh the benefit they may provide, it may not be considered reasonably practicable to implement those controls. However, where risk controls are available, it is the duty of the organisation to demonstrate that the cost of implementation outweighs the benefit or that alternative effective control measures have been implemented. Risks requiring a cost benefit analysis must be fed into the PHA risk register process for wider debate and decision on 'acceptability'.

3.0 AREAS OF RESPONSIBILITY/OWNERSHIP - MANAGEMENT COMMITMENT

The PHA Board has overall responsibility for ensuring that the PHA has effective arrangements in place to respond to an incident affecting service provision.

The Chief Executive is responsible for making the decision to activate the BCP with the advice of the Director of Operations. In exceptional circumstances, the Director of Operations may activate the Plan, as the Senior Responsible Officer for Business Continuity Planning.

The Chief Executive will be supported by the Agency Management Team (AMT) in this role and all members will be expected to assume ownership of the Corporate BCP and any Directorate level strategies implemented as a result.

The Agency Management Team (AMT) comprises the Executive Members of the PHA Board (Chief Executive, Director of Public Health, Director of Operations, Director of Nursing, Midwifery and Allied Health Professions (AHP)) and Director of HSCQI along with the Director of Social Care and Director of Finance from the Strategic Planning and Performance Group (SPPG) and the Director of HR and Corporate Services from the Business Services Organisation (BSO), or their representatives.

AMT's role includes ensuring that the PHA has a workable and tested corporate BCP in place and that actions are taken as required by each Director (including monitoring, approval and decision-making).

AMT's role in the event of the BCP being activated will be to assist with the response to the incident as well as ensuring that business continuity is maintained for PHA time critical and high priority services.

It will be the responsibility of the Chief Executive to provide assurance to PHA Board that the BCP is up-to-date and reviewed annually, or sooner if required, and meets the requirements of the ISO 22301 and any assurances requested by DoH.

All senior managers will ensure the BCP is compatible with the strategic direction of the Agency, integrating Business Continuity requirements into the organisation's Business Processes where possible – Business Continuity Planning will also be discussed regularly at Agency Management Team meetings and staff meetings.

All Directors and Assistant Directors will be responsible for raising awareness, motivating, empowering and engaging staff and ensuring that managers and staff are aware of the BCP Policy, understand their contribution to the effectiveness of Business Continuity, understand the implications of non-conformity and their role at the time of disruption.

They are required to oversee the regular review of their relevant sections of the BCP and time critical services and strategies prioritised within it, identifying to the Plan Administrator any changes required or new threats anticipated. Directors and Assistant Directors will also demonstrate the importance of Business Continuity planning by providing visible and on-going support to Project Team members and staff.

Staff should familiarise themselves with any guidance cascaded regarding Business Continuity, noting that all staff have a role in general Business Continuity Management and some groups of staff may also be contacted to undertake specific roles during an incident.

SPPG, BSO and HSC Trusts are to ensure compliance with contractual arrangements by developing their own robust business continuity arrangements in respect of those functions and supports they provide to PHA.

3.1 Barriers to Effective Planning and Implementation

Threats to the successful implementation of the BCP include lack of awareness, failure of staff and managers to fulfil their duties/roles and failure to ensure the BCP is kept up-to-date.

Effective planning is essential to effective Business Continuity Management. It is important that the Incident Management Team and Incident Management Action Team allow positivity and enthusiasm to flow amongst staff, being approachable, communicating effectively and helping find alternative solutions to problems, reducing the opportunity for fear, communication barriers, poor leadership and lack of creativity to stem strategic planning within the organisation.

The panic and confusion created in any crisis can have a negative impact on how staff adapt to a situation. To alleviate this risk, the Incident Management Team should consist of managers with clear authority and confidence to declare an incident and assign clear roles and responsibilities in terms of hierarchy.

3.2 Maintenance and Review/Performance Evaluation

This BCP will be reviewed by the Agency Management Team annually or more often as required. Directors and Assistant Directors should use these reviews to satisfy themselves that Business Continuity arrangements are in place and working effectively. This will be an opportunity to review key, time critical services and strategies used to restore services. Reviews will also take place in the aftermath of an incident, with the BCP updated accordingly.

Any amendments should be notified to the Plan Administrator (PHA Operations Manager) and the revised BCP formally adopted by AMT and the PHA Board, with the updated BCP circulated as appropriate (see section 1.2: Table 2 Distribution Control and Section 1.3: Location and Access).

Management will ensure any amendments required following exercise or review are implemented without delay and results of any review will be communicated to relevant parties, to allow appropriate action to be taken. Directors and Assistant Directors must ensure staff are kept up-to-date regarding Business Continuity and are informed of any changes affecting them and actions required.

Members of the Project Team meet regularly to discuss the Plan and ensure it is kept updated. Meetings also act as informal checks/internal audits of the Plan, with information being relayed to Directors and Assistant Directors regarding any concerns, ensuring any gaps are addressed – any changes required are taken into account and contribute to the revision of the BCP.

3.3 Exercising and Testing

A BCP must be practiced regularly to ensure participants' ability to adapt, be decisive, command, co-ordinate and communicate – testing will ensure staff feel confident making sound, strategic decisions during a crisis.

This BCP will be tested by means of a Desktop Exercise on an annual basis at an agreed point in the year. (A Desktop Exercise talks participants through each stage of an incident and response without actually undertaking the actions required). This will be carried out in a controlled environment lasting approximately 1-2 hours and will involve an unseen event to be managed by the Incident Management Team, using the latest BCP as a guide. This will involve an appropriate range of scenarios, test the responses laid out in the Plan and will ensure that the strategies in place are as up-to-date as possible in a constantly changing environment.

A review will be carried out following each exercise. Amendments will be made immediately and the outcome of the review communicated to interested parties for appropriate action through the Project Team, identifying any areas for improvement and outlining corrective actions taken.

4.0 ACTIVATION PROCEDURES

4.1 Notification of an Incident - Warning and Communication

Staff who have identified a potential Business Continuity incident should follow the steps below: -

- Immediately notify their Line Manager or an Assistant Director (who will communicate, as appropriate with an Assistant Director or Director)
- The relevant Director/Assistant Director will assess the situation against the provisions of this Plan and discuss with the Director of Operations/Chief Executive to determine the nature of the incident and level of Business Continuity response required, if any
- The Chief Executive, with the advice of the Director of Operations, will decide whether to activate the BCP and convene IMT if necessary. In exceptional circumstances, the Director of Operations may activate the BCP.

4.2 Authority to activate the BCP

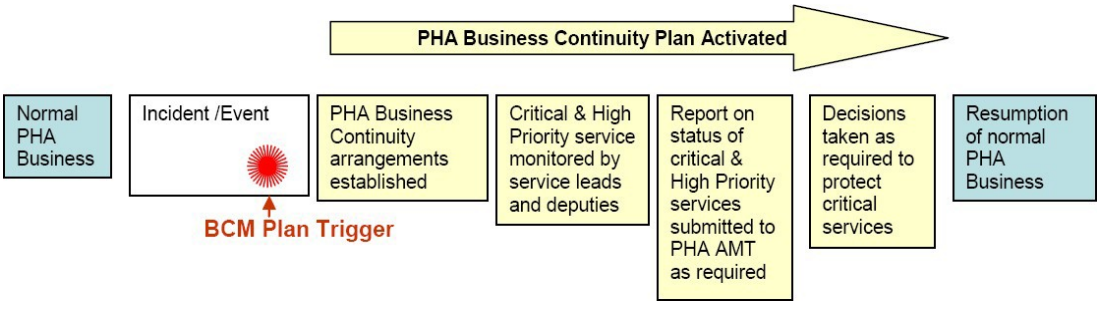
The decision to activate the BCP will normally be taken by the Chief Executive, with the advice of the Director of Operations. In exceptional circumstances, the Director of Operations may make this decision.

4.3 Deciding when to activate the BCP

The decision to activate the BCP should be taken by the PHA Chief Executive, with the advice of the Director of Operations as soon as possible, **preferably within an hour or less of an incident occurring**.

NB: This decision may require, or be prompted by, discussions with fellow IMT members and/or other HSC colleagues, such as HSC Trusts and/or the Business Services Organisation and, in particular, the Strategic Planning and Performance Group (SPPG).

The PHA BCP will be triggered in the event of a substantial incident which significantly impacts on or significantly disrupts the conduct of PHA business or the provision of its key, time critical services.



4.4 Examples of Activation

An incident is defined as any situation which requires immediate, co-ordinated action and/or has a significant impact on the operation or reputation of the PHA.

Incidents which could require BCP activation include natural causes (e.g. severe weather disruption) or manmade causes (e.g. terrorism, arson, industrial action). Cyber Security and events within the political arena, such as EU Exit are also likely to have an impact and should be taken into consideration when Business Continuity planning and during reviews of the Plan.

Generally speaking, these will involve a major disruption to any PHA building or staff group or to those external services upon which the PHA and/or its staff depend for provision of its services and day-to-day business.

Examples which could require the activation of the BCP are outlined below: -

- **Loss of utilities** (e.g. power, water, heat) in a PHA facility (including sole PHA premises or where PHA is a tenant of SPPG or another HSC organisation);
- **Loss of a PHA facility** (e.g. due to fire, flood, unacceptable health & safety issues) - less of an issue now, perhaps, given hybrid working and desk booking systems rolled out across PHA Sites;
- **Loss of all or a significant part of ICT system** (whether by deliberate cyber-attack, unintentionally or failure due to poor systems integrity);
- **Significant loss of staff** due to sickness or other disruption;
- **Public Health or similar emergency (e.g. Ebola, Swine Flu) requiring significant staff/resources to be re-assigned in one or more areas for more than a few hours** resulting in service continuity issues.

Significant disruption will be deemed to have occurred in the event of one or more of the following: -

- Disruption cannot be dealt with through normal operational procedures or local contingency plans
- One or more Priority 1 services cannot be maintained
- Existing contingency response arrangements are in danger of or have been overwhelmed
- A co-ordinated, PHA-wide response is required to deal with the disruption
- An issue is likely to cause more widespread disruption within other areas of PHA
- A major site accommodating multiple services is evacuated for a long period
- Widespread sharing and re-allocation of resources between services is required
- An initially small level of disruption, containable within normal operating procedures or local contingency plans, escalates into widespread disruption
- Prompt, co-ordinated action/invoking the BCP could prevent minor disruption from escalating into serious disruption
- A request is made by the Emergency Planning Team to invoke the BCP as resources/staff have been stretched following an on-going outbreak or widespread incident requiring resources/staff to be taken away from their normal duties for a time, affecting welfare or the provision of services.

4.5 The Impact of Directorate/Division Level Disruption

The possible events described above should manifest themselves in the following ways: -

- Loss of key staff/skills.
- Denial of access or damage to facilities, premises and/or vehicles.
- Loss of or restrictive access to vital records.
- Loss of critical systems/communications e.g. ICT, telephones, printers, e-mail, files and contact details.
- Loss of a key resource/major supplier.
- Service Level Agreements and Contracts not met.
- Services not provided or significant delays in progress.
- Reputation damaged.

The Impact Assessment Table overleaf indicates various levels of response appropriate to the nature and scale of the incident.

For the purposes of this Plan, incidents will have one of four levels of significance. The level will be decided by the Chief Executive and/or the Director of Operations (in discussion with the Incident Management Team (IMT) as appropriate). Typically, activation of the BCP will only occur if an incident is at Level 3 or 4, considering on-going business issues and the Maximum Acceptable Outage (MAO) – the longest time PHA can function without the affected service.

The PHA BCP will be activated in the event of a 'Significant or Major' Incident which significantly impacts on the conduct of PHA business. This may be an event which impacts on staffing availability, access to premises or availability of IT services/equipment. **The response will be commensurate with the level and scale of the incident.**

Figure 3: Impact Assessment Table

Incident Level	**Definition**	**One or more of the following apply**
1	**Minor Incident**	• The incident is not serious or widespread and is unlikely to affect business operations to a significant degree • The incident can be dealt with and closed by local management and/or the Emergency Services • For noting and monitoring
Response/Action	**Incident managed through normal operations or local contingency projects**	
Incident Level	**Definition**	**One or more of the following apply**
2	**Minor Disruption**	• Incident expected to be fully closed within 4 hours or MAO • Access to systems denied but expected to be resolved within 4 hours **or** well in advance of service MAO • One or more ~~a number of~~ local contingency plans activated • Advice/further information required
Response/Action	**Relevant Director advised - managed through normal operations or local contingency projects**	

Incident Level	Definition	One or more of the following apply
3	**Significant Disruption**	• Disruption cannot be dealt with through normal operations/local management • Access to one or more sites denied for more than 8 hours or service MAO • Access to systems denied and incident expected to last more than one working day (see MAOs) • One or more Priority 1 services cannot be maintained • Co-ordinated PHA wide response required • Definite repercussions across Directorates/services • Prompt response by IMT could prevent more serious disruption
Response/Action	**Chief Executive and/or Director of Operations notified – Activate BCP**	
Incident Level	**Definition**	**One or more of the following apply**
4	**Major Disruption**	• Destructive loss of a major or multi-occupancy site • Major wide-scale incident in a geographical area affecting several services • Major disruption to business activities and repercussions • Contingency plans inadequate to deal with incident • IMT action and Emergency Leads contacted if required
Response/Action	**Chief Executive and/or Director of Operations notified - Activate BCP**	

5.0 ACTIVATION OF THE BUSINESS CONTINUITY PLAN

Once the decision has been made to activate the BCP, the Chief Executive and/or Director of Operations will **decide whether IMT should continue discussions by phone/teleconference or videoconference or meet formally.**

NB: IMT may decide to meet jointly with the SPPG IMT at their Control Room in Linenhall Street, Belfast (Conference Rooms) or another location as appropriate (See Appendix 3). Joint meetings will be chaired by either the Chief Executive, Director of Operations, or the Interim Head of Corporate Services (SPPG) depending on the nature of the incident/areas affected. Consultation will also take place, as required, with the Business Services Organisation (BSO).

Should administrative assistance be required the PHA Director of Operations or **a designated member of IMT will instruct the Administrative Support Team** (AST) to assist in setting up the relevant IMT Control Room or arranging teleconferencing/videoconferencing facilities (see paragraph 6.2) and **begin taking notes** as required.

Members of AST will be instructed to join IMT as soon as possible, or between 8am and 9am the next working day if the incident occurs outside normal working hours.

As part of the activation process, IMT will take the following steps: -

- Assess the situation and ensure that relevant Assistant Directors/deputies are kept informed.
- Instruct AST to assist/provide support/formal record keeping
- Instruct IMAT to convene or remain in contact as required
- Communicate with DoH, staff, suppliers and other interested parties (such as SPPG and BSO) as appropriate
- Instruct the Communications Team to convene as required
- IMT, IMAT, AST and the Communications Team (as appropriate) will maintain contact via conferencing facilities/attendance

The Chief Executive will be responsible for keeping the PHA Board and DoH informed of progress at frequencies to be agreed appropriate to the nature of the interruption.

As an incident may change over time as information becomes available, regular reviews and assessments will be carried out by IMT so their response can be escalated or de-escalated as appropriate.

5.1 Control Centre for the IMT, IMAT, AST and Communications Team(s)

IMT should endeavour to hold initial discussions by telephone or by teleconference/videoconference, particularly where travel or access is inhibited.

Meeting Rooms are available at each of the following locations and can be booked by AST using contact details at Appendix 3: -

- 4th Floor Meeting Room, 12-22 Linenhall Street, Belfast
- Conference Room or Meeting Rooms 1 and 2, Linum Chambers, Belfast
- Boardroom or Committee Rooms 1-7, County Hall, 182 Galgorm Road, Ballymena
- Room 222, Tower Hill, Armagh
- Seminar Room or Boardroom, Gransha Park House, 15 Gransha Park, Derry/Londonderry

NB: For some alternatives to these meeting rooms (in/out of hours), see the Accommodation Section of Appendix 12.

5.2 Roles and Structures

The scale of the structures and roles acquired by IMT and IMAT upon activation of the BCP will vary according to the nature of the BC incident, its complexity and duration. This includes whether it is a PHA-only approach or one where SPPG and/or BSO is involved.

Initially, IMT will be supported by AST (the Chief Executive's Office Staff in Belfast) unless an incident occurs elsewhere, in which case administrative support will initially be provided by personal assistants/secretaries in the relevant area.

Local Office Managers will provide initial direction and ~~some~~ assistance until relevant staff arrive.

Support will depend on the nature of the incident and the availability of staff at the time.

5.3 Incident Management Team (IMT)

The key IMT Objective is to: -

> "Provide strategic direction and leadership to all Business Continuity and related Teams to implement all necessary plans and actions to restore the PHA to normal operating conditions, ensuring minimum impact to PHA reputation".

IMT will oversee the management of an incident on every level from the activation of the BCP, through decision-making to recovery.

Depending on availability, the timing of the incident and on-going work priorities, membership of this and other Teams may vary, with nominated Deputies standing in as required, or if any sitting member of IMT is unavailable for more than 2 hours during an incident.

The nominated Deputy will report to the IMT Control Centre for instructions and tasking as soon as possible after being contacted.

5.4 IMT Membership & Deputies

The Incident Management Team will be chaired be the Chief Executive, alongside the following Directors as core members.

Administrative / secretarial support will be provided as previously outlined.

Incident Management Team (IMT) Membership & Deputies

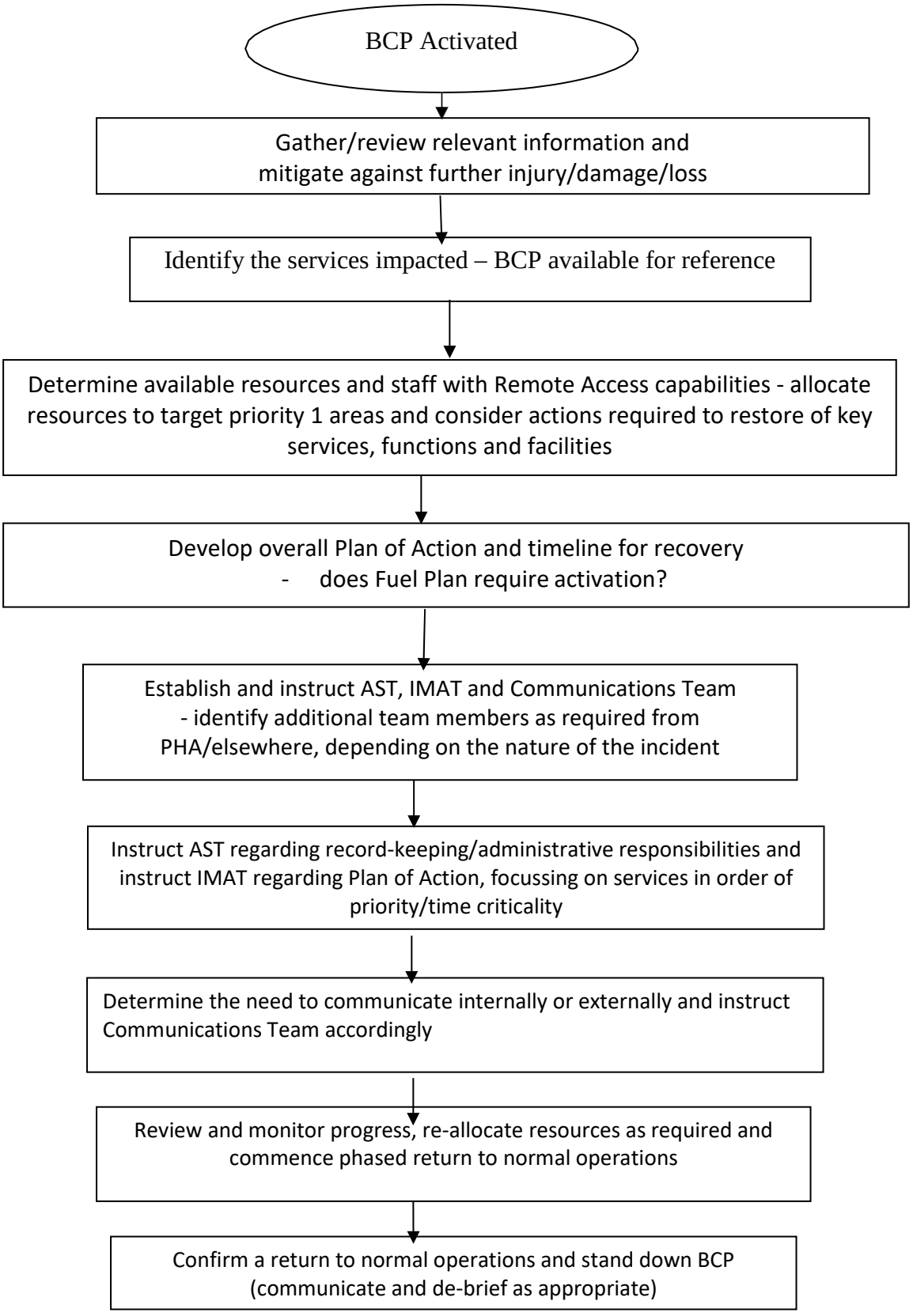
Member	Title	Role	Deputy
Aidan Dawson	PHA Chief Executive	- Overall Decision Maker - Contact Person for Assembly /DOH - Approve expenditure	Stephen Wilson
Stephen Wilson	Director of Operations (Interim), PHA	- IMT Chair - Decision Maker - Approve expenditure	Karen Braithwaite Stephen Murray
Joanne McClean	Director of Public Health/Medical Director, PHA	- IMT Member - Decision Maker - Approve expenditure - Health Protection Liaison	Brid Farrell
Heather Reid	Director of Nursing, Midwifery and Allied Health Professions, PHA	- IMT Member - Decision Maker - Approve expenditure	Michelle Tennyson/ Sandra Aitcheson/ Claire Buchner/ Deirdre Webb/ Siobhan Donald/ Denise Boulter
Tracey McCaig	Director of Finance	- Approve - Monitor expenditure	Andrea Henderson
Aideen Keaney	Director of Quality Improvement	- IMT Member - Decision Maker	Jackie McCall

IMT membership may also include SPPG, BSO and other participants, depending on the nature of the business continuity incident.

5.5 IMT Responsibilities

Figure 4 overleaf illustrates the roles and responsibilities of IMT during an incident, outlining general steps which may be followed.

Figure 4: IMT Roles and Responsibilities



6.0 INCIDENT MANAGEMENT ACTION TEAM (IMAT) AND ADMIN SUPPORT TEAM (AST)

6.1 Incident Management Action Team (IMAT)

IMAT will be responsible for co-ordinating and implementing the actions agreed by IMT, to ensure service continuity can be maintained or recovered during an incident, through to the restoration of normal operations, with minimal impact to welfare and PHA reputation.

Core IMAT Members are listed below: -

Name	Title/Role	Responsibilities to include
Stephen Murray Deputy Karen Braithwaite	Interim Assistant Director of Planning and Business Services	Co-ordinating IMAT Liaising with/instructing AST as appropriate.
Stephen Wilson Deputy Gary McKeown	Director of Operations (Interim) Formerly Assistant Director of Communication and Knowledge Management	Identifying and prioritising key interested parties (liaising with Director of Operations); leading/maintaining communication with employees/interested parties and providing safety/external briefings as appropriate.
Mary Carey Catherine Curran	Emergency Planner Emergency Planner	Linking with Emergency Services and with Emergency Preparedness Team.
Joanne McClean Deputy Declan Bradley ~~Louise Herron~~	Health Protection	Providing Public Health and Health Protection advice; linking with colleagues within Public Health and across the wider HSC as appropriate.
Alastair Ross Julie Mawhinney Deputy Nigel Jackson	Site Liaison Representatives	Site evacuation (inclusive of internal 'shelter at site' activities) and dealing with facilities related matters.
Deirdre Webb Michelle Tennyson	Assistant Director (Nursing) Assistant Director (Allied Health Professions and Public Involvement)	Coordination, provision of Nursing advice and liaising with colleagues across the Nursing Directorate/wider HSC.

Aideen Keaney	Clinical Director (HSCQI Hub)	Coordination and liaising with colleagues across HSCQI.
Roger McCully Deputies Mark Scott Paddy Carville	BSO ITS Manager (if required)	Provision of IT information/assistance/resources.
Paula Smyth Deputies Patrick Hanna Norah Emerson	BSO HR Director (if required) Assistant Director HR Business Partner	Provision of HR information and advice.
Andrea Henderson	Assistant Director, Finance	Provision of financial information and advice.

IMAT and IMT will maintain close lines of reporting throughout any incident.

PLEASE NOTE: Full membership of IMAT will be confirmed by IMT depending on the nature of the incident.

In some circumstances, IMAT may act as a virtual group maintaining contact using telephone/videoconference facilities. In the majority of situations, IMAT will include colleagues from outside PHA.

6.2 Administrative Support Teams (AST)

Once the BCP has been activated and IMT and IMAT established, administrative support will initially consist of the PHA Chief Executive Office/Board Secretariat staff (or Local Office Managers), with IMAT members supported by their own administrative staff. This may vary if other organisations are involved.

A core list of AST members is outlined overleaf.

AST Objective: to establish the IMT Control Room, ensure resources are in place and information flows into/out of the room efficiently with appropriate records taken throughout using Incident Logs. Instruction given by IMAT.

AST members will receive a detailed briefing from IMAT, and instructions and guidance in advance/at an early stage during an incident.

Administrative Support Team Pool	Role
Robert Graham (Belfast) (Chief Executive's Office and Committee Manager)	Co-ordinate, manage and provide guidance and assistance to AST.
Cathy McAuley (Belfast) Maureen Rea (Belfast) Nicolle Little (Ballymena) Alice Grey (Armagh) Michaela Kiely (Derry/Londonderry)	Monitor telephone calls and e-mail queries; Keep accurate notes of decisions made and actions taken throughout the incident; Maintain Incident Logbook and provide general administrative support to the IMT and IMAT; Liaise with and pass instructions and information between IMT/IMAT/Communications Team/others as required.
~~Ashley Stoney (Belfast)~~ Michelle McKibbin (Belfast) Kerry Murray (Belfast)	Arranging meetings/facilities and providing additional administrative support as required by IMT/IMAT.

7 BCP: ACTIONS AND RECOVERY STAGES

The following steps should be taken as the incident progresses. Key elements are also outlined in the standard **IMT Agenda** at Appendix 8. The approach to be adopted will cycle through the stages of:

- Assessment,
- Prevention,
- Preparation,
- Response and
- Recovery.

The aim is to manage the incident through all applicable stages.

The following is an indicative list which IMT and IMAT members should use as a checklist for handling a business continuity incident. This should be modified as appropriate, reflecting the unique circumstances of each continuity situation.

Stage	Checklist Action	Who	Time and Date
1 ***Pre-activation***	Initial discussions with Director of Operations, SPPG and BSO colleagues (Chief Executives/Directors) and other HSC colleagues as appropriate. Take notes from outset.	Chief Executive, Director of Operations	Day 1 Hour 0-1
2	**Determine whether to activate BCP / whether jointly with SPPG/BSO -** communicate nature of incident to IMT and staff.	Chief Executive, Director of Operations	Day 1 Hour 0-1

Stage	Checklist Action	Who	Time and Date
3 ***BCP Invoked***	Instruct AST to attend/provide assistance as required (~~initially take personal notes if possible~~ Record Keeping essential throughout).	IMT/Director of Operations	Day 1 Hour 0-1
4	Communicate nature of incident with IMAT and instruct as appropriate	IMT	Day 1 Hour 0-1
5	Arrange conferencing facilities and/or set up Meeting Room - ensuring it is available and fully equipped.	AST	Day 1 Hour 0-1
6	Instruct IMT and IMAT regarding meeting times/venues (or provide conferencing information).	Director of Operations/ A/D Operations/ AST	Day 1 Hour 0-1
Assessment			
7	Consider information to date Assess situation/damage and welfare of staff/visitors on site Assess level of incident Identify service(s) affected.	IMT (and IMAT)	Day 1 Hour 1
Prevention			
8	Mitigate against further risks/expansion of incident	IMAT	Day 1 Hour 1
Preparation			
9	Identify and review priority services and MAOs/RTOs - check situation at <u>all locations</u> potentially affected– identify and confirm Priorities for Recovery – does Fuel Plan requires activation?	IMT	Day 1 Hour 1
10	Consider and target resources required for incident management and recovery of key services.	IMT	Day 1 Hour 1 and on-going
11	Plan/outline the activities and resources required against a timeline to return to normal service levels.	IMT	Day 1 Hour 1
Response			
12	Instruct IMAT re strategies and plan of action.	IMT	Day 1 Hour 1
13	Commence actions as instructed by IMT (monitoring timelines/priorities) – instruct/provide directions to managers as necessary.	IMAT	Day 1 Hour 1-2

Stage	Checklist Action	Who	Time and Date
14	Instruct/request IMAT to ensure relevant staff work from home/return home/relocate.	IMAT	Day 1 Hour 1-2
15	Maintain log of meetings, decisions, actions and directions taken by IMT/IMAT – include a record of any expenditure incurred if possible **(See Appendix 9 – IMT Meeting Notes template).**	AST	On-going, once convened
16	Set up Communications Team/Spokesperson and identify roles/actions.	IMT/IMAT	Day 1 Hour 1-2
17	Instruct Senior Managers as appropriate and agreed by IMT	Communications Team	Day 1 as required
18	Provide regular updates to IMT (maintain communication).	IMAT	As required /instructed
19	Request **A/D briefings** (template at Appendix 6) re current priorities/anticipated issues/areas requiring resources.	IMAT, Assistant Directors (or nominated Deputies)	Day 1 within 2 hours and each day by 9am
20	Initiate formal communication re disruption (as appropriate/instructed by IMT) - Issue initial advisory email/ABC update to all staff/interested parties (see Section 12) - Use pre-agreed briefings.	Assistant Director of Communication and Knowledge Management	Day 1 Hour 3 and on-going
21	Monitor the situation and potential for escalation - liaise with Emergency Planning Team.	IMAT	As required
22	Continue to review the incident and ensure optimal use of staff and resources – schedule rotas if required.	IMAT/IMT	On-going
23	Provide updates to PHA Board, Chairman and DoH.	Chief Executive	As agreed/ appropriate
Recovery			
24	Monitor recovery - confirm quantity and quality of normal service levels returned.	IMAT, Assistant Directors	Once reached/via daily reports

Stage	Checklist Action	Who	Time and Date
25	Maintain communication with staff and interested parties.	Communications Team/Lead /Spokesperson	Regular/as necessary
26	Confirm staff welfare and requirements throughout the recovery period.	IMAT (with HR)	On-going
27	Identify any tasks that can be handed over to other staff or agencies in the consolidation phase.	IMAT, Managers	Day 1-2, on-going
28	Ensure all relevant logs and data regarding the interruption are captured and safely stored.	AST	On-going
29	Inform IMT that normal services have been resumed.	IMAT	As soon as possible
30	Plan for de-escalation.	IMT	As required
31	Inform staff and interested parties as appropriate.	Communications Team/Lead	Regularly/ On-going – every 2 days
Resumption			
32	Following consideration of progress reports and ad hoc communications with Directors/Assistant Directors/Senior Managers, decide and direct that BCP be stood down.	IMT/Chief Executive/ Director of Operations	As necessary
33	Stand down the IMT Room.	Chief Executive and/or Deputy Chief Executive, Director of Operations	Once normal services are resumed
34	Conduct a formal de-brief of the interruption and of the implementation of the BCP to IMT/IMAT.	Chief Executive	Within 2 -3 days of resumption
35	Cascade updates to all staff/interested parties.	IMAT/ Communications Team	Within 2 -3 days of resumption

Stage	Checklist Action	Who	Time and Date
36	Attend de-briefing to review the incident, timescales and actions taken towards recovery, capturing key points for future learning.	IMAT, IMT	Within 2 days of normal services are resumed
37	Ensure the continued provision of appropriate welfare and support to staff (liaising with HR as appropriate).	IMAT	On-going, after recovery
38	Update the BCP and roll-out revised version.	Plan Administrator, on the instruction of IMT, IMAT	After Recovery and de-briefing

8 STANDING DOWN OF THE BCP

The following steps are required to stand down the BCP: -

Stage	Checklist Action	Who	Time and Date
1	Determine that the BCP should be stood down as normal working is resumed.	Chief Executive and/or Director of Operations	Once normal working resumed
2	AMT, PHA Board and staff informed that the BCP is to be stood down.	Chief Executive, /Director of Operations/ Communications Team/Lead	Once normal working resumed
3	Confirm to all staff/interested parties that the interruption/ incident has ended and/or alternative and appropriate working arrangements have been put in place to enable 'normal' working – via ABC/Connect/PHA Website/cascade lists/otherwise.	Directors, Communications Team/Lead	Once normal working resumed

4	Communicate stand-down to any other interested parties / third parties as appropriate.	Communications Team/Lead	Once normal working resumed
5	Review lessons learned and communicate results to interested parties, via Project Team, or appropriate action.	IMT, IMAT	Once normal working resumed
6	BCP updated accordingly and revised version rolled out.	Plan Administrator	ASAP and once approved by AMT
7	Remind staff of the importance of BCM, their role and contribution.	All Managers	Regularly

9 RESOURCE PROFILE FOR IMT/IMAT INCIDENT CONTROL ROOM

Resource Required	Details
A copy of the BCP	Hard copies available in each Control Room – with restricted Contact Details (individual copies with IMT).
Network Points	The Control Room will have at least 1 network point and 1 live port with an adjoining room/nearby for those providing administrative support/communication. These will allow telephone and internet connection using the VOIP system/Teams.
Chairs/tables	The IMT Control Room has a Conference Table with a minimum of 5 Chairs – meeting rooms available in each alternative site, with a table and a sufficient number of chairs.
Whiteboard, flipchart, pens	AST will make available in each room as required.
Stationery	Internal stationery supplies will be utilised in the short term.
Radio/TV	This will be facilitated via Internet and/or a portable radio/television being made available as appropriate.
Phones	For each telephone point, a handset will be available.

Laptops/mobile phones	IMT/IMAT members and relevant senior managers will, where necessary, use their laptops and carry their mobiles for Internet Access and communication purposes. (All staff now have remote access as an option).
Photocopiers and printers	MFD Printers/Photocopiers scattered around the various sites – IMT and IMAT needs will be given priority.
Conferencing available to all staff via Jabber, PEXIP, Microsoft Teams.	

NB: For the purposes of Business Continuity only, IMT/IMAT requirements will take priority over other activities and IMT/IMAT may need to commandeer phones/PCs across various sites.

10 INCIDENT LOGS – IMPORTANCE OF RECORD KEEPING

The importance of record-keeping during an incident is of vital importance. Records should be kept by all senior staff/IMT and IMAT members from the outset and these should be as accurate as possible in the circumstances to ensure transparency of decision-making and facilitate briefings and a recap of events as soon as IMT convene.

Whilst it would be ideal that complete records of an incident be documented at the time of the event, this is not always practical. **AST must be instructed by IMT to begin recording information**, **with guidance provided regarding format and level of detail required** (see templates provided at Appendices 7, 9 and 10).

AST will document all IMT/IMAT decisions, movements and activities throughout the incident for retention in the **Incident Log File** held in the Control Room (Appendix 7), also prompting IMT and IMAT regarding timely updates due to staff and interested parties.

Members of the IMT, IMAT and Senior Management should endeavour to keep brief records of all telephone calls, discussions and decisions made during an incident should these become necessary for reference purposes or to be included in the Incident Log File.

The Incident Management Team Meeting Notes Template, at Appendix 9, should be used by IMT and IMAT as appropriate to record events discussed and decided upon during their meetings.

The IMT Chair will be asked to sign off records periodically.

NB: Records should also be kept of expenditure, where possible, preferably using the template attached at Appendix 7.

All elements of Business Continuity Management and procedures must be maintained, controlled and stored appropriately.

11 SUBMISSIONS FROM ASSISTANT DIRECTORS

In the event of a Business Continuity incident, PHA Assistant Directors (or nominated deputies) ~~will~~ may be required to submit a **daily report** using the template at Appendix 6. Only one report should be completed per Directorate.

These submissions will be assessed by IMT and IMAT and utilised to make decisions regarding key work priorities during an incident, to ensure that resources and activities have been directed to the most appropriate service/area. These should highlight the key activities/projects currently underway, any key points of interest and the consequences of failing to complete these activities, as well as detailing any staff/groups who might be involved/available to assist the IMT/IMAT.

Submissions, if requested, should be forwarded to IMT within an hour of an incident being declared and, unless otherwise instructed, by 9am each morning after the incident.

12 COMMUNICATIONS

12.1 Core Communications/PR Team

Member	Title/Role
Stephen Wilson	Director of Operations (formerly Assistant Director of Communications) and Knowledge Management; Communications Lead and IMAT member Action – identify/confirm meeting venue for Communications Team following discussions with Director of Operations - instruct staff to meet/join by phone/teleconference or videoconference Arrange communication with staff and interested parties
Gary McKeown	Communications Manager (Corporate and Public Affairs – including PR)
Margaret McCrory	Communications Manager (Public Information Campaigns)
Ruth Knowles	Communications Manager (Publications)

This Team should meet at the request of IMT/IMAT and convene in an office nearby or join by tele/videoconference. Under the direction of the Communications Lead, this Team may need to commandeer nearby offices to begin making necessary arrangements for communication with staff/interested parties/the Public.

The Communications Lead is Mr Stephen Wilson, Director of Operational Services (Interim) and former Assistant Director of Communications and Knowledge Management.

Until separate venues are sourced, with PCs/laptops, Internet connections and television/radio availability to ensure the Team can keep abreast of media developments, members of the Team can assist using remote access.

NB: Outside Office Hours, the PR Team may be contacted on their dedicated PR line 0300 555 0118 (see also Appendix 12 for contact details).

12.2 Communication with the Media

Should a Business Continuity Incident be so widespread as to require urgent communication with the Public or PHA interested parties, a notice outlining the Public Health Agency's alternative arrangements/contacts will be disseminated via the PHA corporate internet site (**www.publichealth.hscni.net**) and/or via the PHA's social media channels.

The Communications Team will use their contacts (included in Appendix 12) to liaise with the Media, providing information agreed by IMT and requesting assistance if necessary, for example, to relay information to staff and/or the Public.

ALL communication with the Media MUST be channelled through the Communications Lead/Communications Team – guidance will be provided as appropriate.

12.3 Communication with Staff

In order that communication channels are kept open between management and staff, the first point of contact (during office hours) will normally be Assistant Directors and/or Office Managers in each area. If an incident occurs outside of normal working hours, staff may check the **Agency Business Continuity** section of the Website - www.publichealth.hscni.net/abc for updates.

Assistant Directors/Office Managers will receive updates and instructions from IMT and IMAT (using pre-agreed templates), which they can relay to staff by phone/mobile/email as appropriate.

IMT may, on occasion, need to refer to next-of-kin/personal contact information held by Human Resources – all staff must ensure this is kept up-to-date.

Although the actual content of messages will be determined at the time of the incident, the following details should be included: -

- That, until further notice, the affected area/floor of the building, in part or whole, is inaccessible and staff should leave the premises in an orderly fashion using Fire Escapes (lifts should not be used), securing/taking with them any laptops/mobiles/ contact details, depending on the situation.

- **Staff are to be reminded that under no circumstances should they make any statements to the Media.** ALL COMMUNICATION must be channelled through the Communications Lead/Team.

- Staff to be reminded of the importance of adhering to Emergency Services instructions and maintaining a safe distance from any cordons, not returning or trying to enter the building for work purposes or to retrieve personal/business items unless permitted to do so.

- Assistant Directors/nominated Senior Managers to be reminded to submit daily reports, outlining details of current Directorate activities/priorities to enable IMT to make an informed decision regarding priorities/resources.

- Staff should remain available and contactable via work mobiles (or personal mobiles/email if they have made this information available). Updates will be provided regularly as appropriate via the ABC section of the **external** PHA Website **www.publichealth.hscni.net/abc** and on the PHA Intranet Site – Connect **http://connect.publichealthagency.org/** – staff to be advised to check these regularly.

12.4 Communication with Customers and interested parties

In order that communication channels are kept open between the PHA, interested parties and colleagues across HSC, updates may be made uploaded (remotely if necessary) onto the PHA Website (http://www.publichealth.hscni.net/) and/or provided directly by the Communications Lead (the Assistant Director of Communications and Knowledge Management), where incidents last beyond a few days. A contact person may also be appointed depending on the situation and duration of the incident.

13 STRATEGIES

A large number of potential strategies for deployment when dealing with interruptions to business were considered and agreed by AMT in the Business Impact Analysis (BIA) Report.

These strategies are not exhaustive but are the most likely options and have been listed against possible tactics for IMT at Appendix 1.

A list of resources required per service is included at Appendix 11 of the Corporate Business Continuity Plan.

14 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

This Business Continuity Plan has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This plan will therefore not be subject to an Equality Impact Assessment.

The plan has also been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

The Business Continuity Plan will be included in the PHA's Register of Screening documentation and maintained for inspection whilst it remains in force**.**

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

Priority Services, Strategies & Tactics — Appendix 1

The tactical arrangements for the implementation of the chosen strategies are as follows.

These should be actioned by IMAT and have been colour coded in terms of Priority.

Definitions: -

Maximum Acceptable Outage (MAO) - the maximum amount of time that the organization can continue to function without its key products or services before the impact is deemed unacceptable and viability is threatened (the "point of no return").

Recovery Time Objective (RTO) – the target time for resuming the delivery of a product or service to an acceptable level following disruption (full service or phased return).

Priority 1 Services – MAO of up to 24 hours				
Service	**MAO (Hours)**	**RTO (Hours)**	**Strategies**	**Tactics**
Doctors' On Call Service (providing cover and advice on Health Protection Emergencies across NI e.g. outbreaks, disease)	12	1	Contact 2nd On Call; Refer to ICT Use pagers/mobiles /paper back-ups; Contact NIAS Control Room; Use Remote Access; Re-locate to another site	Immediately NIAS contact second On-Call (and third and so on) using regularly updated, cascaded contact list Within 20-30 minutes Alert ICT to resolve technical problems; NIAS alerted to any communication issues (should they need to implement their own BCP); PHA staff engage support from SpRs and other Public Health Medicine Consultants as required After 1 hour Use pagers/alternative contact details (rota cascaded to various groups including CMO/Cross Border); Use pagers/mobiles/e-mail etc. to contact On-Call Doctors to advise re any unexpected changes/on-going problems;

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
				First and second On-Call Doctors currently use Remote Access/Laptops and mobiles/pagers– provide access to PCs on alternative site(s) if necessary; Contact Trusts to ensure any possible outbreaks are identified/communicated early, investigated and managed thoroughly; Relocate key staff to a nearby alternative site if necessary, sharing desk space/equipment as appropriate (~~some~~ Remote Access and desk booking systems are available ~~working/sent home~~); Use PCs already set up/share equipment in each site and bring laptops in case Remote Access is required; Use Standard Operating Procedures (SOPs).
Heath Protection Duty Room (providing advice and support by phone/email/fax to all HSC professionals on all Health Protection Issues/emergencies s - during working hours)	12	1	Dynamic risk assessment conducted by Operations Division for the unfolding incident (involving HP AD / nominated representative) will inform HP tactics and level of response.	In the event of power failure, IT issues/VOIP telephone system going down the tactics/level of response are: ASAP or within 30 minutes and for 1 day: 1. The Duty Room landline number 0300 555 0119 will be automatically diverted to the Duty Room mobile number 07583 007232, this will enable staff to receive calls and action as required. The Duty Room mobile has also been configured to the Duty Room email account. ▪ Duty room Administrative staff will confirm HP Consultant/Nursing staff availability in other PHA locations *in preparation for move to next level tactic below* IF NECESSARY i.e….. o If workload/Calls increase/High Volume calls o If incident further Risk Assessed as long duration, or o If the mobile/MTPAS ~~blackberry~~ should fail …

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
			Involve range of staff trained across sites; Refer to Standard Operating Procedures (SOPs); Major outbreaks – consider invoking Emergency Operations Centre (EOC) with SPPG; Consider establishing Back-Up Duty Room in HSC outside Belfast; Access HP Zone remotely; Re-locate key staff	2. Duty consultant contacts IT Support on 028 9536 2400 and ask them to divert the Duty Room number 0300 555 0119 to a number in Ballymena, Armagh or Gransha until the issue is resolved. This divert will be confirmed at the time of the incident dependent on the findings of bullet point 2 above i.e. the availability of suitable HP staff in either Ballymena, Armagh or Gransha. *HP Duty Room Continued....* 3. <u>After further dynamic risk assessment and/or after 1 day:</u> Relocate key staff (Consultant, Nurse and Deputies) to Back-Up Duty Room in County Hall, Ballymena (SEE INSTRUCTIONS BELOW); ▪ A/D informs senior staff that 'back-up duty room in Ballymena office is to be activated. ▪ Ballymena office set-up procedures to be followed ▪ Duty room staff use home-working/Remote Access/mobiles/e-mail/pagers in the alternative location in order to provide acute response Duty Room service ▪ Hard copy back-ups of key information e.g. HP Zone completion forms, contact details and SOPs need to be available in new location (G Drive/ hard copies on 4th floor, Linenhall Street, Belfast). Return to normal working to be confirmed by A/D in HP.

GUIDANCE: - Alternative Health Protection Base (HP Duty Room service +/- Duty Room Staff)

The requirement is for situations when the Duty Room in 12-22 Linenhall Street is not operational and formal Business Continuity arrangements are required. This does not relate to the establishment of an Emergency Operations Centre. **The alternate Duty Room may be either virtual, with the calls moving to another facility (tactic level 2 above) OR the actual room will be set up in Ballymena (tactic level 3 above).** It will be operational Monday – Friday 9am-5pm ONLY and will be in place for no longer than is necessary to enable Health Protection staff to adequately and safely resume activities in the main Duty Room in 12-22 Linenhall Street.

Establishing the alternate Duty Room in Ballymena
The alternate Duty room in Ballymena will be staffed by those medical, nursing and administrative staff involved in operating the Linenhall Street Duty Room and activities would move to the alternate location. Transfer from Belfast to include laptops held by medical and nursing staff with access to HP Zone.

Please note Regular dynamic risk assessments of the situation regarding the likelihood of the Duty Room becoming operational will be made in conjunction with Operations Directorate. If it is judged that, on balance, it is likely that the disruption will go beyond a significant period, the Duty Consultant, with reference to the A/D Health Protection or Director Public Health, will invoke these HP Business Continuity measures.

GUIDANCE: - Alternative Health Protection Base (Continued)

Once business continuity measures have been activated in HP and a decision is made to relocate to alternative facility the Duty Consultant will alert the following officers of the need to put in place the alternate Duty Room:

- PHA Chief Executive & Directors
- NIAS and Trusts

HP Nurse Consultant to ensure telephone messages are adapted to suit and telephones operational
~~HSCB~~ **SPPG** as Landlord will endeavour to facilitate those meetings which may be displaced in other locations. DDIs into Linenhall Street to be transferred to the direct lines into the boardroom County Hall Duty Room.

Dedicated cabinet in PHM County Hall to contain Standard Operating Procedures (SOPs), Phone Numbers/Contact Details, spare docking station for laptops. Multi-Functional Device in PHM to be prioritized for use in Duty Room.
Duty Consultant to alert ~~INFRA~~ VFIRE of move of Duty Room with request to prioritise any support requirements and confirm with ~~HSCB~~ SPPG Corporate Services Manager that access to County Hall is *not* required out-of-hours.

Standing down the alternate Duty Room in Ballymena
Duty Consultant to determine with reference to A/D HP and/or DPH.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
HP Zone (24/7 UK wide, Web Based Health Protection incidents information database - used by HSC professionals and interested parties)	12	1	Refer to SLA with ICT and contact external server; Use SOPs; Use paper back-ups; Divert calls; Use Remote Access; Set up back-up Duty Room outside Belfast if long-term/server lost	Within 30 minutes Contact ICT to recover HP Zone/resolve technical issues; Access remotely from another/local HSC Site using Laptops/PCs; Other staff called in to cover, refer to SOPs; Use paper back-ups to maintain short-term record keeping. After 30 minutes Relocate key staff/establish back-up Duty Room in County Hall, Ballymena – request IT assistance; Use Remote Access/key staff work from home and retain contact via mobile/landlines; Senior managers/key staff use own/others' laptops if buildings inaccessible/use PCs on alternative site(s).
Public Relations (for compilation/ dissemination of important/urgent health messages to Public, interested parties and Media)	12	1.5	Contact ICT; use other means of communication (Teams, Jabber, mobiles etc); Use Remote Access; Re-locate key staff; Train other staff to provide cover	Within 2 hours Maintain minimum service using stretched resources; Re-prioritise and ensure most essential communication functions are carried out by key staff (use alternative communication media); Request ICT assistance; Use other means of communication such as mobiles/e-mail/landlines/pagers; Senior staff use Remote Access/laptops to work from home/alternative site(s); Inform key interested parties affected of delays/disruption; Defer non-urgent work.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
				<u>After 2 hours</u> Senior staff use Remote Access/laptops/local PCs, some staff sent home; Re-locate key staff to alternative site – Belfast/ /Armagh/Ballymena initially as available; Train other staff to provide on-going cover/rotas (long-term); Communicate with DOH and interested parties re delays, provide updates to Public via alternative methods such as other Media/HSC Colleagues/telephone etc.; Provide updates to key interested parties regularly/as appropriate.
Activation of Community Response Plan (CRP)	12	4	Use available methods of communication; (e-mail/telephone/mobile); divert calls to mobiles as necessary; Use Remote Access; Designate key staff to disseminate urgent information to appropriate parties	Up to 4 hours Ensure Community Response Plan protocol is followed regarding communication and actions relating to support services; Contact HSC Trusts to ensure any possible suicide clusters are identified early, investigated and managed thoroughly (and to allow for HSCT implementation of their own BCP if necessary); Alert Community and Voluntary sector to advise of potential delay in the flow of information; Alert ICT to resolve technical problems; and Apply voluntary rota for senior staff in Health and Social Wellbeing Improvement as necessary. After 4 hours Provide status update to appropriate parties Maintain reprioritisation of non-urgent areas of business Ensure media requests are directed to via Corporate and Public Affairs division within a reasonable timeframe Seek method of recovery prior to MAO period (12 hours).

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Internal Communications (of important/urgent messages across all PHA sites using email/Connect/phone)	12	4	Use alternative means of communication (e-mail, phone, mobile, videoconferencing, Teams); Re-locate key staff; Stretch resources, use skeleton staff; Divert calls to mobiles; Train other staff to cover; Designate key staff to disseminate urgent information	Up to 4 hours Maintain contact with/advise PHA Staff using alternative means, e.g. e-mail/phone/videoconference/Website if ICT unavailable or building inaccessible; Raise awareness across PHA using Connect or via Directors/Assistant Directors; Request assistance from ICT; Prioritise urgent messages; defer or accept some delays; Senior Communications Manager act as initial contact for urgent messages. After 4 hours ~~Key staff~~ maintain service using remote access/hybrid working home using alternative site(s)/laptops/Remote Access/other PCs Relocate key staff as appropriate~~, senior staff continue to work from home until service resumed~~; Request other staff to cover using hard copy information/SOPs on Connect; Provide regular updates to AMT and staff (email, via managers, ABC etc); Designated key staff/managers disseminate urgent information using alternative methods until problem resolved; Confirm key communication needs of senior management on a regular basis – appoint Contact Person or Spokesperson.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Operational role of co-ordinating and communicating across local offices - and with BSO and SPPG.	12	4	Other/senior staff cover; Stretch resources; share workload; Re-allocate duties/priorities; use Remote Access, mobiles; hard copies, contact lists; Liaise with Suppliers to resume asap; Re-locate key staff; Maintain contact with external bodies via mobiles/email to raise awareness; Provide training to reduce Single Points of Failure; Use SOPs; Use alternative premises for key staff; Ensure others' BCPs are in place/instruct use	<u>Up to 4 hours</u> Re-allocate less urgent duties to staff in other sites; Restrict some services Refer to procedure on Connect (hard copies of these procedures should be held in each office) e.g. • Answering phones • Logging IT faults • AMT / Board submissions • Booking venues / car parking Maintain communication by phone/mobile/e-mail/videoconferencing; Communicate with interested parties (normally Directors) re delays, provide regular updates – appoint a contact person; Remote working for key staff using laptop/mobiles/home working; Contact ICT to resume e-mail/services online/recover access to G Drive/other Revert to hard copy files and contacts as necessary. <u>After 4 hours</u> Relocate key staff to other premises to maintain a minimum service; Liaise with suppliers/landlords/3rd parties to resume services asap; Communicate, re-arrange/cancel meetings as necessary; Re-prioritise workload Ensure others' BCPs are in place and instruct use as necessary.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Administrative/ secretarial support to Chief Executive/Deputy Chief Executive's Office, including co-ordination/organisation of AMT/Board Meetings	12	6	Reconfigure resources; Share workload; Re-allocate duties; Use Agency Staff; Re-locate staff; Contact ICT; Communicate with AMT/CX/Board; Raise awareness; Use SOPs; Re-arrange/cancel meetings; Contact landlord(s); Use nearby premises; Ensure contact details are accessible by senior managers off-site; Increase Remote Access; Use external facilities/share another site with SPPG other HSC Organisations	<u>Up to 6 hours</u> Stretch resources and maintain minimum service; Postpone non-essential workload Re-allocate duties to other corporate/Admin staff/Agency Staff Refer to procedure on Connect (hard copies of these procedures should be held in each office) e.g. • Answering phones • Logging IT faults • AMT / Board submissions • Booking venues / car parking Maintain communication with/update Chief Executive and interested parties (AMT/Board etc.); Relocate key staff to unaffected sites to maintain minimum service; Access records/contact details (online/hard copies/G Drive); Refer to ICT to resolve technical issues; Rotate duties with other groups of staff on/off-site; Ensure admin support is available to co-ordinate critical/Business Continuity meetings and minute/record actions agreed (IMT); Ensure contact details for key interested parties are available and provided to key staff to update/raise awareness of delays/cancelled or re-arranged meetings; Use online/hard copy contact details as appropriate; Revert to written/hard copy records; Use mobile phones, Teams, Jabber etc.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
				Over 6 hours ~~Senior~~ staff work from home/use Remote Access/laptops to access key information and maintain contact with interested parties; Re-locate key staff to nearby premises in Linum Chambers, Belfast (hot desk/use desk booking system/ share offices temporarily); Instruct/request use of external facilities across HSC/request assistance from colleague HSC Organisations; Focus on Risk Management priorities; Identify individual(s) to liaise with service leads and provide reports to AMT/Director of Operations/Chief Executive; Change venues if necessary to facilitate as full an attendance as possible; CX and Directors' PAs to provide cover for meetings.
*Responding to **critical** patient safety issues, serious and adverse incidents and complaints, both internal and external (Nursing and AHPs)*	24	12	Senior/alternative staff cover; Refer to Serious Adverse Incidents Group; Contact ICT; Use Remote Access; Provide spare/additional laptops;	Under 12 hours Director of Nursing to advise on action. Assistant Director of Nursing to identify senior staff/designated officer/other professionals to provide temporary cover and assess and advise on immediate action required, using e-mail/mobile/landlines as appropriate; Liaise with SPPG and Communications ~~department~~ as required and ensure clear communication pathway between PHA/SPPG and Trusts using email/ mobiles/landlines as appropriate; raise technical issues with ICT.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
				<u>After 12 hours</u> Re-negotiate established timeframes in exceptional circumstances (in agreement with Chair of Regional Serious Adverse Incident Group); Communicate delays to key interested parties by phone/mobile/email/web and provide regular updates; Prioritise actions to minimise impact; Appoint a contact person to maintain communication/communicate delays; Senior staff/key staff work off-site/from home for short time using laptops/Remote Access if building inaccessible; Enquiries and reviews notified to the Director of Nursing/AHP and managed by Assistant Director of Nursing/AHP/nominated Lead; Complaints process still followed, although consideration given to extending timescales for response; Director/Assistant Director of Nursing/AHP/Designate maintain communication re progress with AMT/IMT.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Responding to professional conduct and practice issues including fitness to practise for Nurses and AHPs (public protection) (Nursing)	24	12	Senior staff cover arrangements; Re-prioritise workloads; Use reporting/failsafe systems already in place i.e. direct link with DOH, Directors of Nursing in HSC Trusts, ITS; Accept delay; Defer to Operations for Media queries; Remote Access; Use additional/spare laptops as back-ups for desktop failure	<u>Under 12 hours</u> Director of Nursing to advise on action. Senior staff/designated officer/other professionals identified by the Director / Assistant Director of Nursing to provide temporary cover. Assess and advise on immediate action required including consideration of suspension; Re-prioritise workloads; Maintain communication, use of using e-mail/mobile/landlines as available / appropriate; Raise technical issues with ICT; Use failsafe systems already in place with DOH and HSC Trusts; Accept some delay and raise awareness with interested parties; Senior staff/key contacts/leads work from home/alternative site using Remote Access. Use additional/spare/shared laptops as back-up from alternative sites if building inaccessible/desktop failures.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Continued....				After 12 hours Maintain clear communication pathway between PHA/SPPG, DOH and Trusts; For media queries defer to Corporate & Public Affairs as per normal practice; Priority focus on risk management; Provide relevant brief to internal AMT and wider nursing team if relevant and if information likely to be in public domain; Ensure appropriate responses and actions in place regarding registration and competency to practice; Investigations and referrals to Nursing & Midwifery Council (NMC) (generally made by the Director of Nursing and Assistant Director for AHPs) can, with delegation, be made by designated deputies. Increase use of Remote Access Senior Staff/Leads/Deputies work from home/alternative site using Laptops, mobiles to maintain communication with Trusts/Director of Nursing/AMT/IMT Liaise with colleagues in HSC/Trusts to provide updates/cover; Most senior PHA Executive will sign any necessary documentation to progress service/manage priorities.

Service	MAO (Hours)	RTO (Hours)	Strategies	Tactics
Provision of expert professional advice to commissioning and performance management of HSC services and the independent sector, including approval of **Extra Contractual Referrals (ECRs**) (Urgent) (Nursing and/or AHPs)	24	12	Delegation; senior/other staff cover; Prioritise – urgent ECRs managed first; Contact ICT; Possibly increase use of Remote Access	Under 12 hours Senior staff/designated officer/other professional identified by Assistant Director of Nursing / Assistant Director of AHP & PPI to provide temporary cover, using e-mail/mobile/landlines as appropriate; Delegate duties to most senior staff to process most urgent ECRs first and prioritise workload/services/requests; Resolve technical issues through ICT; Additional named individuals appointed to approve more urgent requests; Accept some delays in short-term. After 12 hours Re-negotiate established timeframes in exceptional circumstances; Prioritise actions to minimise impact; Appoint a contact person to communicate delays; Senior staff/key staff work off-site/from home for short time using Remote Access if building inaccessible; Liaise with colleagues in HSC/Trusts to provide updates/assistance; Most senior PHA Executive will sign any necessary documentation to progress service/manage priorities; Skills and resources of all commissioning staff focused on surge planning – reduce input to normal/regular commissioning activities and gauge/anticipate any areas of particular activity in near future to focus resources Senior staff provide cover/delegate duties; Retract service/accept delays/backlog; Reprioritise services and consider use of Remote Access for key staff if on-going/until ICT issues resolved/premises become available again; Redistribute non-essential staff with no premises to areas requiring more urgent assistance/sharing/pooling resources.

Priority 2 Services – MAO of 2 – 7 days				
Service	**MAO (days)**	**RTO (days)**	**Strategies**	**Tactics**
Public Affairs (Providing information to Assembly, DoH, Minister; Monitoring NI Assembly	2	1.5	Refer to ICT; use other means of communication; re-locate key staff; train other staff to cover (long-term); Divert calls to mobiles/On Call/Out of Hours; Use other media Use Remote Access	Immediately and up to 4 hours Request ICT assistance to resolve technical problems; Provide minimum service using stretched resources; Maintain communication with DoH and interested parties via alternative methods such as mobiles/landlines/e-mail; Divert calls to senior staff mobiles/On-Call/Out-of-Hours number if landlines unavailable; Ensure alternative contact arrangements available on Website if possible/building inaccessible; Prioritise services and action most urgent/widespread. After 4 hours Advise/update re potential delays Use other media/HSC Colleagues Re-deploy staff and train others to cover long-term; Provide/refer to SOPs (some processes available on Connect/hard copy).

Service	MAO (days)	RTO (days)	Strategies	Tactics
Accommodation (single/various PHA Sites)	2	1	Liaise with Landlords/Management Companies (see Appendix 12); Ensure others' BCPs in place/activated; Cancel/reschedule meetings; Re-locate key staff; Communicate with interested parties; Send non-essential staff home; Liaise with ICT; Use mobiles/Remote Access and desk booking systems where possible; Retract services	Up to day 1 Appoint lead to liaise with Landlords/(DOH~~)/Management Firms/Assets & Estates Management Branch / Central Procurement Directorate (DFP)/Belfast HSC Trust~~ regarding ~~various~~ locations (see Appendix 12 for contacts); Relocate lead/key staff to alternate premises to manage incident/return of staff (increase use of mobiles/Remote Access and desk booking systems across PHA) ~~and laptops/working from home/other sites~~); Ensure staff and affected interested parties are kept informed of situation/timescales using email/Website/Communications Lead; Ensure others' BCPs are in place and ready to activate long-term; Send non-essential staff home to work longer-term (Assistant Director liaise with HR); Liaise with ICT if any issues; ~~Senior Staff~~ Maintain essential service and communication using mobiles/Remote Access; Retract services to essential areas only. After day 1 ~~Relocate Key Staff to~~ Consider long-term relocation options to alternative sites to manage/recover service; Retract services, accept some delays and cancel/re-arrange upcoming meetings Local offices to hold hard copy telephone/contact directories. ~~Increase~~ Continue with Remote Access/hybrid working until services are resumed;request activation of others' BCPs as appropriate. Ensure that essential services (access, security, IT, telephones) continue to be provided/are resumed by liaising with landlords/management companies at SPPG, Linum Chambers and other sites, requesting activation of their BCPs as necessary; Use alternative premises for key staff and remind staff re home working/remote access ~~allow senior staff home working where Remote Access is available~~. It will be for individual Directorates to determine who their key staff are. The decision to re-locate staff across Directorates will be made by IMT.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Responding to child and adult protection issues within Nursing AND/OR Allied Health Professions, including Case Management Reviews, reviewing written reports and attendance at multidisciplinary meetings (NB: specific professional expertise required e.g. Health Visitors)	2	1	Delegate; Senior staff provide cover; Use Remote Access/Laptops/Mobiles	Up to day 1 Senior staff/designated officers provide cover for most critical roles; Seek advice from a Trust Named Nurse for Safeguarding Children as appropriate; Maintain communication using e-mail/mobile/landlines as appropriate; Ensure clear communication pathway between interested parties, Trusts and PR Team as appropriate; Raise technical issues with ICT; Postpone meetings/non-urgent cases. After day 1 ~~Increase~~ Relay messages re Remote Access/desk bookings ~~/Home-working for senior staff~~; Communicate expected delays re non-urgent priorities with interested parties; Communicate delays with interested parties and Director/IMT; Liaise with colleagues across SPPG/HSC/Trusts to request assistance/provide cross-cover; Provide regular progress reports re service continuity; Use alternative means of communication such as Website/recorded messages/mobile to maintain essential elements of service.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Acute Surveillance of Communicable Disease (statutory, public function)	2	1.5	Staff use SOPs where available; Other staff trained to provide cover; Train other staff to encourage cross-team working; Use Remote Access ~~for information~~; Provide alternative travel options for staff using Public Transport	Up to 1.5 days Liaise with ICT to resolve any technical issues; Staff refer to pre-prepared SOPs/allow other staff to provide cover if building/team unavailable (on G Drive, hard copies in offices); ~~Key/senior staff provide~~ ~~minimal~~ Maintain service using Remote Access/laptops/desk booking systems ~~to access information~~; Record essential/relevant information in hard copy until ICT issues resolved; Communicate with staff and interested parties affected using mobiles/e-mail/ pre-recorded messages/updates; Reduce non-essential services/re-prioritise. Over 1.5 days Maintain communication/provide updates re delays with interested parties and staff/HSC Colleagues in Trusts/SPPG should assistance be required/available; Provide alternative transport options for staff if Public Transport affected – consider access requirements/alternative locations across PHA/SPPG, relocating key staff if unable to work remotely; Urgent/on-going issues- refer to On-Call Doctor/Lead Consultant in Health Protection/Health Protection Nurse; Involve deputies such as HP Consultants from other areas, HP Nurses, Specialist Registrars or CDSC Consultant in Health Protection; Use existing Trust safeguarding measures in place; Establish key points of contact/local arrangements so information continues to be received by designated officers/deputies in a timely fashion; Raise awareness re potential delays/communication issues and use alternative means of communication where possible, such as mobiles/landlines/E-mails/PHA Website.

Service	MAO (days)	RTO (days)	Strategies	Tactics
				Re-arrange upcoming meetings/postpone/cancel as necessary/non-urgent; Senior staff arrange own photocopying/printing/record maintenance/filing; Use Reprographics if available.
Maintaining adherence to Legal Responsibilities of the Organisation (Health and Safety)	3	1	Re-locate key staff; Use Remote Access; Re-allocate duties to others/prioritise; Maintain communication re any delays; Use alternative site(s) and desk booking systems; Liaise with ICT Use tele/videoconferencing; Refer to policies circulated on Connect Intranet; Arrange back-up facilities for key staff with access to files/information to maintain short-term minimum service; Liaise with SPPG/BSO Leads; Continue to ensure staff are aware of Policies/responsibilities	Up to 4 days Liaise with ICT to resolve technical issues; Send ~~non-essential~~ staff home to work if building(s) inaccessible; Maintain communication using e-mail/phone/Teams/websites; ~~Senior/key staff~~ Use Remote Access/laptops to maintain minimum service/deal with urgent/essential aspects of service ~~Relocate key staff and increase use of Remote Access/use alternative premises.~~ After 4 days Re-allocate duties and send staff with no premises to alternative Directorates/locations to assist/provide cover; (Re-prioritise services); Maintain communication with interested parties re delays; Use videoconference/website facilities for essential services; Arrange back-up facilities for key staff with no access to files/information; Request assistance/cross-cover from SPPG/BSO/HSC Trust Leads; Use e-Learning/email/line manager communication to ensure staff remain aware of their responsibilities; Ensure compliance with urgent /long-standing legal requirements; Identify issues regionally with DoH if appropriate.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Health Intelligence provision of direct support to Public Relations and PHA Senior Management (evidence gathering/analysis)	3	2	Contact IT for assistance; Communicate to raise awareness; Stretch resources; Retract/postpone service; Use manual files; Re-allocate duties; Use staff from other offices/HSC; Increase home-working/Remote Access	<u>Up to 2 days</u> Refer to ICT if server/e-mail down; Communicate to raise awareness amongst key interested parties/staff; Provide minimum/delayed service using stretched resources; Refer to manual files if ICT unavailable; ~~senior~~ staff home-working using Remote Access/laptops/mobiles; Defer non-urgent work. <u>After 2 days</u> Maintain communication with staff/interested parties; Retract/postpone service; Request assistance from staff in other Directorates/across HSC; Refer, if necessary, to information held on G Drive/Internet/ e-mail/off-site/with HSC Colleagues/interested parties; Plan ahead/ascertain key information needs of senior management/interested parties to prioritise recovery.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Provision of professional advice and corporate leadership to commissioning prison health services and palliative care services and to the commissioning and performance management of HSC services, the Independent Sector, AHPs and ECRs.	3	2	Senior staff provide cover; Delegate duties as appropriate; Re-prioritise tasks (most urgent ECRs processed first by most senior member of staff available); Consider increasing Remote Access	<u>Up to 2 days</u> Senior staff provide cover and maintain communication/raise awareness re delays using landlines/email/mobiles; Liaise with ICT to resolve any technical issues; Senior staff/designated officers provide cover for most critical roles; Senior/key staff work from home/use Remote Access/Laptops; If building inaccessible, send non-essential staff home and maintain contact re return. <u>After 2 days</u> Maintain communication with staff/interested parties; Retract/postpone non-essential elements of service; Request assistance from staff in other Directorates/across HSC; Communicate delays with interested parties/DOH; Prepare Press/Media holding report in communication with PR/Communications staff if available/necessary; Delegate duties of Director of Nursing to Assistant Director/Senior Nurse/Consultant; Senior Executives involved if paperwork requires authorisation/signature; Staff relocated to alternative site and use Remote; Access/Laptops/Shared resources to maintain basic service.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Maintaining adherence to Information Governance legal responsibilities - responding to all PHA Freedom of Information Requests (Co-ordinating/ chasing information)	5	3	FOI e-mails copied to Senior Operations Manager and all FOI Team members; Liaise with SPPG Governance for advice; Re-locate key staff/use desk booking systems/Remote Access/laptops/ mobiles; Maintain communication via Jabber/Teams/ mobiles with key interested parties and colleagues to raise awareness; place notice on Website and email re delays Use hard copy files/other means of communication; Train Operations Manager/band 4; Further develop BSO and SPPG support.	Up to 3 days Contact ICT to resolve technical issues; Team refer to joint FOI e-mail account to check FOI emails (also copied to Senior Operations Manager); Maintain communication with interested parties nearing deadlines to expect delays/raise awareness; Refer to hard copy information and contacts on ~~G~~ Shared Drive or on Website/use e-mail communications to develop general/basic level response in interim if necessary; Use mobiles and Remote Access as necessary. After 3 days Communicate/maintain relations with BSO and SPPG Governance leads for advice and cross-cover/support; Relocate key staff to another site/sharing resources/using Remote Access/laptops/mobiles; Train band 4 and ~~Senior~~ Operations Manager to increase their responsibilities if senior staff needed elsewhere/unavailable for longer periods – key staff based in Armagh/Belfast; Appropriate Director/Assistant Director nominate appropriate senior manager/team member to respond within an appropriate/agreed timescale. Liaise with ICO re long-term delays.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Identifying professional leads for Serious Adverse Incidents	7	3	Use designated officers and back-ups in place; Senior officers cover; Use Remote Access where possible	<u>Up to 2 days</u> Retract service; Communicate with ICT re technical issues; Advise key interested parties affected re delays; Senior Staff use Remote Access for urgent areas of work; <u>After 2 days</u> Defer to designated officers and back-up arrangements in place (Senior staff/designated officer/other professional identified by the Assistant Director of Nursing to provide temporary cover using e-mail/mobile/landlines as appropriate); Ensure clear communication pathway between PHA/SPPG and Trusts; Raise technical issues with ICT; Refer to Serious Adverse Incidents Group for assistance/resolution Request assistance from/communicate with SPPG, Trust leads and other HSC Colleagues; Relocate key staff initially and others provide assistance elsewhere until service resumed.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Project Management of connected health projects and RTNI (Remote Telemonitoring) (Centre for Connected Health)	7	3	Staff use mobiles and Remote Access/laptops	<u>Up to 3 days</u> Contact ICT for technical assistance; Raise awareness re delays/retracted service with key interested parties; Key staff/work from home using Remote Access/laptops; Maintain communication using mobiles/landlines/ e-mails/websites. <u>7 days and onwards</u> Provide regular updates re progress to key interested parties/public affected; Establish pre-recorded/website updates as appropriate in conjunction with PR Staff relocated to another site and share resources/use Remote Access/laptops to manage essential aspects of the service.

Service	MAO (days)	RTO (days)	Strategies	Tactics
New-born Blood Spot Screening Programme	7	4	SLAs and contingency arrangements already in place with Trusts/other HSC organisations/AHPs (Health Visiting, Child Health)	Up to 4 days Contact ICT for assistance; Raise awareness re delays/retracted service with key interested parties; Maintain communication using mobiles/landlines/ e-mails/websites; 7 days and onwards Relocate staff to alternative sites; Increase use of Remote Access/laptops until service resumed/new sites established; Refer to Trusts/HSC colleagues in SPPG for assistance/access to information Contact Royal Mail/Trusts to provide support/activate their contingency arrangements (under SLAs).
Maintain commissioning to high quality screening programmes (antenatal etc.)	7	4	Service Providers contingency processes already in place; PHA advised of incidents; Failsafes in place with ICT	Up to 4 days Contact ICT for assistance; Raise awareness re delays/retracted service with key interested parties; Maintain communication using Mobiles/landlines /e-mails/Websites; 7 days and onwards Relocate key staff to alternative sites; Increase use of Remote Access/laptops/working from home until service resumed/new sites established; Refer to Trusts/HSC/SPPG for assistance/access to information; Request Trust/Royal Mail activate their BCPs/invoke their service continuity processes already in place; Maintain communication/ensure information conveyed promptly via e-mail/telephone/mobile/lead contact person; Prepare general press/Public communications.

Service	MAO (days)	RTO (days)	Strategies	Tactics
Fulfilling statutory/PPI duty as regional lead and delivering on Priorities for Action Targets	7	6	Senior staff provide cover/deputise; Use Remote Access/laptops/ mobiles to maintain contact/access information	<u>After 6/7 days</u> Contact ICT for assistance; Raise awareness re delays/retracted service with key interested parties; Relocate key staff/ Senior staff provide cover/work from home using Remote Access/laptops; Maintain communication using mobiles/landlines/ e-mails/websites/Teams; Refer to Trusts/HSC colleagues in SPPG for assistance/access to information activate their BCPs/invoke their service continuity processes already in place; Communicate anticipated delays to DoH;

Colour Key (Appendix 1)	
	Priority 1 Services – MAO up to 24 hours
	Priority 2 Services – MAO of 2-7 days

Appendix 2

Business Impact Analysis

TIME CRITICAL/KEY SERVICES – beyond 7 days

PRIORITY 3

Service	MAO	RTO
Development of Public Information Campaigns in support of key work areas	2 weeks	1 week
Development of Websites in support of work areas (e.g. getting urgent messages to the Public)	2 weeks	1 week
Delivering on DoH action plans pertaining to Allied Health Professions (e.g. SLT action plan)	2 weeks	1 week
Development of print and electronic publications in support of work areas	3 weeks	1.5 weeks
Provision of management information including advising DoH, CMO, and responding to Parliamentary/Assembly Questions (RDO)	3 weeks	1 week
Programme Expenditure Monitoring System (PEMs)	4 weeks	1 week
Governance (including the management of Risk and Risk Registers), Statutory and Regulatory Functions (CAS, Governance Statement, Mid-Year Assurance Statement)	4 weeks	3 weeks
Developing robust quality management arrangements for non-cancer screening programmes – Abdominal, Aortic, Aneurism (AAA) Screening – urgent given nature of illness/outcome fatality	4 weeks	3 weeks
Co-ordination of contracts for voluntary and community organisations	5 weeks	4 weeks
Introducing new, approved screening and testing programmes within available resources	12 weeks	8 weeks

TIME CRITICAL/KEY SERVICES – PRIORITY 4

Service	MAO	RTO
Professional Support to Commissioning across the 12 Teams	5 weeks	3 weeks
Supporting the development of Public Information Campaigns	5 weeks	4 weeks
Evidence reviews and dissemination of information (Health Intelligence)	5 weeks	4 weeks
Resource development and testing (Health Intelligence)	5 weeks	4 weeks
Monitoring and evaluation of health improvement areas/initiatives (Health Intelligence)	5 weeks	4 weeks
Leadership and support to multi-sectoral partnerships	8 weeks	7.5 weeks
Bowel Screening Programme (SDS)	10 weeks	7 weeks
Breast Screening Programme (SDS)	10 weeks	7 weeks
Cervical Screening Programme	10 weeks	7 weeks
Diabetic Retinopathy Screening Programme	10 weeks	7 weeks
New-born Hearing Screening Programme	10 weeks	7 weeks
Provision of expert advice to commissioning and performance management of Health and Social Care	11 weeks	10 weeks
Commissioning and development of Health Improvement Services (HSWI)	12 weeks	11 weeks
Stimulating and supporting community engagement process	12 weeks	11 weeks
Allocating funding to appropriately make best use of resources	12 weeks	11 weeks
Awarding and project managing HSC R&D Division Awards from HSC R&D Fund	12 weeks	10 weeks
Develop Research Governance Policies and Procedures (and co-ordinate policing of these) – RDO	24 weeks	22 weeks
Training and Teaching – SDS (National Process, once a year opportunity)	24 weeks	22 weeks
HSCQI – Health and Social Care Quality Improvement Network – Regional hub and network for Regional Quality Improvement initiatives	24 weeks	22 weeks

Appendix 3

PHA Locations

The Public Health Agency spans a number of sites across Northern Ireland.

The following geographical localities are sufficiently placed to house the Incident Management Team and/or IMAT and Administrative Support Team should a Business Continuity incident arise.

1. 12-22 Linenhall Street, Belfast BT2 8BS
2. County Hall, 182 Galgorm Road, Ballymena BT42 1QB
3. Gransha Park House, 15 Gransha Park, Clooney Road, Derry/Londonderry BT47 6FN
4. Linum Chambers, Bedford Street, Belfast BT2 7ES
5. Tower Hill, Armagh BT61 9DR

Maps and directions are available for each of these sites on the following link:-

https://phaconnect.hscni.net/working-here/offices/

County Hall	182 Galgorm Road Ballymena BT42 1QB	0300 555 0114
Gransha Park House	15 Gransha Park Clooney Road Londonderry BT47 6FN	0300 555 0114
Linenhall Street	12–22 Linenhall Street Belfast BT2 8BS	0300 555 0114
Lisburn Health Centre	Linenhall street Lisburn BT28 1LU	028 9266 5181
Tower Hill	Armagh BT61 9DR	0300 555 0114
Linum Chambers	9th Floor, Bedford Street, Belfast, BT2 7ES	0300 555 0114

NB: See Appendix 12 ~~for further information and Contact Details~~ to book rooms at each of these venues (or to gain access outside normal working hours where available).

ICT On-Call Arrangements

During normal working hours, contact can be made with BSO ITS through the normal Service Desk Number (T: 028 9536 2400) or using the Infra Website Link on the BSO Homepage. Outside normal working hours, contact should be made using the **HSC Emergency On-Call** arrangements (T: 0333 0000 043), details of which are circulated to Assistant Directors on a weekly basis via email and noted at **Appendix 12.**

Appendix 4

IMT/IMAT/AST - Alternative Control Centres/Meeting Rooms (During Working Hours)

Site Affected	Primary Alternative/ Designated Rooms	Contact Persons 1 and 2	Secondary Alternative / Designated Rooms	Contact Person Persons 1 and 2	Third Alternative/ Designated Rooms	Contact Persons 1 and 2
12-22 Linenhall Street, Belfast	Conference Rooms, Linum Chambers, Bedford Street, Belfast BT2 7ES	**1.** Mark Johnston (Operations Manager) 028 9536 3482 **2.** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Carrie Crossan (Linum) T: 028 9536 1684	County Hall, 182 Galgorm Road, Ballymena (Committee Rooms or Boardroom)	**1.** Reception T:0300 555 0114 T:02895 362859 **2.** Nicolle Little (Office Manager) T: 028 9536 2874 **3.** Boardroom T: 028 9536 2853	Tower Hill, Armagh (Room 222)	**1.** Reception T: 0300 555 0114 **2.** (Office Manager) T: 028 9536 3344 **3.** ~~Shirley McReynolds~~ Alice Grey (~~Corporate Business Manager~~) Office Managers T: 028 9536 8506
Linum Chambers, Bedford Street, Belfast	4th Floor Meeting Room, 12-22 Linenhall Street, Belfast (or 2nd Floor Conference Rooms)	**1**. Cathy McAuley (PA)T: 028 9536 3406 **2** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Reception T:0300 555 0114	County Hall, 182 Galgorm Road, Ballymena (Committee Rooms or Boardroom)	**1.** Reception T:0300 555 0114 T:028 9536 2859 **2.** Nicolle Little (Office Manager) T: 028 9536 2874 **3.** Boardroom T: 028 9536 2853	Tower Hill, Armagh (Room 222)	**1.** Reception T: 0300 555 0114 **2.** (Office Manager) T: 028 9536 3344 ~~**3.** Shirley McReynolds (Corporate Business Manager)~~ Alice Grey Office Manager T: 028 9536 8506

Site Affected	Primary Alternative/ Designated Rooms	Contact Persons 1 and 2	Secondary Alternative / Designated Rooms	Contact Person Persons 1 and 2	Third Alternative/ Designated Rooms	Contact Persons 1 and 2
County Hall, 182 Galgorm Road, Ballymena	4th Floor Meeting Room, 12-22 Linenhall Street, Belfast (or 2nd floor Conference Rooms)	**1.** Cathy McAuley (PA) T: 028 9536 3406 **2.** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Reception T:0300 555 0114	Linum Chambers, Bedford Street, Belfast	**1.** Mark Johnston Operations Manager 028 9536 3482 **2.** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Carrie Crossan (Linum) T: 028 9536 1684	Tower Hill, Armagh (Room 222)	**1.** Reception T: 0300 555 0114 **2.** ~~Shirley McReynolds (Corporate Business Manager) T: 028 9536 3197~~ Alice Grey Office Manager T: 028 9536 8506
Tower Hill, Armagh	County Hall, 182 Galgorm Road, Ballymena (Committee Rooms or Boardroom)	**1.** Reception T:028 9536 2859 T:0300 5550114 **2.** Nicolle Little (Office Manager) T: 028 9536 2874 **3.** Boardroom T: 028 9536 2853	4th Floor Meeting Room or 2nd Floor Conference Rooms, 12-22 Linenhall Street, Belfast	**1.** Cathy McAuley (PA)T: 028 9536 3406 **2.** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Reception T:0300 555 0114	Gransha Park House, 15 Gransha Park, Derry/L'derry (Seminar Room, Meeting Rooms 1 / 2 or Boardroom)	**1.** Reception T: 0300 555 0114 **2.** ~~Alice Grey (Office Manager) 02895 361103~~ **3.** Senga Curry PA 028 9536 1101 **4.** Hayley Thomas (Registry Dept) 028 9536 1067 **5.** ~~Denise O'Neill~~ Receptionist 028 9536 1000 E: abhqreception@hscni.net

Site Affected	Primary Alternative/ Designated Rooms	Contact Persons 1 and 2	Secondary Alternative / Designated Rooms	Contact Person Persons 1 and 2	Third Alternative/ Designated Rooms	Contact Persons 1 and 2
Gransha Park House, 15 Gransha Park, Derry/ L'derry	Room 222 Tower Hill, Armagh Boardroom/ Committee Room hold 25 people; Room 222 holds 10-12 people	1. Reception T: 0300 555 0114 2. Michaela Kiely (Office Manager) T: 028 9536 3344/1103 3. ~~Shirley McReynolds (Corporate Business Manager)~~ ~~T: 028 9536 3197~~ Alice Grey Office Managers T: 028 9536 8506	County Hall, 182 Galgorm Road, Ballymena	**1.** Reception T: 028 9536 2859 T:0300 555 0114 **2.** Nicolle Little (Office Manager) T: 028 9536 2874 **3.** Boardroom T: 028 9536 2853	4th Floor Meeting Room or 2nd floor Conference Rooms 12-22 Linenhall Street, Belfast	**1.** Cathy McAuley (PA) T: 028 9536 3406 **2.** Robert Graham (CX Ctee and Office Manager) T: 028 9536 3515 **3.** Reception T:0300 555 0114

Control Centres - Out of Hours

If an incident occurs out of hours which cannot be managed on the morning of the following working day, initial discussions should take place using mobiles and/or via telephone/videoconference facilities, with the initial IMT in-person meeting taking place as soon as necessary once premises open.

IMT members may, outside normal working hours, make contact with the Head of Corporate Services or Ms Liz Fitzpatrick to request that Security open Linenhall Street premises temporarily (see Appendix 12 for contact details).

(Please refer to Appendix 12 for full details regarding venues/key holders)

Appendix 5

INCIDENT NOTIFICATION

Completed by .....

Date & Time .....

Call Details:

Name and Contact Details of Caller:.....

.....

.....

Incident Details

.....

.....

.....

Assessment of Incident/Damage (Level 1-4 as per Figure 3)

.....

.....

.....

Current Status of Incident: (Minor, significant, major)

.....

Hazards: (present/potential)

.....

Number/Group of Staff/Directorate Affected:

.....

PHA Actions to Date:

.....

APPENDIX 6

Assistant Director/Senior Manager Briefings

Report completed by:

Task / Issue	Timescales for completion	Current Position	Consequences if not completed on time	Key Personnel

Appendix 7

Key Decisions Log

Date and Time …… **Completed By ……**

Decision Number	***Decision***	***Person Responsible***	***Expenditure (if applicable)***
1			
2			
3			
4			
5			
6			

Appendix 8

PHA INCIDENT MANAGEMENT TEAM AGENDA

Date:-

Time:-

Venue:-

No	Item	Lead
1	AST instructions	IMT
2	Recap of activity to date	IMT
3	Assessment	IMT
4	Key Services	IMT
5	Duty Room update	IMT
6	Resource review	IMT/IMAT
7	Tactics/Action Plan	IMT
8	IMAT	IMT
9	Briefings	Directors
10	DOH	Chief Executive
11	Communications Team	Mr S Wilson
12	Review of progress	IMAT
13	De-escalation	IMT
14	Formal de-brief	IMT

Appendix 9

Incident Management Team Meeting Notes

Chair:

Date	Action No	Action Agreed	Person Responsible	Status
	1			
	2			
	3			
	4			
	5			
	6			
	7			

Appendix 10

Incident Management Team

Date : _____

New Developments

Appendix 11

Resource Requirement

Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
Health Protection (HP)	Doctors' On Call Service	3	3	3	4	3	3	3	4	3	3	3	4	Access to HP Zone (Internet Access), G Drive, Cascade Lists/ Contact details; Pagers; Laptops with Remote Access, Standard Operating Procedures (SOPs)
Health Protection (HP)	HP Duty Room (providing advice and support by phone/email/fax to all HSC professionals on all Health Protection Issues/ emergencies - during working hours)	HP	3	3	6	3	3	3	6	3	3	3	6	Access to SOPs/Protocols/Guidelines/Reference Manuals; Access to HP Zone (Internet Access); Contact Details
Health Protection (HP)	HP Zone (24/7 UK wide Web Based Health Protection incidents information database- used by HSC professionals and interested parties)	3	3	3	6	3	3	3	6	3	3	3	6	Access to SOPs/protocols/ guidelines/reference manuals; Access to HP Zone (Internet); Laptops with Remote Access

Resource Requirement														
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2-5	Days 6-10	Days 11+	Day 1	Days 2-5	Days 6-10	Days 11+	Day 1	Days 2-5	Days 6-10	Days 11+	
CPA	Public Relations (for compilation/ dissemination of important/urgent health messages to Public, interested parties and media)	4	4	6	6	4	4	6	6	4	4	6	6	Contact Details; mobiles; Laptops with Remote Access; Internet Access
CPA	Activation of Community Response Plan (CRP)	1	2	2	2	1	2	2	2	1	2	2	2	
CPA	Internal Communications (of important/urgent messages across all PHA sites using email/Connect/ phones)	1	1	1	1	1	1	1	1	1	1	1	1	Access to SOPs/protocols/ guidelines/standards, reference manuals; Laptops with Remote Access, mobiles; Pagers

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
Planning and Corporate Services (P&Ops)	Operational role of co-ordinating and communicating across local offices - and with BSO and SPPG	1	1	2	3	1	1	2	3	1	1	2	3	Email; Contact Lists; mobiles
P&Ops	Administrative/ secretarial support to Chief Executive's Office, including co-ordination/ organisation of AMT/Board Meetings	1	1	2	3 to 5	1	1	2	3 to 5	1	1	2	3 to 5	SOPs/protocols/ guidelines/standards/reference manuals; Access to email, G Drive; Hard copy files; Laptops with Remote Access; Contact Details

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
Nursing	Responding to critical patient safety issues, serious and adverse incidents and complaints, both internal and external (Nursing and AHP) NB: Depends on 3rd parties /information received, media interest	2*	2*	3*	3*	2*	2*	3*	3*	2*	2*	3*	3*	* Includes 1 Admin Staff Telephone/Email Contact Lists (personal/client); Personal Electronic files; Paper files (including those in off-site storage if possible); Pagers; Laptops with Remote Access; mobiles; spiderphones

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
Nursing	Responding to professional conduct and practice issues including fitness to practice for Nurses and AHPS (public protection) (NB: Trust may have already been involved before this reached PHA, possibly escalated) Public, Media interest, 3rd party communication vital	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	* Includes 1 Admin Staff Telephone/Email Contact Lists (personal/client); Personal Electronic files; Paper files (including those in off-site storage if possible); Pagers; Laptops with Remote Access; mobiles; spiderphones

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2-5	Days 6-10	Days 11+	Day 1	Days 2-5	Days 6-10	Days 11+	Day 1	Days 2-5	Days 6-10	Days 11+	
Nursing	Provision of expert professional advice to commissioning and performance management of HSC services and the independent sector, including approval of urgent Extra Contractual Referrals (ECRs) (Nursing and/or AHPs) (URGENT#) NB: Record keeping essential, media interest. Patient care May not be regularly received but need dealt with urgently	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	* Includes 1 Admin Staff Telephone/Email Contact Lists (personal/client); Personal Electronic files; Paper files (including those in off-site storage if possible); Pagers; Laptops with Remote Access; spiderphones

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
CPA	Providing information to Assembly, DoH, Minister; Monitoring NI Assembly	1	1	1	1	1	1	1	1	1	1	1	1	Access to Internet; Access to HSC email; Contact Details

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
P&Ops	Accommodation (Single/various sites)	1	1	1	1	1	1	1	1	1	1	1	1	Telephone/email contact lists/ mobiles
Nursing/ AHPs	Responding to child/adult protection issues within Nursing and/or AHPs, including Case Management Reviews, reviewing written reports and attendance at multidisciplinary meetings (NB: specific professional expertise required e.g. Health Visitors)	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	2*	* Includes 1 Admin Staff Telephone/Email Contact Lists; Personal Electronic/paper files; (including those in off-site storage if possible; Pagers; Laptops with Remote Access; spiderphones

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
HP	Acute Surveillance of Communicable Disease (statutory, public function)	3	3	3	6	3	3	3	6	3	3	3	6	Access to HP Zone, G Drive, Cascade Lists, contact details for interested parties; Pagers; Laptops with Remote Access; SOPs;
P&Ops	Maintaining adherence to Legal Responsibilities of the Organisation (Health and Safety)	1	1	1	1	1	1	1	1	1	1	1	1	
HI/Comms	Health Intelligence provision of direct support to PR and PHA senior management	3	3	3	3	3	3	3	3	3	3	3	3	Access to G Drive; Internet; Email

Resource Requirement														
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
Nursing	Provision of professional advice and corporate leadership to the commissioning of prison health services and palliative care services and to the commissioning and performance management of HSC services, the Independent Sector, AHPs and ECRs.	2*	3*	3*	3*	2*	3*	3*	3*	2*	3*	3*	3*	* Includes 1 Admin Staff Telephone/Email Contact Lists (personal/client); Personal Electronic files; Paper files (including those in off-site storage if possible); Pagers; Laptops with Remote Access; spiderphone

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
P&Ops	Maintaining adherence to Information Governance legal responsibilities - responding to all PHA Freedom of Information Responses (Co-ordinating/chasing information)	1	1	1	1	1	1	1	1	1	1	1	1	Laptops with Remote Access; Access to Shared Drive and Emails (FOI Email); mobiles; contact details
Service Development and Screening (SDS)	Identifying professional leads for Serious Adverse Incidents (SAIs)	1	1	1	1	2	2	2	3	2	2	2	3	(1 Consultant per day) Telephone/Email Contact Lists (personal/client); Personal Electronic files; Paper files (including those in off-site storage if possible); Pagers; Laptops with Remote Access; spiderphones
Centre for Connected Health and Social Care (CCHSC)	Project Management of Connected Health Projects and Remote Telemonitoring	0	0	3	3	0	0	3	3	0	0	3	3	Access to Contract Files; G Drive/Server Access; Laptops with Remote Access

Resource Requirement													
Directorate/ Division	Service	Staff				Desks				IT				Other resource requirements (in addition to phones, printers, fax, pens, papers)
		Day 1	Days 2 -5	Days 6 -10	Days 11+	Day1	Days 2 -5	Days 6 -10	Days 11+	Day 1	Days 2 -5	Days 6 -10	Days 11+	
SDS	Newborn Blood Spot Screening Programme	1	1	2 to 3	2 to 3	1	1	2 to 3	2 to 3	1	1	2 to 3	2 to 3	Access to G Drive, Internet, HSC emails; Test materials/Trusts' test systems (e.g. CHS, NIMATS)
SDS	Maintain commissioning to high quality screening programmes (antenatal etc)	1	1	2	2	1	1	2	2	1	1	2	2	Various screening systems; Access to G Drive, Internet; HSC Emails; Outlook; Personal Folders; C Drive
AHP/PPI	Fulfilling statutory/PPI duty as regional lead and delivering on Priorities for Action Targets	2	2	3	5	2	2	3	5	2	2	3	5	Access to G Drive; Contact Details; Laptops with Remote Access; SOPs; mobiles

Appendix 12

Contacts: Key Staff and Interested Parties

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Appendix 13

Fuel Plan:

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POLICY ON BUSINESS CONTINUITY MANAGEMENT

Version	**2.0**
Date version 1 approved by AMT	**31/01/12**
Reviewed policy approved by AMT	**31/03/15**
Scheduled review date	**31/03/18**
Review completed	**23/02/18**
Version 2 approved by AMT	**13/03/18**
Scheduled review date	**31/03/21**

CONTENTS

Glossary

Business Continuity Management (BCM)	Holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised, might cause. It provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of key stakeholders, reputation, brand and value-creating activities.
Business Continuity Management Programme	Ongoing management and governance process supported by top management and appropriately resourced to ensure that the necessary steps are taken to identify the impact of potential losses, maintain viable recovery strategies and plans, and ensure continuity of products and services through training, exercising, maintenance and review.
Business Continuity Plan (BCP)	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level.
Civil Contingencies	Civil contingencies are the events and situations impacting on the community which may or may not occur, but would lead to an emergency if they did. Civil contingencies covers all the hazards and threats which could impact upon human welfare, the environment, national security or the continuity of essentials of life services.
Disruption	Event, whether anticipated (e.g. a labour strike or hurricane) or unanticipated (e.g. a blackout or earthquake), which causes an unplanned, negative deviation from the expected delivery of products or services according to the organisation's objectives.
Emergency	An event or situation that threatens serious damage to human welfare, the environment or the security of the UK.
Emergency Planning	Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency.
Incident	Situation that might be, or could lead to, a business disruption, loss, emergency or crisis
Risk	Something that might happen and its effect(s) on the achievement of objectives.
Risk Management	Structured development and application of management culture, policy, procedures and practices to the tasks of identifying, analysing, evaluating, controlling and responding to risk.
Cyber Risks	Any risk of financial loss, disruption or damage to the reputation of an organisation from failure of its information technology systems.

1 Purpose

1.1 The aim of this policy is to detail a comprehensive framework for Business Continuity Management so that the Public Health Agency (PHA) can continue to function through an operational interruption.

1.2 This document sets out the general principles and processes for the development, maintenance and review of Business Continuity plans for the PHA.

1.3 This Policy is separate from but complements the PHA Risk Management Policy. It has been approved by the PHA Board and is based on BS25999 -1, Business Continuity Management – Code of Practice and ISO 22301:2012 (the new international standard for Business Continuity Management systems).

2 What is Business Continuity Management?

2.1 Business Continuity Management is a business-owned, business driven process that establishes a fit-for-purpose strategic and operational framework that:-

- Proactively improves an organisation's resilience against the disruption of its ability to achieve its key objectives;
- Provides a rehearsed method of restoring an organisation's ability to supply its key products and services to an agreed level within an agreed time after a disruption; and
- Delivers a proven capability to manage a business disruption and protect the organisation's reputation and brand.

2.2 Business Continuity Management involves managing the continuation or recovery of business activities in the event of a business disruption and management of the overall programme through training, exercises and reviews, to ensure that Business Continuity plans stay current and up-to-date.

2.3 Examples of activities which may cause disruption and require activation of the Business Continuity Plan include loss of utilities, loss of a facility, loss of ICT systems, significant loss of staff or Public Health/similar emergency requiring resources or staff to be re-assigned for a significant period of time.

These events can be man-made, natural, deliberate or unintentional – for example, adverse weather, terrorist activity, cyber-attack or systems failure due to poor systems integrity. Events in the local or political arena, most notably EU Exit, may also have an impact requiring business continuity arrangements to be in place.

3 Relationship with Business Planning and Risk Management

3.1 Business Continuity Management shall be part of the planning cycle undertaken within the Public Health Agency. The cycle applies to all levels of planning in the Organisation. All levels shall have business plans, risk registers, Business Continuity plans and processes in place for ongoing maintenance and review. Directorate level Business Continuity plans are not mandatory but may be developed if required. The planning cycle is set out in Figure 1 below:-

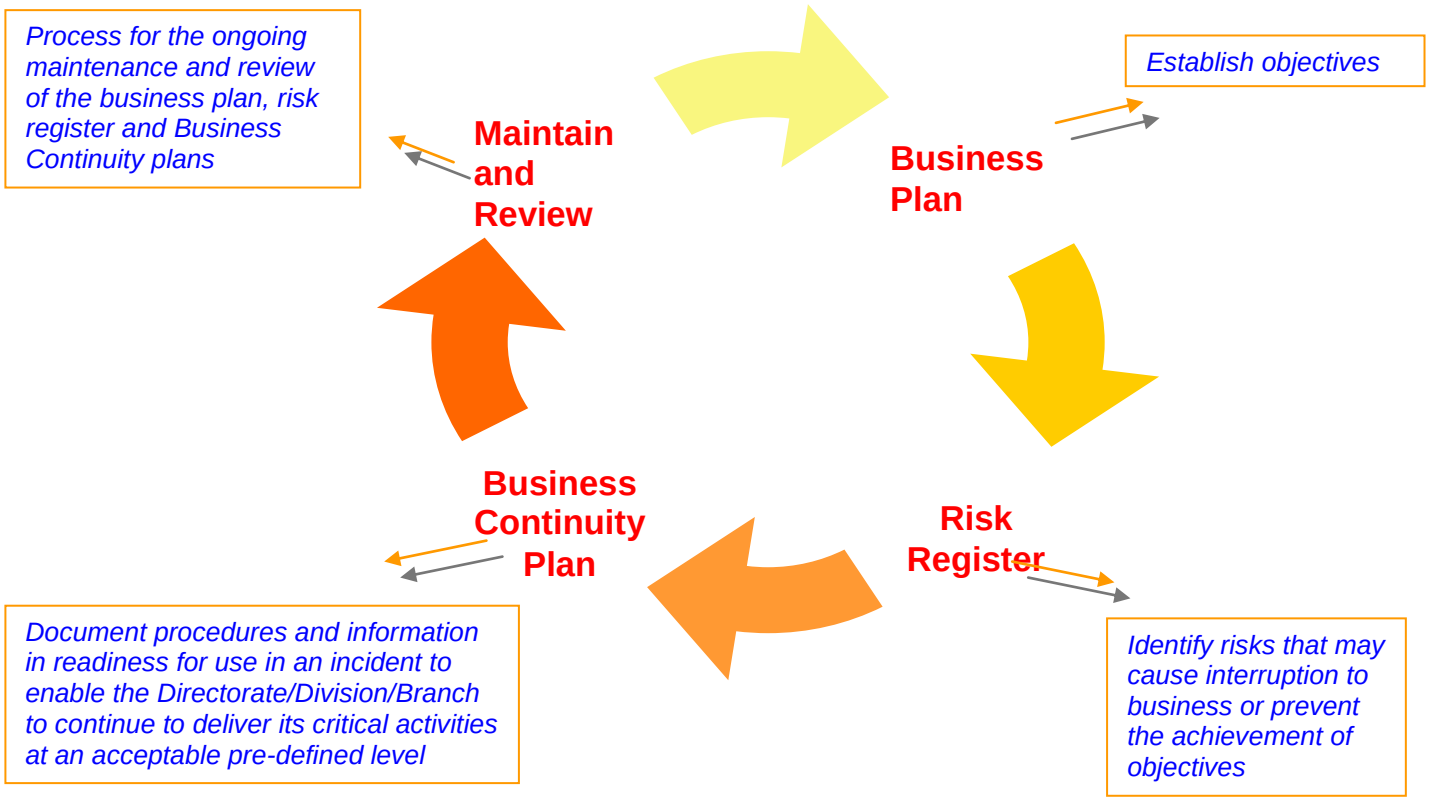


Figure 1

4 Civil Contingencies and Business Continuity Management

4.1 Civil contingencies activities are those undertaken by individuals and organisations to prevent emergencies and critical business interruptions, to mitigate and control their effects and to prepare to respond. These activities include horizon scanning, risk assessment, Business Continuity Management, Integrated Emergency Management, preparedness, validation, response and promotion of recovery and restoration.

4.2 Business Continuity Management provides an organisation with the resilience to continue to function during an emergency and to return to full functionality effectively and efficiently once the crisis has passed.

5 Policy Statement

5.1 PHA is committed to the vision of protecting public health and improving the health and social wellbeing of people in Northern Ireland. It is essential that, irrespective of demands and circumstances, the PHA is able to deliver its critical functions and services.

5.2 PHA shall develop, exercise, maintain and review the Business Continuity Plan for its critical functions and services in the event of a service disruption or disaster. The Business Continuity Plan will facilitate the rapid, efficient and cost effective continuity of the Organisation's functions and services.

6 Framework and Approach

6.1 PHA shall establish a framework of plans which shall be underpinned by a corporate Business Continuity Plan. The corporate Business Continuity Plan shall take account of the key functions and services in the organisation and plan for their ongoing delivery in the event of an interruption to normal business. Further plans shall be developed at Directorate level to support the corporate plan and ensure resilience of key products and services. Directorate level Business Continuity Plans are not required but may be developed if required.

6.2 PHA shall ensure that it adopts a Business Continuity Management Programme which is compatible with the strategic direction of the organisation and shall integrate Business Continuity Management requirements into the organisation's business processes.

6.3 PHA will strive to conform to ISO 22301:2012.

7 Roles and Responsibilities

PHA Board

The PHA Board is responsible for ensuring that the appropriate Business Continuity arrangements are in place to enable the time critical services and functions to be delivered in the event of an interruption to normal business. The Board will receive assurance through an effective Business Continuity Plan, which is fully compliant with the new International Standard ISO 22301:2012.

Chief Executive

The Chief Executive has overall responsibility for ensuring that the PHA has effective, ISO 22301:2012 compliant, Business Continuity arrangements in place to respond to an incident affecting PHA functions and service provision. Supported by the Agency Management Team, the Chief Executive will champion the Business Continuity Management process and ensure this is fully embedded across the Agency. This commitment will include ensuring the provision of support and training for management and staff as appropriate.

Agency Management Team

AMT is responsible for overseeing the development of the Corporate Business Continuity Arrangements, including approving the Business Continuity Plan for onward transmission to the PHA Board.

Directors will develop and maintain a culture of Business Continuity Management within their areas of responsibility. This includes:-

- Ownership of the Corporate and any Directorate Level Business Continuity Plan(s) for their area of responsibility.

- Raising awareness and ensuring that line managers and all staff are aware of their Business Continuity responsibilities.

- Regularly reviewing the PHA Corporate Business Continuity Plan and the prioritised, time critical functions and continuity strategies identified within the Plan, highlighting any changes required or new threats anticipated.

- Participating in the testing of the Business Continuity Plan.

- Satisfying themselves that Business Continuity incidents are being actively managed, with the appropriate strategies in place and working effectively, and proposing new or alternative strategies as appropriate.

- Ensuring that the PHA meets its legal and regulatory Business Continuity requirements.

- Demonstrating commitment to the continual improvement of Business Continuity Management across the PHA.

Director of Operations

The Director of Operations is the lead Executive Director for Business Continuity Management, with responsibility for ensuring that effective and robust Business Continuity processes and systems are established, implemented and monitored within the PHA.

Assistant Directors

In conjunction with the relevant Director, Assistant Directors are responsible for:-

- Contributing to ownership, implementation and monitoring of the corporate and any directorate level Business Continuity Plan for their area of responsibility.

- Ensuring that staff within their area are aware of their Business Continuity responsibilities.

Line Managers and all Staff

All staff are expected to:-

- Familiarise themselves with their individual roles as set out in the PHA Business Continuity Plan and comply with Business Continuity measures when it is invoked.

- Have knowledge of and comply with the PHA's Policy on Business Continuity Management.

- Alert Management to emerging threats or weaknesses in service provision in accordance with the Business Continuity Management Policy and Business Continuity Plan.

- Participate fully in the regular Business Continuity Plan review process.

8 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This plan will therefore not be subject to an Equality Impact Assessment.

The plan has also been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

The Business Continuity Plan will be included in the PHA's Register of Screening documentation and maintained for inspection whilst it remains in force**.**

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

REPORT ON THE TEST OF THE PHA CORPORATE BUSINESS CONTINUITY PLAN

Held on Monday 13 March 2023
at 10.00 am
in the 5th Floor Meeting Room, 12-22 Linenhall Street, Belfast

EXERCISE 'OVER THE HORIZON'

Prepared by: **Carol Hermin**
Assistant Information Governance Manager, PHA
and
Mark Johnston, Operations Manager, PHA

March 2023

1.0 The test format was a desktop exercise, Exercise 'Over the Horizon'. It was held at 10.00am on Monday 13 March 2023 and lasted approximately one hour thirty minutes.

2.0 As approved by AMT at their meeting on 22nd February 2023, the annual exercise for 2022/23 was led by the Director Operations and involved Senior Manager representatives from across the PHA.

3.0 Those present at the test were Stephen Wilson (Interim Director of Operations), Stephen Murray (Interim Assistant Director, Planning and Corporate Services), Deirdre Webb (Assistant Director, Nursing), Levette Lamb (Regional Senior Improvement Advisor) and Catherine Curran (PHA Emergency Planner).

4.0 The test was facilitated by Carol Hermin (Assistant Information Governance Manager) and Mark Johnston (Operations Manager).

5.0 The aims of the test were: -

- to test the robustness of the PHA Corporate Business Continuity Plan;
- to enhance PHA Business Continuity Preparedness, capacity and linkages, through testing the robustness of the PHA Corporate Business Continuity Plan and the overall Agency response during an incident.

6.0 The Objectives of the test were:-

- to achieve the targets identified in the PHA Business Plan and Business Continuity Policy (to test and review the PHA Business Continuity Plan on an annual basis to ensure arrangements are in place to maintain critical services to a pre-defined level in the event of a business disruption);
- to raise awareness of the Business Continuity Plan with key staff;
- to exercise aspects of the plan by highlighting scenarios through discussion-based exercise;
- to identify any amendments required to the plan.

7.0 The purpose of the test was: -

- to give Incident Management Team (IMT) members or their Deputies an opportunity to practise in a safe environment;
- to consider what the corporate response should be during an incident;
- to consider how PHA would communicate throughout an incident.

8.0 The scene was set as normal business across the organisation with Hybrid Working in place and a strike scheduled to take place. PHA Board were due to hold an in-person meeting at 2pm in Linenhall Street, Belfast where a number of visitors were due to be giving presentations. It was also a week before Easter and a number of staff were on leave.

9.0 The first scenario (Inject 1) indicated that fewer staff than anticipated were in Linenhall Street office at 9.15 am on 4th April due to the strike. At 10am it was noted that the SITREP's did not reflect the number of staff actually present and at 11am it transpired that some staff who had been due to be on site suddenly decide to work remotely so as not to have to cross the picket line.

Additional Injects were introduced to the scenario as follows: -

10.0 (Inject 2) Some staff clicked on a link in an email offering free Easter eggs. As a result, shared network drives were encrypted and their PCs begin to shut down immediately.

11.0 (Inject 2 continued)
IT advise that Trusts have also received this link, which had begun to affect the wider HSC network. As a result of PC's shutting down Cisco Jabber and emails were no longer accessible. IT had high volumes of calls and, although working to resolve the issue, delays were expected as resources stretched province-wide (and clinical systems a priority).

12.0 (Inject 2 - Recovery)
IT services confirmed that no data was compromised but it would take a few days for the PCs affected to be re-built. Email and VOIP systems were being restored, but this might also take a few days.

13.0 The Incident Management Team (IMT) were asked to identify the immediate actions for PHA (for staff and visitors), as well as key actions/issues for recovery in the short, medium and longer-term.

14.0 Those present were also asked to consider arrangements to recover any back-log of work following the incident and to identify any areas of the Business Continuity Plan to be updated in light of lessons learned from the Exercise.

15.0 An immediate 'hot debrief' was held at the end of the exercise, to establish what went well, and to consider what areas require further action.

16.0 Exercise Observations

16.1 Inject 1

- Participants noted that Directorates should take stock and identify whether they had sufficient staff on site to meet the demands. This would involve identifying which staff were not present and what actions they were anticipated to undertake.
- It was highlighted that there would be a need to obtain clarification as to whether staff who were not present due to their reluctance to cross picket lines were still planning to work remotely.
- Contact would be sought with other PHA locations to establish whether they were also experiencing issues with attendance.

- Consideration was given to whether the planned Board Meeting should take place virtually. This involved checking with SPPG colleagues who manage the Linenhall Street Reception and the practicalities of allowing staff and visitors access to the office. There was also discussion about the potential impact on PHA corporate image.
- Participants agreed that the Business Continuity Plan would not be activated at this stage.

16.2 <u>Inject 2</u>

- Immediate contact made with IT with the aim of seeking clarification regarding the extent and scope of the issue. It was noted that IT can no longer be contacted via phone and this may require contact between PHA and BSO ITS senior staff.
- Consideration was given to development of a flowchart clearly outlining the process for dealing with a cyber-attack as the chances of this occurring in future are quite high.
- This incident was deemed significant enough to consider/activate the Business Continuity Plan.

16.3 <u>Inject 2 continued Inject 2</u>

- Participants agreed that IMT should be informed and the Business Continuity Plan activated given severity and likelihood of significant disruption.
- As Trusts were now also affected, this may require an HSC wide join response and the implementation of Silver emergency planning. Business Continuity/Working cells and BSO may be taking the lead on some matters at this point. Contact would be made with DoH to notify them of the incident.
- Participants recognised the need to ensure that records were kept of the decisions as they were made and factored this into the limitations on administrative staff (AST) available to carry out these actions.

- Discussions took place regarding the viability of proceeding with the Board Meeting given the Chief Executive and Director of Operations role in IMT and the limited IT capabilities. Time likely a factor/already in progress.
- It was agreed that visitors would be kept informed and communication colleagues prepared for potential media enquiries.
- Those present discussed communication methods – noting that many admin staff would not have mobiles and Cisco Jabber/emails may not be accessible. Mention given to the ABC Section of the Website and Directorate Level communications (possible reference to WhatsApp and less formal methods – and consideration of walkie talkies and access to DeskAlerts).
- Consideration given to asking staff to attend the office if unable to work/assist remotely (noting difficulties in communication and possible unwillingness due to strike action).
- Participants highlighted the need to identify how long these issues would continue and the impact on decision-making regarding the provision of critical services.

16.4 Inject 2 - Recovery

- Participants recognised the need to retrieve affected laptops and move these to a central location for IT to begin repairs. NB: repairs can take approximately 3 days (and IT likely to prioritise Trust/Hospitals/front line). There is a limited number of spare laptops available at present.
- Requests made for impact assessments across each Directorate to identify services affected/key priorities.
- Communications Team to manage potential Media interest.
- PHA Board to be briefed regarding the incident and its impact.
- Participants recognised the need to ensure records were maintained of decisions made/actions taken as well as a post-incident review to identify any learning.

17.0 De-brief

The following points were noted immediately after the exercise: -

- Participants carried out sound, confident decision-making, discussing actions freely and referring to the BCP as a guide.
- Participants quickly identified key issues such as staff and visitor safety, communication, damage limitation and preventing a re-occurrence.
- There was effective communication from the outset, with early discussions taking place at senior level and between PHA, BSO and SPPG.
- Level of damage and impact on staff and services quickly assessed at the beginning of the incident.
- There was awareness of the critical functions of the organisation, with focus quickly aimed at restoring key, time critical, services such as the Duty Room.
- Careful and deliberate actions were taken, using common sense, careful assessment of the facts and previous experience.

18.0 Feedback

- Everyone agreed that the exercise went well, with excellent participation, useful discussion and realistic scenarios.
- Participants' attention drawn to templates in the BCP for recording/monitoring.
- Participants agreed the importance of cyber security in the current climate, with many sites and services, including the PHA Corporate Site, facing attack on a regular basis.

19.0 Further Actions/Considerations

- Consideration of a flowchart clearly outlining the process for dealing with a cyber-attack with particular focus on communicating with IT.
- Possible re-establishment of WhatsApp groups while recognising GDPR implications.

- Longer-term: possible review/new Business Impact Analysis (BIA) to be carried out.
- Further explore and develop the link between Business Continuity and Emergency Planning
- Further awareness raising of Business Continuity generally, including development of Action Cards for staff.
- Communication with IT regarding other options including Desk Alerts access and a BCP Teams Channel.
- BCP to be updated to include reference to new working arrangements such as Desk Booking System.

20.0 Next Steps

- The PHA Corporate Business Continuity Plan will now be shared with Directors to note any further changes, including a review of key Services.
- An updated version of the PHA Corporate Business Continuity Plan will be presented to the Agency Management Team for approval and sent to the Governance and Audit Committee and PHA Board later in Spring 2023.

RISK MANAGEMENT STRATEGY AND POLICY

Version	**2.6**
Date version 2.3 approved by AMT	**04/02/14**
Date version 2.3 approved by GAC	**10/04/14**
Date version 2.4 approved by AMT	**25/07/17**
Date version 2.4 approved by GAC	**11/10/17**
Date version 2.5 approved by AMT	**06/08/19**
Date version 2.5 approved by GAC	**03/10/19**
Date version 2.6 approved by AMT	
Date version 2.6 approved by GAC	
Scheduled review date	**30/06/26**

CONTENTS

1. Introduction

The Public Health Agency (PHA) is committed to developing a robust and effective system of risk management. This Risk Management Strategy and Policy forms a central part of the PHA's internal control and corporate governance arrangements.

It defines the PHA's approach to risk management throughout the organisation. It also ensures a consistent approach to dealing with risks which may have an impact on the PHA's ability to achieve its strategic aims and objectives. It outlines the key aspects of the risk management process, and identifies the main reporting procedures.

The policy is subject to regular revision as the risk management process is embedded throughout the PHA, and will be updated as necessary to reflect the changing environment.

2. Background

The Health and Social Care (HSC) Regional Model for Risk Management (including a Regional Risk Matrix) was endorsed by the HSC Chief Executive's Forum in September 2018. The model, which was developed by a Working Group comprising senior managers working in risk management across the HSC, is based on the principles of the ISO 31000:2018[1] standard. This standard largely has the same broad principles, framework and processes as the AS/NZ standard which was previously used by HSC organisations. All HSC organisations, including the PHA, have agreed to adopt the 'spirit' of ISO 31000:2018 ~~but will not be~~ without seeking accreditation.

The PHA risk management system conforms to the principles of the ISO 31000:2018 Standard, and meets HSC requirements in respect of managing risks, hazards, incidents, complaints and claims.

Adhering to the ISO 31000:2018 Standard will ensure that all HSC bodies have the basic building blocks in place for managing risk through development and implementation of a comprehensive risk management system. The PHA Risk Strategy and Policy shows how the organisation's risk management system meets this standard.

Following an Internal Audit Review of risk management in 2022/23, the PHA has adopted the 3 lines model of assurance for its Corporate Risk Register. This will ensure that controls identified to manage risks are actually operational and that they are effective in managing risk.

This Strategy and Policy, together with the Corporate Governance Framework, Standing Orders and Standing Financial Instructions, provides the basis for statutory reporting through the Governance Statement as required by the Department of Health (DoH).

[1] BSI ISO 31:000: 2018: Risk Management Guidelines

The PHA recognises that the principles of good governance must be supported by an effective risk management system that is designed to deliver improvements in services as well as the safety of its staff and the public.

3. Definition of Risk

While there are many definitions that are used in the area of risk management, HSC organisations are using the following definition based on the ISO 31000:2018 standard:

Risk is the *"effect of uncertainty on objectives".*

Risk is also often expressed in terms of a combination of the consequences (impact) of an event (including changes in circumstances) and the associated likelihood of occurrence. This definition of risk makes a direct connection between risk and the objectives of the organisation as set out in the PHA Corporate Plan and Annual Business Plans.

4. Managing Risk according to ISO 31000:2018

ISO 31000:2018 has three components for managing risk:

(a) The core principles of risk management

(b) Risk management framework and

(c) Risk management processes

4.1 Principles of Risk Management

To be fully effective, any risk management process must satisfy a minimum set of principles or characteristics. ISO 31000:2018 identifies eight principles which provide the foundation for managing risk and should be considered when establishing the organisation's risk management framework and processes and ultimately will help the organisation manage the effects of uncertainty on its objectives.

The principles are that risk management should be:

Integrated
Risk management should be integrated within all organisational activities.

Structured and comprehensive
A structured and comprehensive approach to risk management contributes to assurances in the Governance Statement.

Customised
The risk management framework and process should be customised and proportionate to the organisation's external and internal context related to its objectives.

Inclusive
Appropriate and timely involvement of stakeholders needs to be considered. This will better inform the organisation's risk management system.

Dynamic
Risks can emerge, change or disappear as an organisation's external and internal context changes. The risk management system needs to respond to these changes in a timely manner.

Best available information
Information should be timely, clear and available to relevant stakeholders.

Human and cultural factors
Human and cultural factors significantly influence all aspects of risk management.

Continual improvement
Risk management is continually improved through learning and experience and will feed into the organisation's quality improvement framework/systems.

4.2 Risk Management Framework

ISO 31000:2018 sets out five key elements of a Risk Management Framework, as follows:

Leadership and Commitment
Management needs to ensure that risk management is integrated into all organisational activities and demonstrate leadership and commitment by implementing all components of the framework. This in turn will help align risk management with its objectives, strategy and culture.

Integration
Integrating risk management relies on an understanding of organisational structures and context. Risk is managed in every part of the organisation's structure and everyone in an organisation has responsibility for managing risk.

Design
The organisation should examine and understand its external and internal context when designing its risk management framework.

Implementation
Successful implementation of the framework requires the awareness of all staff within the organisation.

Evaluation
The organisation should periodically measure its risk management framework against its purpose, implementation plans, risk management key performance indicators and expected behaviour. This will ensure it remains fit for purpose.

Improvement
The organisation should continually review, monitor and update its risk management framework to ensure it is fit for purpose.

4.3 Risk Management Process

The third component for managing risk under ISO 31000: 2018 is the risk management process, comprised of the following:

(a) Communication and consultation

(b) Scope, context and criteria

(c) Risk Assessment

- Risk identification
- Risk Analysis
- Risk Evaluation

(d) Risk Treatment

(e) Monitoring and Review

(f) Recording and Reporting

The PHA Risk Management Strategy and Policy incorporates the ISO 31000:2018 components as set out above.

4.4 3 Lines Model of Assurance

This defines assurances received that key controls are effective across the 3 lines model (1st line - Directorate; 2nd line - Organisational Oversight and 3rd line - Independent Assurance). Assurances are then aligned to key controls over which they are providing assurance (focusing more on the gaps in assurance, rather than the gaps in control). A RAG (red, amber, green) rating of the control effectiveness is then applied, based on the assurances available. Page 2 of Annex 3 , the Regional Risk Matrix, provides further definition of the RAG ratings.

Risks are categorised using the Regional HSC "5x5" risk matrix (see Annex 3). In assessing the Likelihood and Impact, it categorises risks at four levels – extreme, high, medium or low. A colour coding is used in a traffic-light system (green, yellow, amber and red). The Risk Analysis Tools Impact Table, also included in Annex 3, gives detail of the impact definitions to be used when assessing each identified risk.

Undertaking assurance mapping on the Corporate Risk Register ensures that:

- Controls recorded are actually operational
- Controls recorded are effective
- Actions to address risk are identified
- Further risks should not materialise
- Corporate objectives will be achieved.

5 The Purpose of Risk Management in the PHA

Risk Management is an essential part of good management and governance which staff already perform on a day-to-day basis. Identifying and taking action to address risks, will aid the achievement of business objectives. A formal systematic approach to risk management should improve decision-making, accountability and performance as well as fostering an environment of '*no surprises'*.

The purpose of risk management is to manage and control risks, not eliminate them — the management of risk rather than risk aversion. It can be defined as:

> "*A systematic process by which potential risks are identified, assessed, managed and monitored*" ("An Assurance Framework: a Practical Guide for Boards of ~~HSSSPS~~ DHSSPS Arm's Length Bodies" March 2009).

When Risk Management processes are in place:

- there is regular and ongoing monitoring and reporting of risk including early warning mechanisms;
- an appropriate assessment is made of the cost of operating particular controls relative to the benefit obtained in managing the related risk;
- the organisation conducts, at least annually, a review of the effectiveness of the system of internal control in place;
- the organisation reports publicly on the results of the review, and explains the action it is taking to address any significant concerns that are identified; and
- Corporate and Directorate Risk Registers are aligned to allow the escalation and de-escalation of risks at a corporate level. Maintaining the Corporate Risk Register is both a top-down and bottom-up process.

Risk management should be a continual process, embedded in the culture of the organisation helping to keep a focus on performance improvement. As such it also complements the corporate and business planning processes. It is not a process for avoiding risk. Rather, when used well, it can actively encourage an organisation to take on activities that have a higher level of risk,

because the risks have been identified and are being well managed so that the exposure to risk is both understood and acceptable.

Risk management is a key element of the PHA's Assurance Framework and the system of internal control, contributing to the achievement of business objectives.

6 The Benefits of Risk Management

A comprehensive and sound Risk Management Strategy will bring the following benefits:

- A clear assessment of the risks affecting the achievement of the PHA's business objectives, providing a supporting role to the corporate and business planning process.

- Enhanced communication within and between Directorates through a greater appreciation and understanding of the risks facing the organisation.

- Better use of resources, by directing these to areas of most need.

- The promotion of a culture of continuous improvement.

- More effective tailoring of internal audit programmes to target areas of high risk.

- A reduction in unwelcome surprises / shocks.

- Reassurance to stakeholders, particularly the DoH, that the PHA is continually reviewing the environment and actively identifying and managing risk.

7 Risk Management Process within the PHA

The key elements of the PHA's risk management process are:

- Board and senior management commitment to risk management – a clear sense that risk management is integral to planning and achieving objectives

- An understanding that certain risks simply have to be accepted and managed accordingly

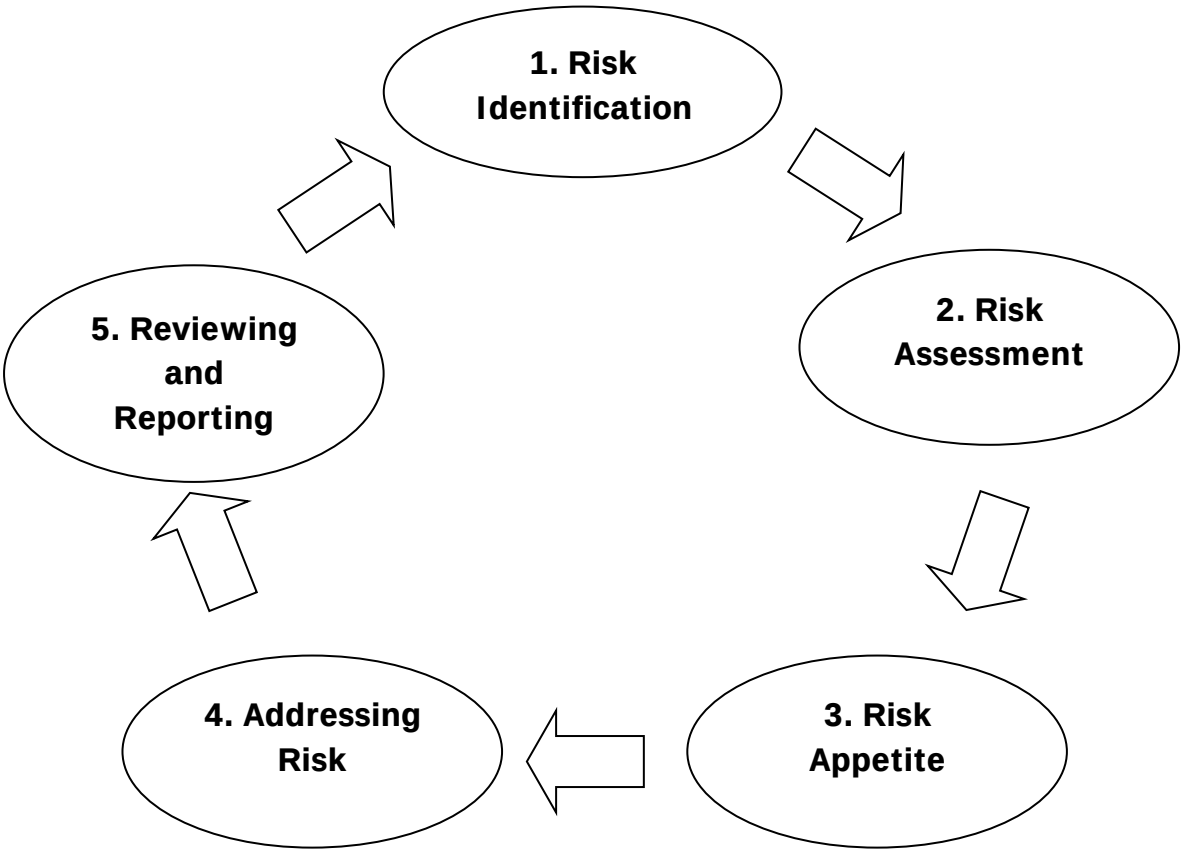
- A consistent approach is taken across the organisation to identify and analyse risks whether those risks are strategic or operational, financial or organisational or related to safety and quality and to assessing their likelihood and consequences.

- That there are established procedures within the organisation for the co-ordination of risk management processes.

Within the PHA there are systems and processes established to effectively identify, assess, manage, record and review risk management activity. These include:

- Risk Management Strategy and Policy
- Corporate Risk Register (see template at Annex1)
- Directorate Risk Registers (see template at Annex 2)
- Governance Statement and Mid Year Assurance Statement
- Review of Corporate and Directorate Risk Registers by the Agency Management Team on a quarterly basis
- Corporate Risk Register submitted to the Governance and Audit Committee on a quarterly basis
- Corporate Risk Register brought to the PHA board at least annually.
- Corporate Risk Register used as the basis for developing the Internal Audit activity plan for the year

Stages in PHA Risk Management Process



Stage 1 Risk identification – the process of identifying risks which may impact on the organisation's ability to achieve its objectives

Stage 2 Risk assessment – assessing the 'likelihood' of a risk occurring and its potential 'impact' on the relevant business objective.

Stage 3 Assessment of risk appetite – the extent of exposure to risk that is judged tolerable for the organisation

Stage 4 Addressing the risk – the response to the risk can be one of four options – Terminate, Tolerate, Transfer or Treat.

Stage 5 Recording and Reviewing risk – the risk management process is evidenced through the maintenance of risk registers (both Corporate and Directorate).

Communication and consultation with appropriate external and internal stakeholders should take place within and throughout all steps of the risk management process.

The 3 Lines Model of assurance mapping, as detailed above, has a key role to play in each stage of the risk management process.

Stage 1 - Risk Identification

Risks are identified in a number of ways and at all levels within the organisation (corporately, by Directorate and by individual staff members (see Annex 5 for risk identification template for all staff). Risks can present as external factors which impact on the organisation but which the organisation may have limited control over or operational which concern the service provided and the resources/processes available and utilised.

Importantly within the organisation risk identification is related to the organisation's objectives (as detailed in the PHA Corporate Plan and Annual Business Plan). Each risk identified is correlated to at least one of the corporate objectives.

Risks are also aligned with the relevant HSC domain as identified in the HSC paper Performance and Assurance Roles and Responsibilities (MIPB 74/09) issued in April 2009 which sets out performance and assurance roles and responsibilities in relation to four key HSC domains. The four domains are as follows:

Corporate Control – the arrangements by which the PHA directs and controls its functions and relates to stakeholders.

Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' needs.

Finance – the arrangements for ensuring the financial stability of the PHA, for ensuring value for money and ensuring that resources allocated by the Minister/DoH are deployed fully in achievement of agreed outcomes.

Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Governance and Ministerial targets and required service improvements.

Stage 2 - Risk Assessment

After risks are identified they are they assessed to establish:

- The **impact** that the risk would have on the business should it occur, and
- The **likelihood** of the risk materialising.

Risks are categorised using the Regional HSC "5x5" risk matrix (see Annex 3). In assessing the Likelihood and Impact, it categorises risks at four levels – extreme, high, medium or low. A colour coding is used in a traffic-light system (green, yellow, amber and red). The Risk Analysis Tools Impact Table, also included in Annex 3, gives detail of the impact definitions to be used when assessing each identified risk.

Stage 3 - Risk Appetite

The organisation carefully considers the risk appetite – in other words the extent of exposure to risk that is judged tolerable and justifiable. There will be times when it is necessary to accept a level of risk in order to progress with business. Risk appetite is built into the risk assessment process as outlined above.

Risk appetite can be defined as the *"amount and type of risk that an organisation is prepared to seek, accept or tolerate".* ISO defines risk appetite as an *"organisation's approach to assess and eventually pursue, retain, take or turn away from risk."*

The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, stakeholders and the organisation alike. Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA's business viability or reputation is significantly high and may outweigh any benefits to be gained.

The level of the risk appetite reflects the PHA's willingness to take opportunity risks and is an indicator of how well risk culture is embedded into management processes.

An **acceptable (or residual) risk** is when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable and/or to reach the level of risk appetite of the PHA for that risk (Annex 4).

Stage 4 - Addressing the Risk

The four traditional responses to addressing risk are:

Terminate – decision is made to cease the activity which causes the risk.

Tolerate – decision is made to accept the risk, eg where it stems from an external source or the impact/likelihood is low and therefore can be carried by the organisation.

Transfer – where another party can take on some or all of the risk more effectively,

Treat – where action is taken to mitigate the risk by adopting actions to reduce or eliminate the risk to an acceptable level.
In practice within the PHA the vast majority of risks are managed via the "Treat" or "Tolerate" route – both of which are underpinned by the identification of an action plan to reduce and ultimately eliminate the risk.

Stage 5 - Recording and Reviewing Risk

Within the PHA the risk management process is recorded and evidenced through the maintenance of Risk Registers.

A **Corporate Risk Register** is in place and on a quarterly basis all Directorates review the corporate risk register, paying particular attention to the corporate risks which fall within their Directorate work area. The Corporate Risk Register details risks of a strategic nature.

Also, each Directorate manages their own **Directorate Risk Register**. These tend to detail risks which are more operational in nature. Again this is reviewed within Directorates on a quarterly basis.

However, both Corporate and Directorate Risk Registers are viewed holistically within the organisation. Risks can be **escalated** to the Corporate Risk Register and also **de-escalated** from the Corporate Risk Register to Directorate Risk Registers in line with quarterly reviews of actions taken to address risks and control measures in place.

The Corporate Risk Register is presented to the Agency Management Team (AMT) on a quarterly basis for review and approval to forward to the Governance and Audit Committee (GAC). It is forwarded for consideration at a PHA board meeting at least annually.

8 Roles and Responsibilities

Chief Executive

The Chief Executive, as the Accounting Officer, has ultimate responsibility for managing the risks faced by the PHA. As Accounting Officer, he/she is required to sign an annual Governance Statement as part of the preparation of the Annual Report and Statutory Accounts. In order to fulfil this responsibility, the risk management process must be fully embedded and operational within the PHA.

The Chief Executive as Accounting Officer will champion the risk management process, and ensure that appropriate commitment from the organisation is given. This commitment will include ensuring the provision of appropriate risk management training for management and staff.

Governance and Audit Committee (GAC)

The GAC supports the PHA board and Accounting Officer by providing an independent and objective review of the completeness of assurances to satisfy their needs and of the reliability and integrity of the assurances. The Committee remit is ultimately to give an assurance to the board each year as to the adequacy and effectiveness of the system of Internal Control.
The GAC has therefore responsibility for scrutinising and advising on governance and finance issues. This includes overseeing the risk management process and reviewing and challenging the Corporate Risk Register to provide assurances that the arrangements are actively working in the organisation. The GAC will review the Corporate Risk Register on a quarterly basis.

PHA board

The PHA board is responsible for ensuring that appropriate systems are in place to ensure effective risk management, across all the services for which the PHA is responsible. These systems should be in line with the key elements detailed within the PHA's Governance Framework and associated policies and procedures. The Corporate Risk Register is presented to the full board at least annually.

The PHA board is responsible for reviewing the effectiveness of the internal controls –financial and organisational. The board is required to give assurance that it is doing its reasonable best to manage the PHA's affairs efficiently and effectively through the implementation of controls to manage risk. The PHA Corporate Risk Register is an important tool for recording all risks and the controls in place to remove or reduce those risks. The board should also ensure this arrangement is reviewed annually or when procedural, legislative or best practice changes occur.

Agency Management Team (AMT)

AMT members will develop and maintain a culture of risk management within their area of responsibility. This includes:

- Determining what types of risks are acceptable and which are not.
- Ensuring that line managers and all staff are aware of their risk and control responsibilities.
- Determining the level of risk that the PHA will carry in relation to specific major activities or projects across the organisation as a whole.
- Approving major decisions affecting the organisation's risk profile or exposure.
- Identifying risks and monitoring their management and control.
- Satisfying themselves that the less significant risks are being actively managed, with the appropriate controls in place and working effectively.
- Annually reviewing the PHA's approach to risk management and approving changes or improvements to key elements of its processes and procedures.
- Ownership of Directorate Risk Registers for their area of responsibility.
- Complying with the process as set out in the "Serious Adverse Incidents Policy" and implementing controls to address weaknesses where appropriate.
- Ownership and approval of the Corporate Risk Register through quarterly review at AMT meetings.

Directors

Director of Operations

The Director of Operations is the lead executive Director with responsibility for ensuring that effective and robust risk management processes and systems are in place to ensure good corporate governance within the PHA.

All Directors

Each Director is responsible for ensuring that risk management processes are adopted within their Directorate and that risks are appropriately and timely managed, ie included in Directorate/Corporate risk registers and escalated/de-escalated between these registers as necessary.

Director of Finance

The SPPG~~HSCB~~ Director of Finance is responsible for providing financial services to the PHA and is accountable to the Chief Executive for ensuring that effective processes and systems are in place to ensure good financial governance within the PHA.

Assistant Directors

In conjunction with the relevant Director, Assistant Directors will be responsible for ensuring that an effective risk management system is put in place for their area of responsibility. This should reflect the overall governance arrangements within the PHA.

Line managers and staff

All line managers and staff are expected to:

- Have a knowledge of and comply with the PHA Risk Management Strategy and Policy and related policies.
- Alert management to emerging risks or control weaknesses. The Risk Identification template (See Annex 5) is available for all staff to use.
- Participate fully in the regular risk review process.
- Assume responsibility for risks and controls within their own areas of work.

Internal Audit

Although risk management and internal control are management's responsibility, Internal Audit supports the maintenance of effective internal control through its annual programme of work and subsequent reports. The Head of Internal Audit adopts a risk based approach to planning their work, referring to the PHA risk registers in identifying topics for review across all Directorates. Individual audit reports are presented to the GAC throughout the year, with a mid year and annual internal audit report prepared giving the Head of Internal Audit's opinion on risk management, control and governance to support and inform the Chief Executive's (Accounting Officer) Mid Year Assurance Statement and Governance Statement.
"*The work of Internal Audit is likely to be the single most significant resource used by the Audit Committee in discharging its responsibilities. This is because the head of Internal Audit, in accordance with the Government Internal Audit Standards, has a responsibility to offer an annual audit opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes*." (HM Treasury – Audit Committee Handbook).

Internal Audit also has a role to play in:

- Acting as an independent advisor by providing advice on the management of risk, especially those issues surrounding the design, implementation and operation of systems of internal control.

- Monitoring, reporting and providing assurance on the effectiveness of the risk and control mechanisms in operation.

- Promoting risk management and control concepts across the PHA.

9 The Reporting of Risk

The process of regularly updating and reviewing the Corporate Risk Register will be monitored by the GAC.

Alternative Format

Every effort will be made to provide information in an alternative format if written format is not accessible to a member of staff.

Equality Considerations

This policy has been screened in accordance with the PHA's statutory duty and is not considered to require a full impact assessment. The screening outcomes will be published on the PHA website.

Human Rights Act

This policy is compliant with the requirements of the Human Rights Act 1998.

Corporate Risk Register Template **ANNEX 1**

~~Corporate Risk~~			
~~RISK AREA/CONTEXT:~~ ~~Date Risk Added:~~			
~~DESCRIPTION OF RISK:~~			
~~LINK TO ASSURANCE FRAMEWORK:~~ (Domain)			
~~Link to Annual Business Plan 20xx/xx:~~			
~~GRADING~~	~~LIKELIHOOD~~	~~IMPACT~~	~~RISK GRADE~~
~~LEAD OFFICER:~~ (Lead Director):			

~~Existing Controls~~	~~Internal and External Assurances to the Board~~	~~Gaps in Controls and Assurances~~	~~Action Plan/Comments/ Timescale~~	~~Review Date~~

Corporate Risk XX					
RISK AREA/CONTEXT:					
DESCRIPTION OF RISK:					**DATE RISK ADDED:**
LINK TO ASSURANCE FRAMEWORK: Corporate Control / Safety and Quality / Finance / Operational Performance and Service Improvement					
LINK TO ANNUAL BUSINESS PLAN 20XX/20XX: Corporate Objective XX					
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**		
Current					
Target					
LEAD OFFICER: Director of XX					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating (RED)**	**Action Plan/Comments/ Timescale**	**Review Date**

Directorate Risk Register Template **ANNEX 2**

DOMAIN:

RISK TITLE:

Date Added to Risk Register:

Risk Ref	Description of risk	Existing Controls	Likelihood	Impact	Risk Rating	Treatment / Action Plan & Timescale	Lead Officer	Status	Review Date

ANNEX 3

HSC Regional Impact Table – with effect from April 2013 (updated June 2016 and August 2018)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service.

staffing (number and competence), premises and equipment)	• No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016 and August 2018)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016 and August 2018)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

ANNEX 4

Acceptable/Residual Risk

- The PHA acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, service users and others. The PHA will therefore make all efforts to reduce risk or ensure that risks are contained and controlled so that they are as low as reasonably practicable.

- It is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. A balance needs to be struck between the costs of managing a risk and the benefits to be gained.

- Where a risk has been reduced to the point where the cost of further controls to reduce the risk outweigh the benefit they may provide, it may not be considered reasonably practicable to implement those controls. However, where risk controls are available it is the duty of the organisation to demonstrate that the cost of implementation outweighs the benefit, or, that alternative effective control measures have been implemented. Risks requiring a cost benefit analysis must be fed into the PHA risk register process for wider debate and decision on 'acceptability'.

ANNEX 5

RISK IDENTIFICATION TEMPLATE FOR ALL STAFF

All staff have a role in how governance and areas of risk are managed within the Public Health Agency (PHA)

Each Directorate within the PHA has a risk register detailing specific risks. Each risk is assessed according to likelihood of it happening and impact it will have on the organisation. Each risk will have an action plan to mitigate the risk.

Please use this form to inform your manager without delay of any areas of risk or concern you may be aware of and which you feel should be considered as a possible Directorate risk. This might be about a system of work, a policy/protocol or something specific to your area of work.

Description of Risk	What action could be taken to manage this risk?

Directorate: _____

Date: _____

ANNEX 6

The Following PHA Policies should be read in conjunction with this Strategy/Policy:

- Assurance Framework
- Corporate Governance Framework
- Health and Safety Policy
- Security Policy
- Incident and Near Misses Reporting Policy and Procedure
- Policy on Business Continuity Management
- Standing Orders
- Standing Financial Instructions
- Whistleblowing Policy
- Fraud Response Policy and Plan
- Gifts and Hospitality Policy
- Standards and Guidelines for Monitoring and Handling of Complaints
- ISO 31000:2018 Standard

Records Management Policy

Version	**1.4**
Approved by IGSG	
Approved by AMT	
Approved by GAC	
Review Date	

Version Control

Version	Changes	Approval Process
1.1		IGSG 07/06/2012 and approval of implementation plan by AMT on 26/7/2012
1.2	Presentational changes	IGSG: 19/01/2016 GAC: 04/02/2016 Board: 18/02/2016
1.3	Presentational / clarification changes including removal of Appendix 1 and editing of Appendix 2 (now renamed Appendix 1)	Reviewed by RMWG on: 16/01/2020 Approved by IGSG on: 29/01/2020 Approved by AMT on: 11/02/2020 Approved by GAC on: 28/02/2020

~~January 2020~~
September 2023

CONTENTS

1. Introduction

This Records Management Policy sits within the context of the Information Governance Strategy ~~(2018~~ 2023 to ~~March~~ December 2026 ~~2022~~). The Information Governance Strategy sets out the framework in which the Public Health Agency (PHA) meets its obligations for planning, developing and implementing records management policies and procedures which are consistent with legislation and the business requirements of the PHA.

This Records Management Policy:

- Sets out the requirements that must be met for the records of the PHA to be considered as a proper record of the activity of the PHA;
- Outlines the requirements for a PHA records management system and processes;
- Should be considered alongside the Department of Health ~~and Social Services and Public Safety (DHSSPS~~ publication Good Management Good Records (GMGR) 2017 ~~November 2011 (and subsequent updates)~~ which has been officially adopted as the PHA Retention and Disposal Schedule;
- Highlights the quality and reliability standards which must be maintained to provide a valuable information and knowledge resource for the PHA;
- Sets out the arrangements for monitoring compliance.

It relates to all corporate, clinical and non-clinical operational records held in any format by the Public Health Agency as detailed in the Department of Health ~~and Social Services and Public Safety (DHSSPS)~~ publication Good Management Good Records (GMGR) November 2017 ~~2011~~ [1].

The Policy is supplemented by detailed procedures, as set out in Section 5.

[1] ~~http://connect.publichealthagency.org/policy/records-management-good-management-goodrecords or http://www.dhsspsni.gov.uk/gmgr.htm~~ *Records Management Policy | PHA Connect (hscni.net)*

2. Policy Statement

Information is a corporate asset and the records of the PHA are important sources of information including patient/client, administrative, financial, legal, evidential and historical information. They are vital to the PHA in its current and future work, for the purposes of accountability, and for an awareness and understanding of its history. They are the corporate memory of the PHA.

The PHA will create, use, manage and destroy or preserve its records in accordance with all statutory requirements.

Systematic records management is fundamental to the PHA's efficiency. It ensures that the correct information is:

- captured, stored, retrieved and destroyed or preserved according to need;

- fully utilised to meet current and future needs, and to support change;

- accessible to those who need to make use of it; and that the appropriate technical, organisational and human resource elements exist to make this possible.

3. Aims

The records management system aims to ensure:

- a consistent systematic and planned approach to records management covering records from creation to disposal;

- compliance with statutory requirements and to increase efficiency by improving the flow of information, and greater coordination of records and storage systems;

- awareness of the importance of records management and the need for responsibility and accountability at all levels.

All staff of the PHA who create, use, manage or dispose of records have a duty to protect them and to ensure that any information that they add to the record is necessary, accurate and complete. Confidentiality must always be of primary concern to PHA staff. Appropriate training and guidance will be provided on the management of records.

4. Scope

The Records Management Policy should be read in conjunction with other relevant PHA governance policies and documents including:

- PHA Information Governance Strategy and Information Governance Framework
- PHA Data Protection and Confidentiality Policy
- Data Breach Incident Response policy
- PHA Access to Information Policy
- ~~Information Management~~
- PHA ICT Security Policy and Associated Policies
- Risk Management Policy
- ~~DHSSPS~~ DoH Guidance Document 'Good Management, Good Records' (GMGR) 2017 ~~(and subsequent updates)~~

5. Records Management Process

Implementing and maintaining an effective records management system depends on the knowledge of what records are held, where they are stored, who manages them, in what format(s) they are made accessible, their relationship to organisational functions and their appropriate and timely disposal.

The process includes:

- Classification of the records into a records management system, with meaningful titles and a consistent reference code.

- Individuals creating records being responsible for classifying them appropriately and ensuring that they are recorded and maintained correctly.

- Having sequences of reference codes that can facilitate both paper and electronic (where appropriate) records to enable tracking and recall, and eventually align with a single PHA records management system~~, and that~~ to enable tracking and recall of records.

- Checking that the correct records have been allocated to the appropriate reference code and that meaningful titles are used.

- Auditing to ensure that the records management system makes sense and records are traceable.

- Ensuring good records management practice is applied to all files – business/corporate files and patient/client/staff files through all stages of the record cycle from creation to disposal. All PHA staff have a responsibility to ensure records are retained and ultimately destroyed in accordance with this guidance.

The detail of the records management processes are defined in a suite of records management factsheets which outline the procedure for each stage of the record lifecycle. The procedures relate to records regardless of formats, throughout their lifecycle, from planning and creation through to disposal, ensuring that all records are kept in an accessible format. The factsheets have been developed in line with Good Management Good Records (GMGR) and include the following:

- File Covers and File Content
- Closing Files
- Disposal of Records
- Contemporaneous Notes and Marginalia
- The Use of Folio Numbering and Folio Sheets
- Management of Handwritten Notes / File Notes

- Preparing Agendas and Minutes
- Managing Electronic Records including E-mails /File Naming Conventions
- Version Control
- Preparing Records for Archive
- Transporting Records
- Security of Records
- What is a master file and what is a working file?
- Accessing External Confidential Waste Disposal Company
- Protective Markings on File Covers
- Filing Systems

6. Off-site Records Management

It is not possible to store all records locally; therefore, some will be stored in secure off-site storage through the regional contract. The principles set out in this policy also apply to the management of off-site records.

All records held in off-site storage should have a review or retention date recorded. It is the responsibility of the relevant information asset owner to ensure that these dates are recorded for each record.

7. Accountability

All records created by the PHA are public records as defined in the Public Records Act (Northern Ireland) 1923.

7.1 Statutory Responsibility

"Good Management Good Records" states that the Permanent Secretary, Departmental Information Manager, Chief Executives and senior managers are personally accountable for records management within their organisation and have a duty to make arrangements for the safe keeping and eventual disposal of those records under the overall supervision of the Deputy Keeper of Public Records at PRONI.

Organisations are also required to take positive ownership of, and responsibility for, the records legacy of predecessor Organisations and/or obsolete services.

Robust records management procedures are required to meet the requirements set out under the Data Protection Act 2018 (DPA 2018), UK General Data Protection Regulations (UK GDPR), the Freedom of Information Act 2000 (FOI Act 2000) and the Environmental Information Regulations 2004 (EIR 2004).

7.2 Roles and Responsibilities within PHA

The formal roles and responsibilities relating to records management are set out in section 3 of "Good Management Good Records". Within the PHA these roles and responsibilities are as follows:

- **All Staff** – All staff have a responsibility to comply with the records management strategy, policy and associated procedures.

- **Chief Executive** – The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DoH directives.

- **Senior Information Risk Owner (SIRO)** – The SIRO (Director of Operations) is the focus for the management of information risk at Board level. The SIRO should lead and foster a culture that values, protects and uses information for the public good. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process.

- **Data Protection Officer (DPO)** - The DPO is the first point of contact for the ICO and for individuals whose data is processed (employees, members of public etc).

- **Assistant Director Planning and Business** Services (AD P&B) ~~Operational Services~~ – The AD P&B has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda including records management.

- **Governance Manager** – The Governance Manager is operationally responsible for the day to day implementation of all aspects of Information Governance including records management.

- **Office Managers** – Responsibility for coordinating and overseeing implementation of records management within their offices.

- **The Personal Data Guardian (PDG)** – The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the 'conscience' of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.

- **Information Asset Owners (IAOs)** ~~–~~ are senior individuals whose primary role is to understand what information is held and~~The IAO's primary role is to~~ manage and address risks associated with the information assets within their function. They are required ~~and~~ to provide assurance to the SIRO on the management of those assets. Each Assistant Director or other senior manager is the IAO for their function and ~~also~~ sit on the Information Governance Steering Group.

- **Information Asset Assistants (IAA's)** – IAAs may be identified in each function to support the IAO.

- **Information Governance Steering Group (IGSG)** – Consisting of representatives from all PHA Directorates the primary function of the IGSG will be to lead the development and implementation of the Information Governance framework across the organisation. The Group will be chaired by the SIRO, or their deputy, and will meet not less than three times per year.

- **Records Management Working Group (RMWG)** – Chaired by the Assistant Director of Planning and Business, or their deputy, this Group will address the Records Management function within the PHA developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will in turn cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.

- **PHA Governance and Audit Committee (GAC)** – The GAC has responsibility for providing the PHA board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress against the Information Governance Strategy.

- **PHA Agency Management Team (AMT)** – AMT will receive updates on Information Governance matters (including Records Management) on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The PDG will also report on matters relating to patient identifiable information where appropriate.

Appendix 1 outlines the relevant legislation and drivers in relation to legal and professional responsibility for records management.

8. Monitoring Compliance

Compliance with this policy and associated procedures will be monitored by audits of sample records and records storage areas as well as through self-assessment of the Information Management Assurance Checklist and Internal Audit audits as appropriate.

Records Management will also be subject to periodic audit by internal and external audit. These audits will seek to:

- identify areas of good practice which can be used throughout the PHA;

- highlight where non-conformance with the procedures is occurring; and

- if appropriate, recommend changes to the records management system and processes and to how compliance can be achieved.

9. Review of Policy

The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

This policy will be reviewed in August 2027 or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

10. Equality and Human Rights Screening

This policy has been screened in accordance with the PHA's requirements under Section 75 of the Northern Ireland Act 1998. Cognisance has also been taken of human rights. The policy and screening outcomes are published as part of our agreed process for publication.

APPENDIX 1

Relevant Legislative Compliance, Standards, Guidelines and Policies

- The Access to Health Records (Northern Ireland) Order 1993
- The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991
- The Common Law Duty of Confidentiality
  ~~– Confidentiality: DHSSPS code of practice (PDF 111KB)~~
  The (DoH) Code of Practice on protecting the Confidentiality of Service User Information (April 2019)
- The Computer Misuse Act 1990
- UK General Data Protection Regulations (GDPR) 2018
- The Data Protection Act (DPA) 2018
- The Data Protection (Processing of Sensitive Personal Data) Order 2000
- The Electronic Communications Act 2000
- ~~The Environmental Information Regulations 2004~~
- The Electronic Communications Act 2000
- The Environmental Information Regulations 2004
- The Freedom of Information Act (FOIA) 2000
- The Privacy and Electronic Communications (EC Directive) Regulations 2003
- Public Health Act (Northern Ireland) 1967
- The Public Interest Disclosure (Northern Ireland) Order 1998
- The Public Records Act (Northern Ireland) 1923
- Disposal of Documents Order (Northern Ireland)1925
- The Re-use of Public Sector Information Regulations 2005

- Lord Chancellor's Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000

- DoH Good Management Good Records, Guidance for Management of Records 2017

- PRONI, The Northern Ireland Records Management Standards (NIRMS)

- Professional Codes of Conduct

- BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005 BS 7799-2:2005 (Information Security management)

- ISO 15489 International Standards on Records Management

- ISO 19005 – 1:2005 Electronic Document File Format for Long Term Preservation

- BSI DISC BIP 0008 British Standards on Electronic Information Management

HSC Public Health Agency

item 16

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Information Governance Strategy / Framework
Reference	PHA/06/10/23
Prepared by	Information Governance Team
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the updated PHA Information Governance Strategy / Framework.

2 Information Governance Strategy / Framework

A review has been carried out of the PHA Information Governance Strategy incorporating the Information Governance Framework.

Changes to the Policy are minimal following this review, consisting mainly of formatting changes and some updates to Section 2 (Scope) and Section 6.2 (Roles and Responsibilities). All suggested changes are highlighted in red.

The revised Information Governance Strategy / Framework and Policy was approved by the Agency Management Team on 20 September and by the Governance and Audit Committee on 10 October.

3 Next Steps

Following approval by the PHA Board, the updated Strategy / Framework will be shared with PHA staff.

Information Governance Strategy

incorporating the

Information Governance Framework

~~2018 – 2022~~
2023 – 2026

Version	**3.0**
Version 3 approved by	**IGSG: 28/07/2023** **GAC:** **PHA Board:**
Version 2 approved by	**IGSG: 06/11/18** **GAC: 12/12/18** **PHA Board: 20/12/18**
Version 1 approved by	**IGSG: 13/01/15** **GAC: 19/02/15** **PHA Board: 19/03/15**
Review Date	December 2026 or sooner if required by PHA Reshape and Refresh programme

Table of Contents

1.0 Introduction

The Public Health Agency (PHA) is heavily dependent on the information and records it holds and considers all of the data it processes as an asset. It recognises that its records and information must be appropriately managed, handled and protected to serve its business needs and acts openly, while at the same time ensuring that personal and sensitive data is protected. It must demonstrate compliance with all relevant legislation[1] as well as standards set by the Department of Health (DOH).

In recognising its public accountability, the PHA will make every effort to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability and structures provide a robust governance framework for information management. The framework will ensure that information is accessible while also ensuring the confidentiality of personal data (client and staff), and corporately sensitive information, through adopting robust security measures to protect that information from accidental loss, accidental disclosure or deliberate unauthorised disclosure.

2.0 Scope of Information Governance

The effective use of information is central to the planning and delivery of care across the Health and Social Care Environment. The effective use of information will assist in addressing the Quadruple aim outlined in the Bengoa Report, 'Systems not Structures' ie. enhancing patience experience, improving population health, reducing costs and improving the work life of staff.

The Information Governance Strategy sets out the framework to ensure that the PHA meets its obligations in respect of information governance; it will also be the vehicle for improving information governance in the PHA. The Strategy covers the 3 year period from 2023 to 2026 and will be supported by annual Action Plans setting out how it will be implemented. The action plans will be monitored by the Information Governance Steering Group[2], chaired by the Senior Information Risk Owner (Director of Operations) or deputy. A report will be submitted to the PHA Governance and Audit Committee on a regular basis.

3.0 Purpose

The general purpose of the Information Governance Strategy is to provide clear direction to the PHA in delivering the requirements of information governance including legislative requirements and associated policies. The strategy will assist in establishing and maintaining a robust and effective Information Governance Framework[3] that allows PHA to fully discharge its strategic duties, ensuring that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant codes of practice.

The Information Governance Strategy cannot be seen in isolation as information is central to all areas of work in the PHA. It outlines the necessary engagement with PHA

[1] *Appendix 1 Legislation and Guidance*
[2] *Appendix 2 PHA Information Governance Steering Group (IGSG) Terms of Reference (TOR)*
[3] *Appendix 3 PHA Information Governance Framework*

Information Asset Owners, providing specialist advice and support, helping to build robust Information Asset Registers.

Information Governance is also a key element of corporate and clinical governance. This strategy is, therefore, closely linked with other strategies, policies, procedures, guidance and staff training to ensure integration with all aspects of the Agency's business activities.

4.0 Benefits

Benefits of a robust and fully implemented Information Governance strategy can be summarised as follows:

- Ensures that decisions are based on readily accessible, high quality information;
- Ensures that information is held and handled securely, and that personal and sensitive information is safeguarded;
- Reduces risks associated with poor and unregulated systems and processes;
- Reduces data losses and the negative impact such losses have on corporate image;
- Ensures that legal and other DOH requirements are met;
- Supports good corporate governance and underpins the assurance framework and corporate risk register;
- Ensures that information and information assets are managed in a coherent manner reducing duplication of effort and increasing availability.

5.0 Objectives

The key objectives of this strategy are to ensure the effective management of Information Governance by:

- Complying with all legislation - Data Protection Act (DPA) 2018 and ~~EU~~ UK General Data Protection Regulation (GDPR), Environmental Information Regulations 2004
- Complying with DOH recommendations and best practice;
- Establishing, implementing and maintaining policies for the effective management of information;
- Recognising the need for an appropriate balance between openness and confidentiality in the management and use of information;
- Providing assurance that all information risks are identified, managed and, where possible, mitigated;
- Minimising the risk of breaches and inappropriate use of personal data;
- Ensuring that the public are effectively informed and know of their right of access (subject access requests) ~~how to access their information and exercise their right of choice;~~
- Ensuring that all PHA staff are sufficiently trained and enabled to follow and promote best practice in regard to the management of information;
- ~~Achieving and improving compliance with the~~ Completion of the regional Information Management Assurance ~~Standard~~ Checklist.

6.0 Information Governance Framework

The Information Governance Framework[4] is an overarching framework which is intended to pull together the various strands of policy and activity covered by 'Information Governance'. This is important as there are several policies[5] which impinge on Information Governance. It will enable PHA to set out and promote a culture of good practice around the processing of information and use of information systems throughout the organisation. That is, to ensure that information is handled to ethical and quality standards in a secure and confidential manner. The PHA requires all employees and Non-Executive Board Members (Members) to comply with policies, procedures and guidelines which are in place to implement this framework.

6.1 Information Governance Policy Statement

A clear policy framework is critical to ensuring a coherent approach to Information Governance across all PHA functions and locations. This strategy is supported by a suite of information governance policies[6]. All Information Governance related policies will be reviewed and updated as necessary on a regular basis.

6.2 Roles, Responsibilities and Reporting Arrangements

- **Chief Executive –** The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DOH directives. The Chief Executive is required to provide assurance through the Governance Statement that all risks, including those relating to information, are effectively managed and mitigated.

- **PHA board –** The PHA board is responsible for ensuring appropriate systems are in place to ensure effective Information Governance across all of the services for which PHA is responsible. An Information Governance report (included in the PHA Annual Report) will be presented to the PHA Board annually.

- **PHA Governance and Audit Committee (GAC) –** The GAC has responsibility for providing the PHA Board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress on the implementation of this Strategy on an annual basis.

- **PHA Agency Management Team -** AMT will receive updates on Information Governance matters on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The Personal Data Guardian (PDG) will also report to AMT on matters relating to patient identifiable information where appropriate.

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[4] *Appendix 3 PHA Information Governance Framework*
[5] *Appendix 4 PHA Information Governance Policies*
[6] *Appendix 4 PHA Information Governance Policies*

- **Information Governance Steering Group (IGSG)** - Consisting of representatives from all PHA Directorates (Information Asset Owners or their representatives) the primary function of the IGSG will be to lead the development and implementation of the Information Governance Framework across the organisation. The Group will be chaired by the SIRO and will meet ~~at least three times a year, on a quarterly basis~~ in line with its Terms of Reference.

- **Senior Information Risk Owner (SIRO) -** The SIRO (Director of Operations) is the focus for the management of information risk at board level. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process. The SIRO is a member of the Regional Cyber Security Programme Board.

- **The Personal Data Guardian (PDG)** - The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the 'conscience' of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners (IAOs) where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.

- **Information Asset Owners (IAO's)** - Each IAO is responsible for the processing of data within their area/s of responsibility and must maintain and review, on an annual basis, an information asset register for their Directorate. The IAO is also responsible for the management and addressing of risks associated with the information assets within their function and providing an assurance to the SIRO on the management of those assets. Each PHA Assistant Director is the IAO for their function and also sits on the Information Governance Steering Group.

- **Information Asset Assistant** — The Information Asset Assistant has responsibility delegated from the IAO to support them in the management of the information assets within their function.

- **Assistant Director Planning and Business ~~Operational~~ Services (AD P&B)** - The A/D P&~~Ops~~ B has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda. The Assistant Director is also the Data Protection Officer.

- **Data Protection Officer (DPO)** - The DPO has responsibility for monitoring and ensuring compliance with this policy, UK GDPR and other, relevant data protection legislation, acting as the contact point with the Information Commissioners' Office, training staff, advising on data protection impact assessments (DPIAs) and conducting internal audits as necessary across the organisation~~.~~

- **Senior Operations Manager (Delivery) -** The Senior Operations Manager (Delivery) is operationally responsible for the day to day implementation of all aspects of Information Governance.

- **Records Management Working Group (RMWG)** – Chaired by the Senior Operations Manager (Delivery), this Group will address the Records Management function within the PHA, developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will, in turn, cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.

- **All Staff** - All staff have a responsibility to comply with this strategy and all information governance policies and procedures including the completion of Information Governance Awareness and Cyber Security mandatory training on an annual basis. ~~and three yearly basis respectively~~

- ~~Cyber Security – Cyber Security is managed by the BSO~~

6.3 Leadership

Effective leadership is essential to create and nurture a corporate culture conducive to effective Information Governance. A culture of corporate and individual ownership and responsibility is essential when looking to effective compliance with all statutes and codes of practice.

6.4 Supporting Staff

Clear accountability arrangements will ensure that staff are accountable for the work that they do and the information assets they process and manage. There should be an open and supportive environment in which errors, mistakes or concerns can be raised immediately, with management and corrective measures implemented swiftly and processes changed accordingly.

This culture will further mitigate risks associated with the handling and processing of sensitive information, both corporate and personal in nature.

6.5 Communication

It is important to ensure that staff are aware of Information Governance issues, with updates provided as required. Effective and timely communication of Information Governance matters to all PHA staff is essential if the PHA is to meet the aims and objectives associated with this strategy.

As well as ensuring compliance with this strategy and associated policies and procedures, the wider Information Governance agenda within the Public Sector is a fast moving and quickly developing one. It will often be necessary to communicate new directives or initiatives to staff. Communication to staff must be handled with care to ensure that the message is not lost amongst a wealth of material.

6.6 Training

It is also essential to ensure that all staff understand and have the knowledge and skills necessary to put the Information Governance Strategy and associated policies and procedures into operational use. The PHA will ensure that appropriate training is developed and available to up-skill existing staff and for new staff entering the service. This will include the use of the e-learning platform. All staff are required to undertake mandatory Information Governance training. The responsibility for ensuring that staff participate in these programmes rests with the relevant IAO and line managers, with support from the Information Governance Steering Group. Members should also avail of relevant information governance awareness and training.

6.7 Implementation and Performance Monitoring

An Information Governance Action Plan will be prepared annually. This will also provide a mechanism by which progress can be monitored. The following reporting arrangements will apply:

- ~~Quarterly p~~Progress reports on the Information Governance Action plan will be agreed through the Information Governance Steering Group;
- ~~Quarterly~~ Reports on progress against the Information Governance action plan will be provided to the Governance and Audit Committee following each IGSG meeting;
- Reports to the Agency Management Team as required;
- An annual report will be brought to the PHA board as and when required.

Performance will also be monitored annually through the Information Management Assurance Checklist (IMAC). The IMAC includes an assurance, signed by the Chief Executive, to be returned to the DoH. An assurance on the management of information risk is also provided through the Mid-Year Assurance Statement and the Governance Statement.

7.0 Summary and Conclusion

Information Governance is a vital and integral part of the PHA's overall Governance programme. The implementation of the Information Governance Strategy and its subsequent policies, procedures, protocols and guidelines will ensure that the PHA has the appropriate framework in place to meet legislative and organisational requirements and it will drive the development and implementation of improvement plans year on year.

8.0 Equality and Human Rights Considerations

8.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This policy will therefore not be subject to an Equality Impact Assessment.

8.2 This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

8.3 This policy is included in the PHA's Equality Screening Documentation.

9.0 Review of Policy

9.1 The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

9.2 This policy will be reviewed by December 2026, or earlier if relevant guidance is issued.

Appendix 1

Legalisation and Guidance

There are a number of pieces of legislation and guidance which have a significant impact on records management and information governance. A selection of these is listed below.

Public Records Act (Northern Ireland) 1923

All HSC records ·are public records under the terms of the Public Records Act (Northern Ireland) 1923. Chief Executives and senior managers of all Health and Social Care organisations are personally accountable for records management within their organisation. They have a duty to make arrangements for the safekeeping and correct disposal (under the Disposal of Documents Order (Northern Ireland) 1925) of those records under the overall supervision of the Deputy Keeper of Public Records whose responsibility includes permanent preservation.

Data Protection Act 2018 and UK ~~EU~~ General Data Protection Regulations (GDPR) 2018

The Data Protection Act (DPA) 2018 places a statutory responsibility on the PHA to protect the personal data, which it holds. In relation to records management this means that the PHA must implement measures to:

- Maintain the accuracy of records held;
- Protect the security of personal data;
- Control access to the personal data; and
- Make arrangements for secure disposal once the record is no longer required.

The ~~EU~~ UK General Data Protection Legislation (GDPR) gives individuals additional rights about how their personal data is used by organisations and applies to all UK and EU organisations that control and or process personal data. It is based on the premise that individuals ('data subjects') should have knowledge of what data is held about them, how it is held, how long for and how it is used.

Confidentiality and Data Protection Act

All HSC bodies and those carrying out functions on behalf of the HSC have a common law duty of confidence to patients/clients and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the HSC who records, handles, stores or otherwise comes across personal information has a personal common law duty of confidence to patients/ clients and to his/her employer. The duty of confidence continues even after the death of the patient/client, or after an employee or contractor has left the HSC.

The Data Protection Act (DPA) 2018 includes electronic and manual records. The Act, which applies to the whole of the United Kingdom, sets out requirements for the "processing" of personal data (i.e. meaning obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data).

A "data subject", namely, a living individual who is the subject of personal data, has a right of access to their personal data and, in certain circumstances, can have their data corrected or even deleted.

The UK GDPR sets out 7 key principles which lie at the heart of data protection, and must be followed by all data controllers and processors:

Personal data shall be:

"(1) processed lawfully, fairly and in a transparent manner in relation to individuals ('**lawfulness, fairness and transparency'**);

(2) collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be considered to be incompatible with the initial purposes ('**purpose limitation'**);

(3) adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed ('**data minimisation'**);

(4) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ('**accuracy**');

(5) kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the GDPR in order to safeguard the rights and freedoms of individuals ('**storage limitation'**);

(6) processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures ('**integrity and confidentiality'**)."

Additionally,

"(7) The controller shall be responsible for, and be able to demonstrate compliance with, principles (1) – (6) above ('**accountability**')."

The Information Commissioner, who has responsibility for the enforcement of this legislation, provides guidance on the application of data protection legislation.

Further information on the Data Protection Act 2018 and UK GDPR is available from the Information Commissioner's Website (https://ico.org.uk/).

Freedom of Information Act 2000

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (with some exemptions). The Act makes provision for the Lord Chancellor to issue guidance on how records systems should be maintained in order to facilitate public access to information held. In particular S46 (1) states:

"The Lord Chancellor shall issue, and may from time to time revise, a *code* of *practice providing guidance to relevant authorities* as *to the practice which it would, in his opinion, be desirable for them to follow in connection with the keeping, management and destruction* of *their records".*

The Act was brought fully into force on 1 January 2005. The HSC has two main responsibilities under the Act. The HSC has to maintain its 'Publication Scheme' (effectively a guide to the information which is publicly available) and to deal with individual requests for information.

Anyone can make a request for information, although the request must be made in writing (including email). An Environmental Information Regulation (EIR) request, may, however, be verbal. The request must contain details of name and address of the applicant and the information sought.

The HSC is obliged to produce information recorded both before and after the Act was passed. It is vital that records are held within a structured Records Management system in order to meet the HSC obligations under the Act. It should be noted that the responsibility for responding to information access requests lies with the authority that holds the information. The Act is intended to change the way in which public authorities do business, making them more accountable. The foreword to the Code of Practice on Records Management published by the Lord Chancellor under Section 46 of the Act states:

> *"Any freedom* of *information legislation is only as good* as *the quality of the records to which it provides* access".

This highlights the importance of good Records Management in the PHA.
Further information on the Freedom of Information Act is available from:
https://ico.org.uk/.

Good Management, Good Records

These guidelines offer an overview of the key issues, solutions and best practice for HSC teams to follow when preparing a records management strategy. It represents the joint view of DOH and the Public Records Office (PRONI) view of how records should be administered and sets the standard required of the HSC.

The Disposal Schedule has been approved by PRONI. It sets out minimum retention periods for HSC records of all types, except for GP medical records, and indicates which records are most likely to be appropriate for permanent preservation. It also explains the reasoning behind the determination of minimum retention periods, including legal requirements where relevant.

The Schedule does not replace the requirement for PHA to develop and agree their own disposal schedules with PRONI, however, it should form the basis for such schedules.

https://www.health-ni.gov.uk/articles/gmgr-records-management

The PHA has in place a systematic and planned approach to the management of **all** records which ensures that, from the moment a record is created until its ultimate disposal, the PHA can control both the quality and quantity of information it generates; can maintain that information in a manner that effectively services its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

Information Management Assurance Checklist (IMAC)
The PHA will complete the Information Management Assurance Checklist (IMAC) and submit to the Department of Health annually.

Legislation, in particular the Data Protection Act 2018, UK GDPR, Freedom of Information Act 2000, the Environmental Information Regulations (EIR) 2004 and Access to Health Records (Northern Ireland) Order 1993 impact significantly on the record keeping arrangements in public authorities.

ISO 15489: International Standard on Information and Documentation Records Management

The International Standard on managing recorded information, initially based on an earlier Australian standard, was adopted by ISO in 2001. The Standard acts as an enabler towards accreditation and renewal of IS0 9001 and other quality standards. It also provides a specification against which record management practices may themselves be audited.

Appendix 2

PHA INFORMATION GOVERNANCE STEERING GROUP (IGSG)

Terms of Reference (Reviewed June 2022)

Purpose

The purpose of the PHA Information Governance Steering Group, is to lead the development and implementation of the Information Governance Framework across the organisation. It will report to the PHA Agency Management Team (AMT) and Governance and Audit Committee (GAC) providing assurance for the PHA board on the effectiveness of Information Governance systems and practices within the PHA.

Remit

- Ensure that information governance systems are in place across the PHA, in line with the PHA Information Governance Framework and relevant Standards and legislation.
- Develop Strategic solutions to Common Information Governance problems.
- Provide a forum to raise awareness and share experience and best practice in Information Governance.
- Provide direction to the work of Records Management Working Group.
- Act as direct point of contact for Information Governance related issues such as Freedom of Information, Information Security and Data Protection etc.
- Agree and monitor the information governance action plan, ensuring actions are taken forward.

Working Arrangements

- The Group will meet at least three times a year.
- The Group may from time to time call upon advisors e.g. ICT Security Manager.
- The Group will be chaired by the SIRO, or his nominated deputy.
- The Governance Manager will provide the secretariat for the meeting.
- The agenda and papers will be issued no less than 3 working days in advance of the meeting. Minutes of meeting will be produced and agreed with the chair prior to issue. Draft minutes will be circulated as soon as possible after the meeting, and brought to the next meeting for approval.
- The Group will review its TOR every three years, or sooner if required.

Reporting Arrangements

The Group will report to:

- AMT
- PHA Governance and Audit Committee

Membership List

SIRO
Director of Operations – Chair

PDG
Director of Public Health

Governance & Audit Committee Representative
Non-Executive Director

IAOs
Please note if an IAO cannot attend, their Deputy IAO, or IAA should attend to represent them. Appendix A provides a more detailed list of IAOs, IAO Deputies and their IAAs.

Operations
- Assistant Director Planning and Operations
- Assistant Director Communications and Knowledge Management

Public Health
- Assistant Director Health Protection
- Assistant Director Screening
- Assistant Director Service Development
- Assistant Director Health & Social Wellbeing Improvement
- Assistant Director Research and Development

Nursing
- Assistant Director AHP &PPI
- Assistant Director Nursing (CYP)
- Assistant Director Nursing
- Assistant Director Nursing
- Assistant Director Nursing
- Assistant Director Nursing

(NB. Normally, one Assistant Director Nursing will attend on behalf of all the Assistant Directors in Nursing in addition to the Assistant Director AHP & PPI)

Health and Social Care Quality Improvement
- Clinical Director HSCQI

Connected Health
- Programme Director

SBNI
- Professional Officer

Governance Team
- Senior Operations Manager (Delivery)
- Assistant Governance Manager

Further details on the membership of this Group is available at Appendix A.

Appendix 3 – PHA Information Governance Framework

INFORMATION GOVERNANCE FRAMEWORK		
Heading	**Requirement**	**PHA Structure**
Senior Roles	• IG Lead • Senior Information Risk Owner (SIRO) • Personal Data Guardian (PDG) • Data Protection Officer (DPO)	• The Chief Executive as Accountable Officer has overall accountability for IG and is required to provide assurance that all risks to the PHA are effectively managed. • SIRO for the PHA is Director of Operations & Chair of the Information Governance Steering Group. • PDG for the PHA is Director of Public Health / Medical Director. • IAOs for the PHA are Assistant Directors within each Directorate. • DPO is the Assistant Director of Planning and ~~Operational~~ Business Services (P&B~~Ops~~)
Policy	• Over-arching IG Policy Data Protection Act, UK GDPR and Data Protection and Confidentiality Policy • Organisation Security Policy • Information Lifecycle Management (Records Management) Policy • Corporate Governance Policy	• Corporate Governance Framework • Information Governance Strategy Incorporating the Information Governance Framework • Information Governance Policy Statement • Data Protection/Confidentiality Policy • ICT Security Policy • Secure Mobile ICT Equipment • Use of the Internet Policy • Use of Electronic Mail Policy • Use of ICT Equipment Policy • Records Management Policy • Freedom of Information Procedures • Access to Information Policy • Data Breach Incident Response Policy

Key Governance Bodies	IG Board/Forum/Steering Group	• PHA Governance & Audit Committee • PHA Information Governance Steering Group • PHA Records Management Working Group
Resources	Details of key staff roles and dedicated budgets	• Assistant Director of Planning & ~~Operational~~ Business Services • Senior Operations Manager (Delivery) • Governance Administrative Officer (NB none of the above 3 posts are full time Information Governance)
Governance Framework	Details of how responsibility and accountability for IG is cascaded through the organisation.	• All staff contracts include IG clauses • Staff responsibility set out in IG Strategy • Information Asset Register • Notices on Intranet Site (Connect)
Training & Guidance	• Staff Code of Conduct • Training for all staff • Organisation Security Policy • Training for specialist IG roles	• Code of Conduct • IG e-Learning Training mandatory for all staff • PHA ICT Security Policy • SIRO, PDG and IAO's training completed
Incident Management	Documented procedures and staff awareness	• PHA Risk Management Strategy and Policy • Information Sharing Protocol • Guidance for reporting IG related incidents • Data Breach Incident Response Policy (including reporting mechanisms to GAC) • IG Leaflet • Incident and Near Miss Reporting Policy and Procedure

Extract from IM CAS:

The Information Governance Framework may be described in a single one page standalone document or incorporated within an over-arching IG Policy or an IG Strategy and should provide a summary/overview of how an organisation is addressing the IG agenda

Appendix 4 – PHA Information Governance Policies & Guidance

PHA Information Governance Strategy and Framework 2023 - 2026

PHA Records Management Policy (reviewed at GAC xx/09/23)

PHA Short Protocol for the handling of requests for information made under the Freedom of Information Act 2000/Data Protection Act 2018 (*reviewed at IGSG 28/7/2023)*

PHA FOI Act Information Handler's Guidance (*reviewed at IGSG 28/7/2023)*

PHA Freedom of Information Internal Review Procedures (*reviewed at IGSG 28/7/2023)*

PHA Data Breach Incident Response Policy

PHA Data Protection/Confidentiality Policy

PHA Guidance on transferring hard copy personal information

PHA Access to Information Policy

PHA Data Protection Impact Assessment Policy and Guidance *(reviewed IGSG* 4/04/2023)

PHA Information Governance: What you need to know leaflet (*reviewed at IGSG 28/7/2023)*

PHA Information Security Leaflet

PHA Email Top Tips Guide

PHA Small Cell Sizes Disclosure Protocol (*due for review at IGSG on xx/10/23)*

~~*PHA* ***Corporate and Public Affairs****: Corporate Social Media Policy and Guidelines 2014*~~

DoH Records Management - Good Management Good Records

DoH Code of Practice on protecting the confidentiality of service user information

Regional Guidance on the use of Digital Recorders

BSO ITS *PHA* ICT Security Policy

BSO ITS Procedure for provisioning new starts with access to IT services

PHA Data Access Agreement

BSO ITS Application for mobile phone

BSO ITS Application form for provision of an encrypted USB memory stick

BSO ITS Safestick/Kingston User Guide SafeXS usage

BSO ITS Application form to enable access to removable media

BSO ITS Application form for secure remote access

BSO ITS Regional HSC Secure Email Service User Guide

BSO ITS Use of Email Policy 2015

BSO ITS Sophos Antivirus Software for Home use 2019

BSO ITS Use of PHA ICT Equipment 2015

BSO ITS Securing Mobile ICT Equipment (adopted by PHA) 2012

HSC Public Health Agency

item 17

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Equality and Disability Action Plans 2023/28
Reference	PHA/07/10/23
Prepared by	BSO Equality Unit
Lead Director	Stephen Wilson
Recommendation	For **Approval** ☒ For **Noting** ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the PHA's Equality and Disability Action Plans 2023/28.

2 Equality and Disability Action Plans 2023/28

Following feedback from the Joint Consultation co-ordinated by BSO Equality Unit this paper presents the finalised PHA Equality and Disability Action Plans 2023-28 for PHA Board approval.

In line with advice received from BSO Equality Unit the plans were submitted to the Equality Commission in draft before 30th September and the finalised version to be submitted following their approval at today's PHA Board meeting.

3 Next Steps

Following approval by the PHA Board, the Plans will be formally submitted to the Equality Commission.

Public Health Agency (PHA)
Equality and Disability Action Plans 2023-28

1. Equality Action Plan 2023-28: What we will do to promote equality and good relations

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Service Development and Screening Support the implementation of an online booking system for diabetic eye screening. *	**Disability, Dependants, Age** The online booking system allows participants to select a date for screening more suitable to them via a link within their invitation letter. The objective of this system is to give more flexibility to individuals with caring responsibilities, young people and those of working age. It is also hoped that this in turn will reduce the number of clinic DNAs.	Usage of the system will need to be restricted until the programme has recovered sufficiently and has capacity to offer a variety of screening clinic slots online. The other impact will be the implementation of a low risk pathway in 2023/24, the effects of this new pathway will not be realised until 2025/26 as eligible patients will be moved in a phased approach over 2 years. The impact of the system will be reviewed by the Belfast HSC Trust along	The implementation and management of the booking system is the responsibility of the Belfast HSC Trust, however the PHA will support the implementation and the impact of the system will be kept under review by the NIDESP Operational Group (with PHA and Belfast HSC Trust membership) Aim to have full implementation by March 2026.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
		with input from PHA Screening.	
Allied Health Professions Through partnership working with key stakeholders, both statutory and non-statutory to help to determine and plan for the predicted healthcare needs of children and young people with Special Educational Needs (SEN). **Specific action 1** – The development of a standardised regional pathway and process across the health and social care system for the identification of children with Special Educational Needs, advice and recommendations on the provision required to meet these needs and the intended outcome of this provision in meeting these needs.	**Disability, Age** Children and young people (CYP) with SEN will benefit from a standardised health statutory assessment process towards timely access to AHP support/recommendations within the educational setting.	Health services will more consistently meet KPI in respect of the submission of health reports for SEN statutory assessment process.	PHA AHP by Sept 2024 PHA AHP by Sept 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Specific action 2 - The development of an integrated model of support across the health and educational sector that can assist to meet the child and young person's needs holistically and which meets requirements within the Children's Services Co-operation Act (2015).	CYP will benefit from a holistic approach to addressing their AHP needs within the school environment, reducing duplication and enhancing consistent messaging.	Review of training programmes provided by health and education towards model with greater regional consistency and evidence of cross organisational partnership working.	PHA AHP by Sept 2024
Cancer Screening Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people • Take forward a process to retender for the contract with an external organisation with	**Ethnicity, Disability, Sexual Orientation** Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening. To engage with those in the above S75 groups and deprived areas across NI to	The service provider will deliver 240 Cancer Screening Awareness Sessions annually, in an accessible manner, to participants in target groups and living in socially deprived areas across NI. The annual average number of session attendees from target groups will be approx.	Tender process led by Lead Consultant and Project Manager in Screening (working with PALs and Operations). Contract will be awarded to a service provider in Q1 2023/24, to undertake this work for the next 4 years (at a minimum).

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
community links to undertake this work. • Once tender is awarded, manage contract and monitor progress to ensure targets are met and target groups reached. PMR, session impact data and equality data will be submitted quarterly and Annually. Contract review meetings will be undertaken quarterly.	raise awareness of cancer signs and symptoms.	2,400. (N.B. targets would be revised in light of future waves of the pandemic.) Increase session attendees' awareness of the Cancer Screening Programme by 40% Increase session attendees' intention to attend cancer screening when next invited by 20%. Increase session attendees' knowledge of cancer signs and symptoms by 20%.	Contract management will be undertaken on an ongoing basis, by Project Manager in Screening with input from Lead Consultant and others as appropriate.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Infectious diseases in pregnancy screening (IDPS): - Ensure that all women from section 75 categories have access to IDPS early in pregnancy and that there is equality of access into clinical care for those screening positive for infections. 1. We will provide information leaflets about the IDPS programme in an accessible format in different languages. 2. We will liaise with community groups if necessary who can provide transport for women to clinic appointments if necessary. 3. We will monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.	**Persons from ethnic minority groups, asylum seekers and migrants.** 1. We are trying to ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening. 2. We are trying to ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.	1.Quarterly statistics will be collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments. The target would be that performance against each standard would reach the acceptable level and hopefully achieve the achievable level (top level) 2. Audit in progress around women screened positive for hepatitis B- this will highlight inequalities of access	PHA Regional antenatal infection screening programme co-ordinator–data collected quarterly.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
		amongst women attending specialist services.	
Health Improvement Refugees, Asylum seekers, Minority Ethnic & Migrant communities should have the opportunity of equal access to Health and Social Care services in Northern Ireland. • Engage with SPPG & DoH to consider additional funding needs in the short term and to develop a regional Northern Ireland New Entrants Service (NINES) which is consistent & effective across NI • Submit a paper to SPPG to highlight the issues to be addressed and develop a business case for the funding requirements.	**Persons of different racial groups** Equal access for all Asylum Seekers, Minority Ethnic &Migrants to initial health assessments and associated screening across the Region	Written evidence of engagement and paper submission Formation of working group to address issues relating to capacity for NINES/allied services, membership to include PHA and SPPG commissioning/primary care	PHA Nursing and PHA Health Protection End March 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
HSC LGBTQ+ Staff Forum Facilitate a minimum of 4 annual meetings the HSC LGBTQ+ Staff Forum. Work in partnership with other HSC organisation promote membership of the HSC LGBTQ+ Staff Forum. In partnership with members outline the key priorities for the HSC LGBTQ+ Staff Forum. Participate in and contribute to Diversity Champions events with other LGBTQIA+ Staff Networks in NI.	**Gender, Sexual Orientation** Provide an opportunity for HSC LGBTQ+ Staff to: • have a space to have their voice heard in the HSC. • be able to contribute to decision making that affects LGBTQ+ people. • Provide a community were LGBTQ+ people can feel better supported, recognised and included by the HSC. take an active role in promoting inclusion and diversity in the HSC	Population outcome: LGBTQ+ staff working in the HSC see the HSC values realised. Performance accountability: • Promotion of the Staff forum in each HSC organisation • Increase in HSC LGBTQ+ Staff Forum membership and in active participation. Production of a document outlining Staff Forums key priorities.	PHA Health Improvement with support from Employment Equality Leads in all HSC organisations by March 2024

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Equality Monitoring Commitment to collect additional equality data and outline planned analysis to be carried out on specific data that will be collected.	**All S75 Groups** Gather additional information relating to S75 groups and explore how this can be used to inform wider decisions	Audit what information is currently gathered and develop plan to identify opportunities to collect additional data Identify data that allows further analysis to be carried out	PHA Health Improvement and Operations End Mar 2028
Equality Working Group Establish a PHA Equality Working Group	**All S75 Groups** Ensure Equality is considered at a strategic level within PHA Aim to change culture of organisation to ensure equality issues are being considered and addressed	Group established and meeting regularly – TOR agreed and action plan in place	PHA Planning and Operational Services End Mar 2028

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.	**All S75 Groups** Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC	Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA. Increase in understanding of the rationale for embedding best practice in equality matters.	Lead by the PHA PPI Team, with guidance from BSO Equality colleagues, HSC partners and service users and carers

*Due to an ongoing post Covid recovery programme and the implementation of an extended screening interval in 2023/24, the availability of the online booking has had to be restricted to smaller groups, initially it is being used with those who have previously DNA'd. A review will then be carried out looking at functionality, and uptake amongst those targeted. Following this it is expected that availability will be extended to other groups within our eligible population, e.g. those newly diagnosed with diabetes, younger age groups etc.

2. Disability Action Plan 2023-28: What we will do to promote positive attitudes towards people with a disability and encourage the participation of people with a disability in public life

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Service Development and Screening **Infectious diseases in pregnancy screening (IDPS) programme** Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against. 1.We will continue to encourage all staff involved in the care of pregnant women to attend HIV awareness training at least every 3 years. 2.The PHA will develop a regional power point training presentation on the IDPS, which includes HIV. This	**Promoting positive attitudes and Encouraging participation in public life** To ensure equality of care for all pregnant women screened positive for HIV.	Regional Power point training presentation for the IDPS programme developed.	PHA Regional antenatal infection screening programme co-ordinator, by early 2024.

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
will ensure standardisation of training regionally . 3.The PHA will work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.	To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.	QA structures for the IDPS programme agreed and implemented. (will be resource dependent)	PHA Consultant responsible for the IDPS programme and Regional antenatal infection screening programme co-ordinator by end 2025
Awareness Days Raise awareness of the lived experience of people with specific disabilities and conditions.	**Promoting positive attitudes:** Increased staff awareness of a range of disabilities and conditions.	2 awareness days profiled every year. >50% of staff taking part in the evaluation indicate they know more about people living with disabilities and conditions as a result of the awareness days.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Placement Scheme Create and promote meaningful placement opportunities for people with disabilities.	**Promoting positive attitudes and Encouraging participation in public life:** People with a disability gain meaningful work experience. People with a disability are successful in applying for paid employment after they have completed a placement.	At least 3 placements in the PHA offered every year. Feedback through annual evaluation of scheme indicates that placement meets expectations. At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028
Tapestry Network Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its priorities.	**Encouraging participation in public life:** Staff with a disability feel more confident that their voice is heard in decision-making. Staff with a disability feel better supported.	Tapestry staff survey Increase in Tapestry membership or in participation at meetings	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Strategic Planning Teams Create and promote opportunities for people with disabilities to participate in PHA's strategic planning process to ensure the needs of people with disabilities are appropriately reflected when setting commissioning priorities.	**Encouraging participation in public life:** People with a disability are meaningfully involved in setting commissioning priorities initially in the following areas (to be regularly reviewed): • Mental Health • Older People • Alcohol and Drugs	Review current participation opportunities Develop and implement engagement plan	PHA Planning and Operational Services AD End Mar 2028
Providing information in signed video format Undertake an audit of PHA websites to: 1) identify key information to be made available in signed video format and 2) ensure relevant contact details are available and up to date in relation to requesting signed format versions.	**Encouraging participation in public life:** Ensure that content is accessible to people who are deaf	Complete audit to identify key information to be made available and where contact details are provided	PHA Planning and Operational Services End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Disability Training Plan Working together with Tapestry, we will co-produce, commission and deliver, and evaluate a training plan for staff on disability equality.	**Promoting positive attitudes:** Raise awareness of issues facing those with a disability and identify/develop suitable training and development opportunities	Engage with Tapestry to identify training required and explore how this can be implemented.	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028
Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability. Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC	**Encouraging and facilitating participation in public life.** Help to inform HSC staff how they could support and encourage active involvement of service users and carers with a disability**.** Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC	Production of a Guide targeted at informing staff about ways in which to support involvement of service users and carers with a disability. Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities	PHA PPI Team in collaboration with Tapestry, 3rd sector Advocacy organisations – ongoing during 2023-28

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide	**Encouraging and facilitating participation in public life**. Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.	Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances. Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities.	PHA PPI Team working in collaboration with the DoH, HSC partners & the PCC by the end of 2024.
Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland	**Improve opportunity for people of NI to provide feedback on experiences across HSCNI**	All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability	PHA PCE Team working in collaboration with HSC partners and charitable partners; Complete by the end of 2024