PUBLIC HEALTH AGENCY

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2026

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Laid before the Northern Ireland Assembly under Schedule 2, para 17(5) of the Reform Act for the Regional Agency, by the Department of Health on 3 July 2026

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2025/26 in delivering our corporate priorities and highlights examples of work undertaken during this period. It shows how this work has contributed to meeting our wider objectives and fulfilling our statutory functions.

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

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

Other formats

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

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Performance Report

The purpose of the Performance Report is to provide a brief summary of the role, purpose, activities and values of the Public Health Agency (PHA).

The Public Health Agency – our role, purpose and activities

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

Central to our role is working in close partnership with individuals, communities and organisations from across the community, voluntary and statutory sectors. The PHA was established to provide system-wide public health leadership and to:

- protect the population from communicable and environmental health threats;
- improve health and social wellbeing across the life course;
- reduce health inequalities and address the wider determinants of health;
- provide professional public health advice to support the commissioning, planning and delivery of health and social care services.

The PHA also has responsibility for the direct commissioning, management and oversight of a range of regional public health services and programmes, including health protection, screening, immunisation and health improvement services.

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

Our purpose

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

Our vision

A healthier Northern Ireland.

HSC values

The PHA endeavours to translate the Health and Social Care values into its culture by putting individuals and communities at the heart of everything we do

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

Chair's Foreword

It is my privilege to introduce you to the Annual Report for the Public Health Agency for 2025/26.

This has been a year of both significant challenge and change as we have continued to protect and improve the health and wellbeing of the population across Northern Ireland.

The Agency has remained focused on improving outcomes and reducing health inequalities, guided by prevention, partnerships and evidence-based practice. Our work has prioritised early intervention and support for those most at risk, reflecting our commitment to proportionate universalism and long-term population health improvement.

We have continued to operate throughout the year within a very constrained financial environment impacting health and social care and across our wider society. This has and will undoubtedly continue to require difficult decisions and a strong focus on prioritisation, efficiency and value for money. In response, I am pleased to report the Agency's progress in developing our new operating model under the Reshape and Refresh programme which has seen a new organisational structure implemented and a fresh focus on multi-disciplinary planning teams engaged in delivering the first year of our life course based Corporate Plan during 2025/26.

Despite the pressures, we have continued to support the transformation of our health and social care system and responding to increasing demand in areas such as mental health, substance use and chronic disease. Partnership working has remained central to our approach, enabling a coordinated and effective response to complex public health challenges. In this regard, I am pleased to note that the Agency has played a key role in developing the *"This is our Health"* public engagement programme. A key part of the Minister's Reset initiative, at the heart of the programme is a much-needed public conversation about how we build better health together in Northern Ireland.

At Board level we have also witnessed further change including the retirement of Heather Reid as Interim Director of Nursing, Midwifery and Allied Health Professionals, and Mr Joe Stewart, who concluded his final term as a PHA Non-Executive Director during the year. I would like to put on record my thanks and appreciation of the roles played by both of these colleagues. They have each contributed significantly to the work of the Board providing significant professional insight and skill in their own exemplary manner.

I would also like to acknowledge the dedication and professionalism of our staff, whose commitment continues to be critical in delivering for the population during a period of financial constraint and organisational change. I also thank our many partners across society for their continued collaboration.

While significant challenges remain, particularly in relation to financial sustainability, I believe that the Agency is currently well positioned to continue making a meaningful contribution to improving health and wellbeing. By maintaining a clear focus on prevention, reducing inequalities and embedding organisational transformation, we will continue to support better outcomes for all.

On behalf of the Board I commend this Annual Report to you.

Colin Coffey

Chair of the Board

Public Health Agency for Northern Ireland

Chief Executive's Foreword

I am delighted to present this Annual Report which reflects another year of significant progress for the Public Health Agency, as well as important growth in strengthening the foundations needed to deliver effective public health leadership for Northern Ireland.

A defining feature of 2025/26 has been the completion of our Reshape and Refresh programme and the transition to a new operating model. This year also marked the first year of implementation of the PHA Corporate Plan 2025–2030. The Corporate Plan sets out a clear, outcomes-focused framework to address the major health challenges facing our population over the next five years, underpinned by evidence, partnership and a strong focus on reducing health inequalities. Since autumn 2025, the new operating model has been fully in place, centred on core public health functions and supported by clearer governance arrangements, including the introduction of Public Health Planning Teams aligned to our strategic priorities. While the formal programme has concluded, continuous improvement remains central to how we now operate.

The Agency also continues to support the work of the Department of Health and facilitated the delivery of new and innovative ministerial priorities including *"Live Better"* and *"This is our Health"*, working with communities to understand and support health challenges for people living in Northern Ireland. We participated in the UK wide national pandemic exercise ('Exercise Pegasus'), to ensure that we contribute to build capability for future pandemics and improve preparedness.

All of this work has been undertaken within a challenging financial environment. The Health and Social Care system in Northern Ireland continues to operate under significant financial pressure, and the PHA is no exception. Throughout 2025/26, the Agency has focused on maintaining financial control, achieving break-even, and ensuring that limited resources are directed to areas of greatest population health need. This has required difficult choices, increased scrutiny of contracts and programmes, and closer collaboration with commissioning partners to maximise value for money while safeguarding quality and equity.

I wish to commend the work of the PHA Board under the leadership of the Chair, Colin Coffey. Their commitment and expertise have supported the organisation to set the direction and ensuring effective oversight of the important work of the Agency. During the year there were changes to the membership of the Board. I would like to place on record my sincere thanks to Heather Reid, who retired from her post as Interim Director of Nursing, Midwifery and Allied Health Professionals on 30 November 2025, for her leadership, professionalism and valued contribution to the Board and to the wider Health and Social Care system. I would also like to thank Joe Stewart, whose term of office came to an end on 31 December 2025, for his commitment, insight and constructive

challenge as a Board member and as Chair of the Governance & Audit Committee. His contribution supported the strengthening of governance arrangements and the Agency's focus on delivering its public health responsibilities during a demanding period.

I am pleased to welcome Emily Roberts, who joined the Board from 1 December 2025 as Interim Director of Nursing, Midwifery and Allied Health Professionals. Emily has already made a positive contribution, bringing valuable professional expertise and leadership as the Agency continues to embed its new operating model and deliver its Corporate Plan.

Finally, I would like to thank staff across the PHA for their professionalism, resilience and commitment during a year of considerable change. Without them, the work of PHA would not be possible. I am also grateful to the Department of Health, Health and Social Care partners, and colleagues across the community and voluntary sector for their continued support and challenge. Together, these efforts place the PHA on a stronger footing to meet future demands and to deliver on our shared ambition of a healthier Northern Ireland.

Aidan Dawson HMFPH

Chief Executive

Public Health Agency for Northern Ireland

Performance Analysis

This is the first year of delivery under our Corporate Plan 2025-2030. During 2025/26, we focused on establishing the foundations required to deliver our long-term ambitions, including the development of our Annual Business Plan and a supporting three-year Implementation Plan to guide progress towards our five-year goals. We also focused on gathering baseline information, establishing ongoing monitoring of population health indicators, and developing new digital systems and processes to support informed decision-making.

As part of the Reshape and Refresh Organisational Transformation Programme, our Planning and Performance team led the implementation of key elements of the new operating model. Central to this was the establishment of five Public Health Planning Teams (PHPTs), aligned to the priority areas set out in the Corporate Plan (Protecting Health, Starting Well, Living Well, Ageing Well, Mental Health & Learning Disability).

All five teams were operational by the end of 2025/26. The focus has now moved to building strong and sustainable foundations for delivery, alongside clear accountability processes to support effective planning and performance management. We also strengthened our approach to service planning, performance monitoring and resource management. This included a review of contracts across the PHA and the introduction of a new Trust Accountability process, developed in partnership with Health and Social Care (HSC) Trusts and the Strategic Planning and Performance Group (SPPG), to maximise the effective use of shared resources.

We worked with colleagues across our programme areas and Procurement and Logistics Services (PaLS) to deliver our 2025/26 procurement plan in line with the requirements of the Procurement Act 2023. This resulted in a number of key services going out to tender, including Adult Step 2, Workforce Development, Needle and Syringe Exchange Equipment, Work Well Live Well, the Elevate Programme, and the Cognitive Behavioural Therapy (CBT) Programme, offered both in person and online. This work supports the delivery of high-quality, value-for-money services for the people we serve.

The Annual Business Plan is monitored on a quarterly basis and updates across all KPIs are provided to the PHA Board. The figures in the following table set out the position achieved at 31 March 2026:

	Action completed	17
	Slight delay in completing Action	6
	Action significantly delayed/unable to be completed.	4
	TOTAL	**27**

The following pages highlight some of the key actions taken forward during 2025/26 and the progress achieved across our priority areas.

1. Protecting Health

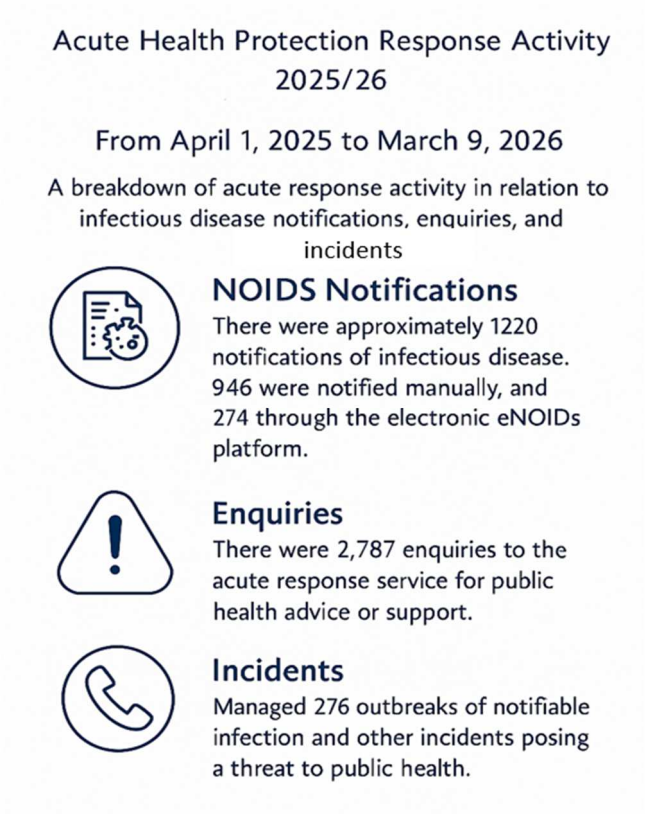
Our key work in protecting the health of the Northern Ireland population includes health protection and surveillance, immunisation and vaccination, screening, emergency planning, and infection prevention and control (IPC). Together, this work has helped keep people safe, strengthened our ability to respond to health threats, and ensured a joined-up public health response across the year.

Health protection and surveillance

Throughout 2025/26, our health protection team responded quickly and effectively to urgent Not Otherwise Infectious Disease (NOID) incidents. The team managed outbreaks, investigated serious infections, and gave timely expert advice to health partners and local communities.

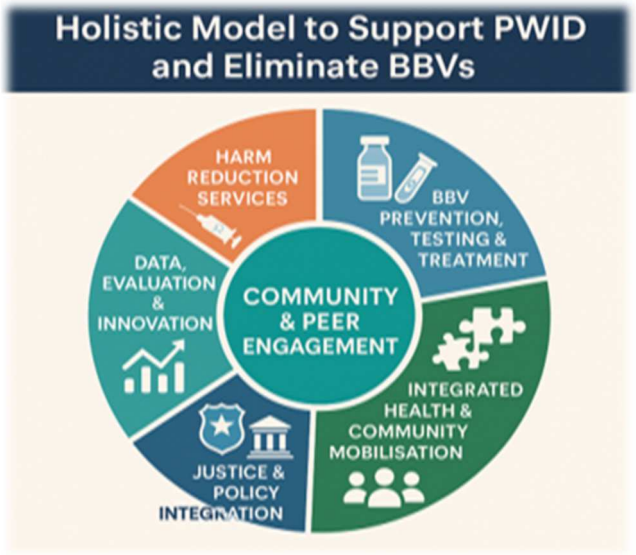
We made major improvements to our disease monitoring and surveillance systems this year. These included launching a new digital system to notify GPs and primary care teams of infectious diseases, and embedding a new tool to help detect unusual rises in infection rates as part of our routine outbreak monitoring.

We also made good progress on monitoring illness patterns in primary care. We piloted a new approach using wastewater testing to track COVID-19 (SARS-CoV-2), flu and polio, and are now evaluating the results. We assessed how well the flu and RSV (respiratory syncytial virus) vaccination programmes are working and shared our findings with policymakers and in published research.



We strengthened partnerships across the island of Ireland and the wider UK. Highlights included hosting the first all-island Health Protection Conference, developing new joint disease monitoring work with the Health Protection Surveillance Centre (HPSC) in the Republic of Ireland, and securing regular death registration data from the Northern Ireland Statistics and Research Agency (NISRA) to strengthen our health security monitoring. We also updated surveillance pathways for Creutzfeldt-Jakob Disease (CJD) following UK-wide changes, and produced evidence to support the Department of Health's (DoH) planning for environmental health surveillance and genomics.

Our wider health protection team progressed work across a range of priority areas, including tuberculosis (TB), respiratory infections, gastrointestinal (gut) infections, zoonotic diseases (infections that spread between animals and people), sexual health, people who inject drugs (PWID), blood-borne viruses (BBV) and antimicrobial resistance (AMR), the growing problem of infections that no longer respond to antibiotics and other medicines.



A draft review of TB services in Northern Ireland mapped the full patient pathway and set out recommendations to improve prevention, governance and consistency of care. We also raised TB awareness among the public and healthcare professionals, and worked with the Department of Agriculture, Environment and Rural Affairs (DAERA) and farming partners to prevent TB spreading from animals to people.

On AMR, we focused on public engagement, including delivering the e-Bug education programme in 15 schools and running a region-wide roadshow for World Antimicrobial Awareness Week. The blood-borne viruses programme promoted a joined-up model of care and developed peer-led initiatives in communities and prisons.

Infection prevention and control

In 2025/26, we made significant progress in improving infection prevention and control (IPC) across health and care settings in Northern Ireland.

All organisations agreed to use a new shared learning template to record and share lessons from IPC incidents and outbreaks. We also introduced a decision-support tool from the UK Health Security Agency (UKHSA) to help GP practices and care homes diagnose and manage urinary tract infections (UTIs) more effectively.

In November 2025, 58 healthcare practitioners in Northern Ireland received specialist training from the High Consequence Infectious Disease (HCID) Network on how to use protective equipment when assessing patients with high consequence infections. These practitioners can now pass on this training to colleagues across relevant health and care settings.

Emergency planning

In 2025/26, we participated in Exercise Pegasus, a UK-wide exercise led by the Department of Health and Social Care and the UK Health Security Agency (UKHSA) to

test preparedness and response arrangements for a new infectious disease. Working alongside colleagues from the Strategic Planning and Performance Group (SPPG) and Business Services Organisation (BSO), we contributed specialist expertise in surveillance, health protection, and operational planning. The exercise helped confirm what is working well within our current plans and identified opportunities for further improvement. Staff from across relevant services participated fully, ensuring Northern Ireland's contribution was robust and aligned with wider UK preparedness work.

Population screening programmes

Population screening programmes support the early detection of disease, when treatment is most likely to be effective. In 2024/25, the most recent year for which validated data is available, Northern Ireland's nine screening programmes completed 424,037 screening tests.

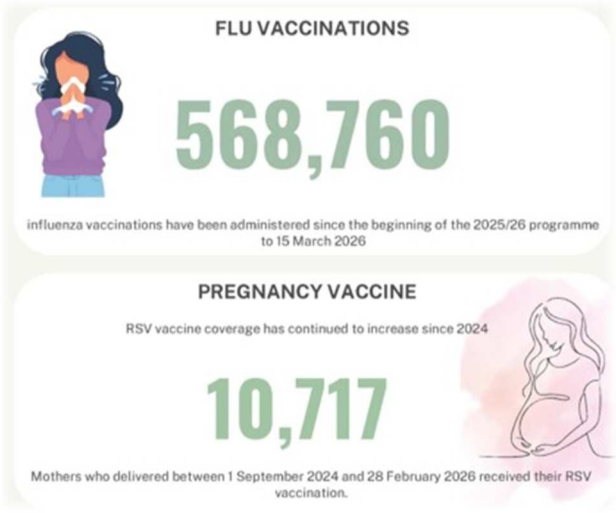
We continued to strengthen the cervical screening service during 2025/26. The new regional laboratory is now established, and progress has been made in implementing the recommendations arising from the Southern Health and Social Care Trust (SHSCT) cervical screening incident. The PHA worked closely with the SHSCT to carry out a review of the incident and the screening service. The aim of the review was to identify women whose screening samples had been examined by specific screeners identified in the report, ensuring appropriate follow-up.

We also led the planning work needed to expand the bowel cancer screening programme. Currently, people are invited for screening from age 60. We have developed a phased plan to lower this to age 50, which will allow us to detect bowel cancer earlier in more people. The programme is ready for implementation, subject to confirmation of funding.

Immunisation and vaccination

This year brought the most significant changes to the childhood vaccination schedule since 2015.

One vaccine has been removed from the schedule, the Hib/MenC vaccine, and a new appointment has been introduced at 18 months. At this appointment, children will receive a fourth dose of a combined vaccine protecting against diphtheria, tetanus, whooping cough, polio, Hib disease and hepatitis B, alongside the MMR vaccine protecting against measles, mumps and rubella.



In January 2026, Northern Ireland introduced the chickenpox vaccine as part of a new combined vaccination that also covers measles, mumps, rubella and varicella. In some children, chickenpox can lead to serious complications, so this addition strengthens the protection offered to young children. The shingles vaccination programme has been expanded. It now covers adults aged 18 and over who have a weakened immune system, helping to protect them from the pain and longer-term effects that shingles can cause.

Health and Social Care (HSC) Trusts have also begun delivering an expanded RSV vaccination programme. Respiratory syncytial virus (RSV) is a respiratory infection that can cause severe illness and hospitalisation, and can be fatal in vulnerable people. The expanded programme now offers protection to care home residents.

To help improve flu vaccine uptake, particularly among health and social care workers, we worked with Queen's University Belfast to use a World Health Organization approach for tailoring vaccination programmes to the needs of specific groups. This generated practical, evidence-based recommendations to support our vaccination communications.

2. Starting Well

In 2025/26, our Starting Well work focused on giving every child in Northern Ireland the best possible start in life. Working with partners across health, education and the voluntary sector, we tackled some of the most important challenges facing children and families.

Protecting children and young people from domestic abuse

We led a regional review of how midwives, health visitors, school nurses and family nurses ask about domestic abuse when they see patients. Working with the Department of Health, HSC Trusts, Women's Aid, and Ulster University, we developed new guidance on this topic. The guidance was launched on 6 March 2026 in the presence of the Ministers for Health and Justice. It fulfils a commitment under the Domestic and Sexual Abuse Strategy 2024 to 2031 and supports the Executive's work to end violence against women and girls.

Infant mental health

Following engagement with key stakeholders, we launched a refreshed Infant Mental Health Framework and Action Plan in January 2026. Around 100 delegates attended the launch, including the Health Minister.

The framework represents a commitment by the PHA, HSC and academic, research, voluntary and community organisations across Northern Ireland to improve interventions from the antenatal period through to children aged three years old.

The new framework builds on the strong foundation of early intervention with families during pregnancy and throughout the first 1,000 days of a child's life.

Breastfeeding action plan

Working with the DoH, we reviewed the existing breastfeeding strategy and prepared a draft Breastfeeding Action Plan for Northern Ireland. Subject to ministerial approval, the plan sets out the evidence for breastfeeding benefits and aims to:

- increase breastfeeding rates across Northern Ireland at all stages;
- promote World Health Organization guidance on supporting women and families;
- create a breastfeeding-friendly culture in public places, workplaces and communities.

Early Intervention Support Service

The Early Intervention Support Service (EISS) is a service that offers short term support to families with children 0-18 years who have additional needs or are facing challenges that are difficult to overcome, such as:

- difficulties with developmental or health related issues;
- issues at school;
- behavioural difficulties;
- emotional wellbeing;
- coping with illness or bereavement;
- family difficulties.

In 2025/26 we improved how the Early Intervention Support Service is delivered, updating guidance, streamlining the support pathway and refreshing contract targets. A development workshop for staff focused on emotional health, wellbeing and professional development. In 2025/26 the service:

- received 760 referrals, with 414 families taking up the offer of support;
- closed 776 cases, with 610 families completing the programme;
- was rated 'Excellent' by 89% of parents and 83% of children and young people.

Connect with Me

We supported the continued rollout of Connect with Me, an initiative that encourages parents to read with their children and build stronger relationships through a structured programme. The co-produced resource is being tested and evaluated in a number of Sure Start and early years settings. It aims to support children's mental health, early learning and communication development.

Special Schools partnership

Working with seven special schools across Northern Ireland, we delivered vision awareness training for teachers, allied health professionals (AHPs) and families. The project strengthened staff confidence and skills in supporting children with visual impairments. Families said the virtual reality element of the training was particularly powerful.

National Bereavement Care Pathways

We worked with SANDS to develop five National Bereavement Care Pathways and standards for Northern Ireland, ensuring consistent, compassionate care for women and families after pregnancy or baby loss. Bereaved parents shaped the pathways through involvement in the process. The pathways are due to launch in summer 2026. In preparation, we delivered staff workshops in March 2026.

Active school travel programme

In 2024/25 (which is the most recent complete data available), 526 schools took part in the programme, equating to 54% of all schools in Northern Ireland. Key results included:

- the proportion of pupils travelling actively to school rose from 35% to 45%;
- the proportion being driven to school fell from 58% to 49%;
- the proportion getting 60 minutes of daily exercise rose from 25% to 35%; and
- more than 1,600 activities delivered, reaching over 57,000 pupils, parents, siblings and teachers.

Child Health System - migration to Encompass

We have been working with HSC Trusts, General Practitioners (GPs), laboratories and other partners to move the Child Health System onto Encompass, Northern Ireland's shared health and care IT platform. The aim is to create a single health record for every child in Northern Ireland. This work is progressing well and moving at pace.

3. Living Well

Our key theme of Living Well focuses on ensuring that all people in Northern Ireland have the opportunity to live and work in a healthy way, in order to enable them to live longer, healthier and more independent lives.

During 2025/26 we focused on the following key areas of work.

Physical Activity Referral Scheme (PARS) Level 3

PARS Level 3 is a PHA-funded community programme that helps inactive people with specific health conditions become more physically active. We are currently reviewing how well the programme is working across Northern Ireland's five Health and Social Care (HSC) Trust areas and 11 council areas.

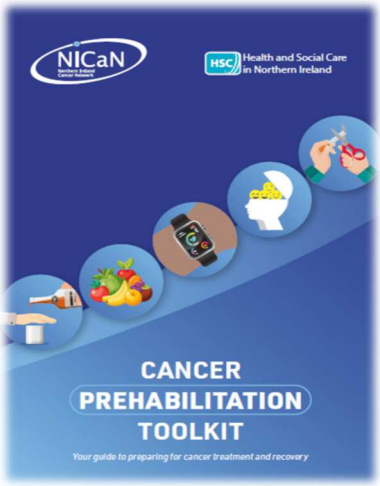
The review covers four areas:

- **Research evidence**: drawing on national and international studies and existing evaluation frameworks;
- **Programme data**: looking at referral numbers, completion rates, outcomes, and cost per person completing the programme;
- **Service user experience**: exploring what participants think of the programme, their satisfaction, and the outcomes they achieve;
- **Provider feedback**: gathering views from leisure centre staff who deliver the programme through a series of workshops.

A final draft of the PARS 3 review has been completed and will inform the direction of PARS commissioning with stakeholders moving forward.

Cancer Prehabilitation

The Regional Cancer Prehabilitation Toolkit helps patients prepare for cancer treatment. It covers physical fitness, nutrition, emotional wellbeing, and lifestyle changes, and explains why starting early makes a difference. Patients can use the toolkit's tips, videos, links, and self-reflection tools to set goals, track progress, and get support from their healthcare team.



The Northern Ireland Cancer Network (NICaN) has also produced a briefing paper making the case for a regionally commissioned cancer prehabilitation service. Evidence from a Macmillan-funded pilot showed clear benefits: patients were better prepared for treatment, had improved physical and mental health outcomes, recovered more smoothly, and spent less time in hospital.

The Macmillan-funded pilot demonstrated significant benefits, including improved patient readiness, better physical and psychological outcomes, smoother recovery, and indications of reduced hospital stays.

Better Days chronic pain programme

Better Days is a community-led support programme for people living with chronic pain, jointly overseen by the PHA and the Healthy Living Centre Alliance (HLCA). Around one in four people in Northern Ireland live with chronic pain, and this programme was designed with those people in mind.

The Health Minister described it in 2025 as "an excellent example of an innovative, community-driven solution to a complex health challenge." An independent evaluation found strong results:

- 27% increase in exercise and relaxation;
- 12% reduction in people feeling severely or extremely anxious or depressed;
- 39% reduction in high reliance on medication; and
- fewer unplanned visits to primary care.

In 2025, Better Days was shortlisted for the Partnership Working in Public Health award at the Advancing Healthcare Awards Northern Ireland.

Stop smoking services

Stop smoking services, delivered through community pharmacies and Health and Social Care (HSC) Trusts across Northern Ireland are currently under review. The review will look at the challenges pharmacies face when supporting people to stop smoking in areas with high smoking rates and higher levels of deprivation. In HSC Trusts the aim is to ensure services are consistent, measurable, and reflect both population need and best practice.

The results of the review will be available in 2026/27.

4. Ageing Well

More people in Northern Ireland are living longer, but many are doing so with long-term health conditions, and some face growing risks of poor health and social isolation. Helping older people stay well, stay connected, and get the care they need when they need it is a priority for the PHA.

Supporting healthy ageing

We continued to invest in programmes that help older people stay physically active, maintain their wellbeing, and live independently.

We made progress on a regional Safer Mobility model to improve access to strength and balance classes across Northern Ireland. These programmes help reduce falls and support people to stay active and independent.

Through Linking Generations NI, intergenerational programmes brought older and younger people together, helping to tackle ageism and build stronger communities. Arts and Health funding and local grants helped community groups run creative and social activities that improve wellbeing and reduce isolation.

We focused particularly on reaching older people in more disadvantaged communities, where health inequalities are greatest.

Age Friendly Northern Ireland

PHA is working towards the World Health Organization's Age Friendly Communities Framework, which helps create places that support people as they grow older.

PHA-funded Age Friendly Coordinators are now in post in all eleven local councils, leading local action plans covering outdoor spaces, housing, transport, social participation, and access to services.

In November 2025, we hosted the first Age Friendly Summit, bringing together councils, older people, and partner organisations to share progress and learning. Independent evaluation confirms the programme is well established and delivering real benefits.

The PHA has also committed to becoming an Age Friendly Employer.

Home accident prevention

Northern Ireland is the only region in the UK with a dedicated Home Accident Prevention Strategy.

Working with local councils, we offer free home safety checks to families with young children and adults aged 65 and over. For older people, these checks look at risks such as

poor lighting, trip hazards, and unsafe layouts. Where needed, minor adaptations are made and people are referred to other services to help them stay safe and independent at home.

From 1 April 2025 to date, a total of 3,898 home safety checks have been completed, with over 24,926 pieces of equipment provided across these visits. This has led to measurable improvements such as reduced fall risks, increased uptake of home adaptations, and greater confidence among participants in managing home safety.

Improving services for older people

Frailty, where the body becomes less able to recover from illness or injury, is a high priority across the HSC due to its particularly high prevalence in Northern Ireland. Identifying it early helps prevent people's health declining unnecessarily.

The Frailty Network, working with Health and Social Care (HSC) partners, has embedded the Clinical Frailty Score (CFS) into the Encompass system as the standard assessment tool for people aged 65 and over. This means earlier and more consistent identification across all care settings. Work is also under way to measure how common frailty is across Northern Ireland, to support better service planning.

A regional Frailty Education Programme, developed by the Frailty Network and endorsed by the Department of Health (DoH) for roll-out across HSC, has strengthened staff skills and knowledge, with over 13,000 certificates issued in the past year. A Frailty Care Bundle (a coordinated set of actions to identify frailty early and deliver safe, holistic, person-centred care to reduce risk and improve outcomes) is being tested across hospitals to improve inpatient care. New community-based models for identifying and managing frailty are also being tested with Area Integrated Partnership Boards, laying the groundwork for a Neighbourhood Model of Care.

To better understand older people's experience of hospital care, we worked with Age NI to deliver a Patient Experience of Hospital Care Survey in 2025/26. Older people conducted peer interviews across hospital sites, giving an authentic picture of what it is like to be a patient. Findings will be published in the My Hospital Journey report and will inform improvements.

We updated guidance on nutrition and hydration for care homes, improved support for meaningful activity, and strengthened clinical input to reduce avoidable hospital admissions.

Work continued to improve palliative and end of life care, with a particular focus on reaching marginalised groups, including people experiencing homelessness.

A PHA-led regional review of District Nursing found strong performance and identified opportunities to improve further. Planned next steps include a refreshed framework, a regional tool to assess patient need, and stronger governance, all supporting a

sustainable, neighbourhood-based model of care that will be essential for meeting future demand.

This work reflects our commitment to helping people in Northern Ireland age well: staying independent, safe, and connected, and receiving compassionate, person-centred care when they need it.

5. Mental Health, Substance Use and Learning Disability

While we take a ‘life course’ approach to our work, mental health, substance use and learning disability are key priorities that cut across all these stages and are relevant throughout life.

Substance use services

We continued to deliver high-quality drug and alcohol prevention, early intervention, and treatment services across Northern Ireland.

In 2025/26 we recommissioned the community-based adult drug and alcohol treatment service and began preparing to retender youth treatment and hidden harm services. We also recommissioned the regional workforce development programme, which builds skills and capacity among substance use and mental health staff across Northern Ireland.

We expanded the Take Home Naloxone Programme, which gives people who use drugs, and those around them, access to naloxone, a medicine that can reverse a potentially fatal opioid overdose. The programme now operates from 50 sites across Northern Ireland, including hostels.

Constipation in people with learning disabilities

Constipation is a common but often overlooked health issue for people with learning disabilities. If left untreated, it can have serious effects on a person's health and wellbeing.

In 2025/26 we looked at the specific needs and risk factors for constipation in people with learning disabilities across all age groups. This helped us understand how well current services across Northern Ireland are identifying, managing, and treating this preventable condition.

We also scoped approaches taken across the UK and Ireland to inform plans for a public awareness campaign, learning from existing practice and avoiding duplication. Phase 1 of the campaign will begin once an Expert Reference Group has been appointed.

Suicide prevention

We supported the review and update of the Protect Life 2 Suicide Prevention Strategy Action Plan for 2025 to 2027, along with its companion Implementation Plan. Both were launched by the Health Minister in September 2025.

Working with local Protect Life Implementation Groups (PLIGs), community-based groups that coordinate suicide prevention activity, we helped revise their local action plans for 2026 to 2029. These plans are being reviewed using a regionally agreed screening tool before sign-off. We also co-produced new regional terms of reference for PLIGs, and

guidance on PLIG membership is in development.

Across Northern Ireland, PLIGs delivered a wide programme of mental health, emotional wellbeing, and suicide prevention activity, focused on raising awareness, early intervention, and building community capacity. Highlights from each area include:

Northern area: three public engagement roadshows reached 254 young people through Take 5 learning sessions. Multilingual Ready to Help resources were developed, and a further 25,000 leaflets and 15,000 wallet cards distributed to raise awareness of local support.

Belfast: funded five shared learning events across key neighbourhoods, improving awareness of mental health support pathways and promoting Lifeline, Take 5 and Minding Your Head. Funding also supported new resources to raise awareness of early intervention and bereavement support.

Southern area: activity included public awareness events, lived experience publications, staff training, bereavement book club resources, targeted rural programmes, reflective practice sessions, and a local action planning workshop.

South Eastern area: a programme delivered joint workshops for Health and Social Care (HSC) Trust staff and community and voluntary sector (CVS) partners, introduced bereavement guidance, strengthened local Suicide Prevention Task Groups, and supported targeted distribution of Take 5 materials.

Western area: funded short digital films to raise awareness of available services and make it easier for people to find support.

6. Our Organisation and People

Our Annual Business Plan sets out a series of key actions in order for us to make best use of our people, structures and money to meet our priorities and responsibilities.

Reshape & Refresh

The Reshape & Refresh Programme has transformed the way the PHA is organised and operates. Informed by the Hussey and Ernst and Young (EY) reviews, the programme focused on clarifying roles and responsibilities, strengthening governance arrangements, and fostering a healthier organisational culture. This work is now complete, with the new operating model in place since late 2025.

As part the transformation, new Assistant Director and Head of Service roles were established, with the majority of posts now filled. All staff transitioned into the new structure on 1 September 2025. Further design work is planned for the Population Research and Intelligence Directorate once its senior leadership team is complete.

The new model organises the PHA around its core public health functions. Two new governance mechanisms support this: a Senior Leaders Forum to improve strategic alignment and collaborative leadership, and Public Health Planning Teams to oversee delivery of the five-year Corporate Plan.

While the programme is formally drawing to a close, improvement will continue within a clearer and more stable organisational framework. A new four-year People Strategy will be launched in April 2026 alongside the Corporate Plan, setting out the agency's ambitions for its workforce. A final evaluation will assess progress in leadership, culture, resilience, data-driven planning, and overall effectiveness.

PHA input into Health and Social Care Commissioning

Commissioning in health and social care is the process through which services are planned, procured and monitored to meet identified population health and social care needs. The commissioning cycle covers everything from identifying what services people need and deciding priorities, to planning and purchasing services, and then monitoring and evaluation.

The PHA leads on commissioning services that help prevent illness, including programmes delivered at a population level, such as vaccination and screening programmes. This work happens across Northern Ireland, based on where need is greatest. Public health professionals are involved throughout, making sure decisions are based on evidence and focused on improving health and reducing health inequalities.

During 2025/26, the PHA worked closely with SPPG and other HSC colleagues to help commission high-quality health services tailored to the needs of people across Northern

Ireland. This work was largely undertaken through newly established Joint Planning Teams, which are aligned to specific service delivery areas.

One example is the Women and Children's Health Planning Team, which plans services across areas including children's health, maternity and gynaecology. These teams include PHA staff from a range of backgrounds including public health specialists, nurses and allied health professionals, reflecting the wide range of expertise needed to design services that work.

A key part of the PHA's contribution is identifying what health needs exist across the population, including inequalities in health, health behaviours and access to services. This is done mainly through health needs assessments, which help ensure resources are allocated where they will make the biggest difference. One current example is an assessment of women's pelvic floor and bladder health needs, being carried out through the Women's and Children's Health Planning Team. This was prompted by growing pressures on services, an ageing population and a rise in related health conditions. The findings will shape future decisions about these services.

The PHA also helps make sure commissioned services are based on the best available evidence and meet recognised standards.

As well as shaping how services are designed, PHA staff work with HSC Trusts and clinical teams to support good practice within existing services. During 2025/26, this included helping the acute sector prepare for serious infectious disease cases, and supporting changes to how chest pain is assessed and managed by the Northern Ireland Ambulance Service. The PHA also takes part in regional clinical networks. For example, the Stroke Clinical Network worked during 2025/26 to improve stroke thrombolysis rates and develop proposals for a round-the-clock stroke thrombectomy service, with significant public health involvement.

The PHA also provides public health expertise to workforce planning and performance monitoring. This includes working with HSC colleagues to review services, considering staffing capacity, long-term sustainability and the wider health impact of how services are organised. The PHA contributes to oversight and quality assurance, helping to identify and manage risks within HSC services.

More broadly, the PHA plays an important role in bringing together different organisations and professions across the health and social care system, and in contributing to health policy through representation on Department of Health groups, including the Adult Neurology Review and the Hyperacute Stroke Programme Board.

Public inquiries

The PHA continues to support a number of longstanding public inquiries into issues of serious public concern. In 2025/26, the main focus was the UK COVID-19 Inquiry. The agency submitted written evidence for three modules: Module 6 (Care Sector), Module 7

(Test, Trace and Isolate), and Module 8 (Children and Young People). Staff also gave oral evidence for Module 8.

Partnership and Engagement

Listening to patients, service users, and carers, and acting on what they tell us, is central to delivering safe, high-quality, person-centred care across the Health and Social Care (HSC) system.

In 2025/26, the PHA brought together two teams, Patient and Client Experience (PCE) and Personal and Public Involvement (PPI), into a single Partnership and Engagement team. Both approaches are underpinned by legislation and policy.

The PCE team runs two regional feedback programmes: Care Opinion, an online feedback platform, and 10,000 More Voices. Both capture the lived experiences of people using HSC services, helping to shape how services are planned and delivered. Regular reports go to HSC Trusts, the PHA, the Strategic Planning and Performance Group (SPPG), the Department of Health (DoH), and other partners. In 2025/26, campaigns on smoking cessation, continuity of midwifery care, and dementia services gathered experiences from more than 6,500 people.

The PPI team provides regional leadership, advice, and guidance to ensure patients, carers, and the public have a meaningful role in shaping HSC services. In the past year, more than 120 projects received PPI support, covering cancer, neurology, mental health, screening, patient safety, and more. Over 66,000 people were recorded as actively involved across 635 projects, helping to co-design policies, plans, and services.

The PHA has published an updated involvement and consultation scheme setting out how we support staff and encourage service users and carers to get involved. A new Partnership and Engagement Strategy and Action Plan will be in place from April 2026.

Communications

The Communications team delivered a wide range of activity across the Agency's portfolio in 2025/26, working closely with HSC Trusts, the Department of Health, and other key partners.

Work included public campaigns, printed materials for the public and professionals, social media, news releases, media briefings, and managing sensitive reputational issues. The team advised colleagues in each Public Health Planning Team on how to communicate health messages effectively and support behaviour change in areas such as smoking prevention, mental health, early years, and physical activity.

In 2025/26, a digital discovery exercise was carried out to inform the PHA's digital communications strategy. The exercise

involved research and engagement with internal and external stakeholders. It identified strategic options, success measures, and implementation pathways to guide future decisions. This will inform the development of a new, integrated digital hub for the PHA in 2026/27 to better reach and influence public health behaviours.

While the Department of Health's pause on mass media advertising continued into 2025/26, two campaigns were approved.

Talking Really Helps ran across multiple channels from November to March, encouraging anyone experiencing anxiety, distress, or crisis to talk to someone. The campaign promoted Lifeline, Northern Ireland's crisis helpline, using testimonials from service users. Previous evaluations show strong reach: 65% of adults were aware of the campaign, and 86% of those who saw it reported taking at least one positive action for their mental health. Calls to Lifeline increased during and immediately after the campaign. The campaign won 11 PANI Awards in 2025.

In early December, *Flu Hits Hard, Protection is Easy* promoted flu vaccination following a rise in cases.

Work continued throughout the year to raise awareness of organ and tissue donation. Key activities included launching new resources for post-primary schools and marking Organ Donation Week. As a result, Northern Ireland registrations to the NHS Organ Donor Register reached 60%, the highest of any UK region.

HSC Research and Development Division

The HSC Research and Development (R&D) Division continued to support world-class health and social care research across Northern Ireland through funding for infrastructure and programmes. A highlight this year was the launch of the One NI Clinical Research Delivery Centre (CRDC). Together with the new South Eastern HSC Trust (SEHSCT) Clinical Trials Unit, this will support the full delivery of clinical trials, giving people in Northern Ireland access to the latest treatments and interventions.

Data and digital

The PHA continued moving data processes to the Northern Ireland Health Analytics Platform (NIHAP) in 2025/26, including migrating the Neonatal Cot Locator and producing more detailed coverage data to support the cervical screening programme. The team also supported the NI Cancer Registry in deploying its new digital system across HSC. Health Protection Surveillance's use of NIHAP is now managed by a new in-house Data Science team.

To support the new Public Health Planning Teams and the wider agency, a Public Health Master Dataset was developed and population health modelling was extended to cover bowel screening, obesity, and disease prevalence.

The Vaccine Management System now saves time for GPs, Trusts, and community pharmacies through a new clinic mode. Management of the system has moved fully in-house, replacing contracted roles with PHA staff.

Work to restore secondary care data flows, disrupted by Trust go-live activity on Encompass, is ongoing. The Child Health System is on track to go live on Encompass in 2026/27, with the team providing substantial support to the programme.

The PHA's wider digital work will move into the new Population Research and Intelligence Directorate in 2026. This year saw major progress on key Encompass projects, the Child Health System, Family Nurse Partnership, and Lifeline integration, as well as the development and demonstration of a potential single-platform solution for breast and cervical screening. If approved, this could transform how population screening is managed across Northern Ireland.

Financial Performance Report

Financial Planning

The PHA Finance team, led by the Director of Finance & Corporate Services, is responsible for the delivery of finance functions, including financial planning, financial governance, financial management and financial accounting services.

The team worked closely with senior leaders across the organisation and with Department of Health officials to develop a balanced Financial Plan for 2025/26, which was approved by the PHA Board. Financial performance was closely monitored against the opening financial plan assumptions throughout the year. The savings and efficiencies delivered during 2025/26 have supported financial balance in-year and will inform future financial planning by contributing to the management of ongoing pressures and the development of sustainability plans for future years.

The financial context in the Health and Social Care sector remains extremely challenging. The PHA management team will continue to work closely with partners to maintain sound financial management and will engage with the Department of Health to prioritise resources in support of statutory responsibilities and ministerial priorities.

PHA Financial Management and Stability

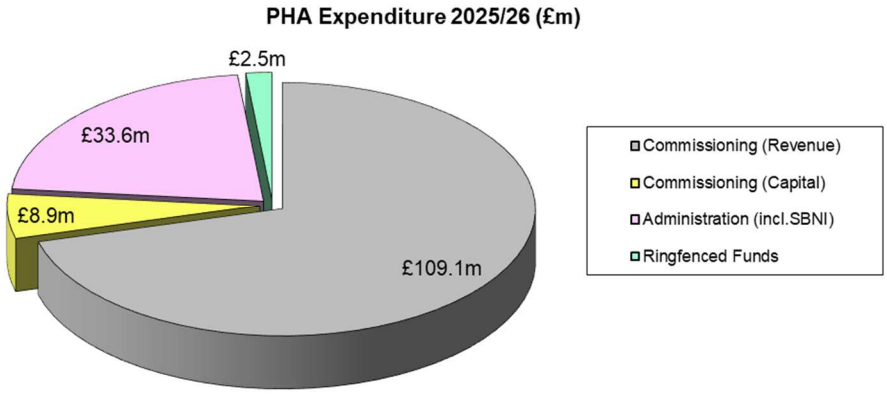
The PHA received a revenue resource budget of £145.3m in 2025/26, along with £1.1m income from other sources, and £8.9m in capital funding. The financial statements presented in this Annual Report and Accounts confirm that the PHA successfully delivered its breakeven duty reporting a revenue surplus of £88k.

This position was achieved through significant and diligent efforts of PHA budget holders, supported by the Finance team, in managing in-year slippage and pressures across a range of budgets, against a backdrop of system-wide inflationary pressures and ongoing operational challenges across Health and Social Care.

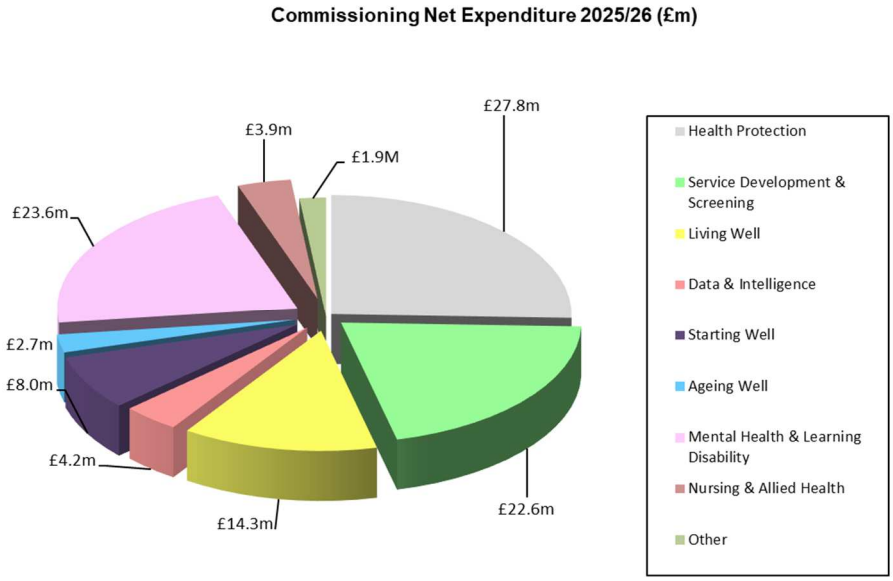
The outlook for 2026/27 and beyond continues to be challenging, and the Finance team will work closely with Directors and budget holders to ensure the PHA fosters a strong culture of sound financial management and focuses on value for money across all programmes.

The following charts illustrate how the PHA's revenue funds have been utilised during 2025/26.

a. Net Expenditure by Area 2025/26



b. Commissioning Expenditure by Budget Area 2025/26

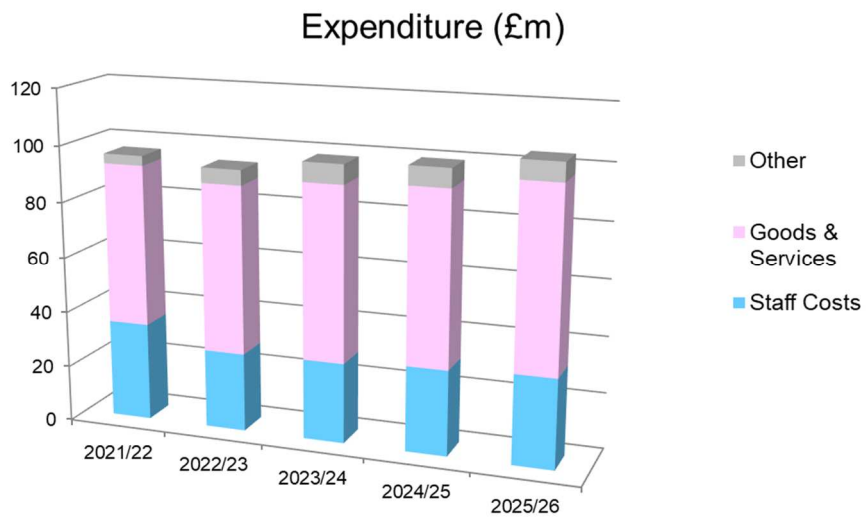


COVID-19 Allocations and Expenditure

During 2025/26, specific ring-fenced allocations earmarked for COVID-19 were allocated to the PHA from DoH. These allocations amounted to £2.1m (2024/25, £2.3m) which allowed the PHA to continue to support the region in its response to the pandemic, primarily through Covid-19 and Flu vaccination programmes.

Long Term Expenditure Trends

The following chart highlights how the main categories of expenditure within the Statement of Comprehensive Net Expenditure (SoCNE) have moved over the last five years. This relates to the revenue expenditure of the PHA excluding allocations to Trusts.



Prompt Payment Performance

a) Public Sector Payment Policy - Measure of Compliance

The Department requires that PHA pay their non-HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The PHA's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is detailed in the table below.

	2025/26 Number	2025/26 Value £000s	2024/25 Number	2024/25 Value £000s
Total bills paid	4,709	£76,101	5,786	£85,373
Total bills paid within 30-day target or under agreed payment terms	4,505	£72,412	5,537	£82,969
% of bills paid within 30-day target or under agreed payment terms	**95.7%**	**95.2%**	**95.7%**	**97.2%**
Total bills paid within 10-day target	3,901	£61,841	4,697	£62,803
% of bills paid within 10-day target	**82.8%**	**81.3%**	**81.2%**	**73.6%**

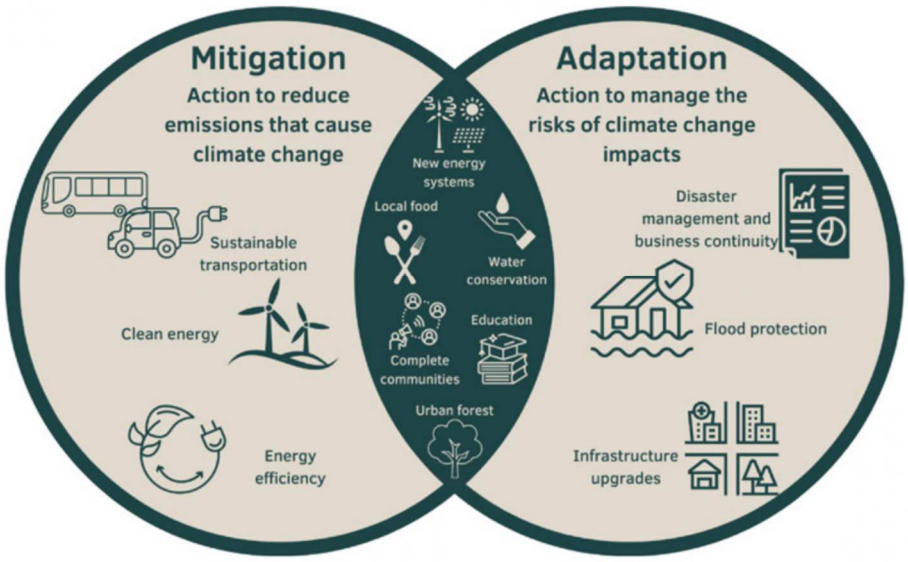
The PHA performed above the 95% target on volume for payments within 30 days, at 95.7% (2024/25, 95.7%) and has performed well above the 70% target of payments within 10 days, at 82.8% (2024/25, 81.2%).

b) The Late Payment of Commercial Debts Regulations 2002

The PHA paid no late payment fees in 2025/26 (£nil for 2024/25).

Sustainability Report

The PHA reports on sustainability following guidance from the Northern Ireland Executive and the Department for Agriculture, Environment and Rural Affairs (DAERA). Under the *Climate Change (Reporting Bodies) Regulations (Northern Ireland) 2024*, the PHA is required to produce regular reports on climate mitigation and adaptation. In line with the Government Financial Reporting Manual (FReM), the Agency has adopted a proportionate approach to climate-related disclosures, reflecting its size and operating context.



During 2025/26, the PHA submitted two reports. The first, submitted in October 2025, covered climate mitigation. It set out how much greenhouse gas the PHA produces, where those emissions come from, and our plans to reduce them. This report establishes a baseline for future comparisons, with the next report due in 2028. It also prompted a review of our existing policies on sustainability, the environment and waste. We will develop a new overarching Sustainability Strategy in 2026/27, led by the Finance and Corporate Services Directorate working with internal and external partners.

The second, submitted in March 2026, covered climate adaptation. It looked at how climate change could affect the PHA's work and what we need to do to respond. The next adaptation report is due in 2030. A key next step is developing a PHA Climate Action Plan, which will address risks such as rising temperatures, increased vector-borne diseases and extreme weather events. These will also feed into our Business Continuity Planning.

The Director of Finance and Corporate Services leads on climate change within the PHA, providing regular updates to the Agency Management Team (AMT). Issues are escalated to the PHA Board as needed, with the Governance and Audit Committee overseeing governance arrangements. We also continue to work with the Procurement and Logistics Service (PaLS) to make sure sustainability and climate considerations are built into procurement decisions and future business cases.

Equality and Diversity

Work progressed during 2025/26 (year three) of the PHA Equality and Disability Action Plans 2023–2028. The Equality Action Plan focuses on actions to address inequalities across all Section 75 equality categories, while the Disability Action Plan sets out measures to promote positive attitudes towards disabled people and to support their participation across our areas of work. Progress against year two of both Action Plans was reported through the Annual Progress Report submitted to the Equality Commission for Northern Ireland in August 2025.

With support from the BSO Equality Unit, which provides specialist advice and guidance on equality matters, the PHA delivered two Disability Awareness Days during the year. Staff were invited to suggest topics for these events, and attendance and engagement continued to be positive. The focus of the 2025/26 sessions was autism and ADHD (attention deficit hyperactivity disorder), and chest, heart and stroke conditions. Each event included a live online session delivered by an expert in the field, either a health or social care professional or an individual with lived experience.

Significant work was also undertaken during 2025/26 to establish an internal PHA Equality Forum. This work is now being taken forward in collaboration with Personal and Public Involvement (PPI) colleagues to develop a PHA Equality, Experience and Involvement (EE&I) Associates Working Group, strengthening organisational learning and engagement in equality, experience and involvement activity.

Rural Needs Act (Northern Ireland) 2016

The purpose of the Act is to ensure that public authorities have ‘due regard’ to the social and economic needs of people in rural areas and to provide a mechanism for ensuring greater transparency in relation to how public authorities consider rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.

The Act seeks to help deliver fairer and more equitable treatment for people in rural areas which will deliver better outcomes and make rural communities more sustainable.

The completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project. In particular, ensuring consultation with rural dwellers when planning services and consideration given to alternative service delivery methods where appropriate to meet their needs.

Complaints and Compliments

On 1 January 2026, the Northern Ireland Public Services Ombudsman's Model Complaints Handling Procedure (MCHP) became operational for the health and social care sector. In response, the PHA updated our complaints management processes to ensure alignment with the requirements of the MCHP, supporting a complaints process that is simple, accessible and compassionate for complainants.

During 2025/26, the PHA received ten complaints. Although the number of complaints was low, learning lessons remains a vital aspect of the complaints process and where improvements are identified they are implemented across the PHA on an ongoing basis.

The PHA was pleased to receive nine compliments in 2025/26. The general theme from the compliments related to the PHA's professionalism, effective communication and constructive engagement across a range of activities, including outbreak management, major event planning and our media communications.

Complaints and compliments information is reported quarterly to PHA senior leaders, at both Executive and Non-Executive level. The PHA also publishes an annual Complaints and Compliments Report on the PHA website.

Information Requests

Between 1 April 2025 and 31 March 2026, the following requests were received:

- 89 Freedom of Information Requests;
- 12 Environmental Information Regulations Requests; and
- 7 Subject Access Requests.

On behalf of the PHA, I approve the Performance Report encompassing the following sections:

- Performance Overview;
- Performance Analysis.

Aidan Dawson

Chief Executive

Date: 18 June 2026

ACCOUNTABILITY REPORT

Non-Executive Directors' Report

The primary role of the PHA Board is to establish strategic direction within the policy and resources set by the DoH, monitor performance, ensure effective financial stewardship and ensure high standards of corporate governance are maintained in the conduct of the business of the organisation.

The board is comprised of a Chair, seven non-executive Directors (two of which were vacant during 2025/26), the Chief Executive and three Executive Directors. The Head of the Chief Executive's Office attends board meetings. The Department of Health appoints the Non-Executive Directors, with the approval of the Minister of Health. The Chairs and Non-Executive Directors are:

- Mr Colin Coffey (Chair);
- Mr Craig Blaney;
- Mr John Patrick Clayton;
- Ms Anne Henderson;
- Mr Robert Irvine; and
- Mr Joseph Stewart (left 31 December 2025).

The board and its committees held regular meetings during the year. During 2025/26 the board held 10 meetings.

The ***Governance and Audit Committee*** assists the PHA Board by providing assurance, based on independent and objective review, that effective internal control arrangements are in place within the PHA. The Committee met on five occasions during the year. It was chaired by Mr Joe Stewart up to December 2025 and subsequently by Ms Anne Henderson, who provides regular reports to the full board. The Committee also completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness.

The ***Remuneration Committee*** is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives subject to the direction of the Department of Health. The Committee is chaired by Mr Colin Coffey, and met once during the year.

The ***Planning, Performance and Resources Committee*** is responsible for keeping under review the financial position and performance against key non-financial targets of the board and to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources, and that corporate/business planning arrangements are working effectively. The Committee is chaired by Mr Colin Coffey and met four times during the year.

Corporate Governance Report

The Corporate Governance Report provides information on the composition and organisation of the PHA's governance structures, which support the achievement of the PHA's objectives. It comprises the Directors' Report, the Statement of Accounting Officer's Responsibilities and the Governance Statement of the organisation.

Directors' Report

PHA Board

The board of the Public Health Agency meets frequently throughout the year and members of the public may attend these meetings. The dates, times and locations of these meetings are advertised on our main corporate website at www.publichealth.hscni.net

Board Member	Position
Colin Coffey	Chair
Aidan Dawson	Chief Executive
Dr Joanne McClean	Director of Public Health
Heather Reid *(left 30 November 2025)*	Interim Director of Nursing, Midwifery and Allied Health Professionals
Emily Roberts *(from 1 December 2025)*	Interim Director of Nursing, Midwifery and Allied Health Professionals
Leah Scott	Director of Finance & Corporate Services
Craig Blaney	Non-Executive Director
John-Patrick Clayton	Non-Executive Director
Anne Henderson	Non-Executive Director
Robert Irvine	Non-Executive Director
Joseph Stewart *(left 31 December 2025)*	Non-Executive Director

Further background information on all board members is available on the PHA website at: https://www.publichealth.hscni.net/pha-board

Related party transactions

The PHA is an arm's length body of the Department of Health and as such the Department

is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts. During the year, none of the board members, members of the key management staff or other related parties have undertaken any material transactions with the PHA.

Register of Directors' interests

Details of company directorships or other significant interests held by Directors, where those Directors are likely to do business, or are possibly seeking to do business with the PHA where this may conflict with their managerial responsibilities, are held on a central register. A copy is available on the PHA website at www.publichealth.hscni.net/about-us/freedom-information/lists-and-registers

Audit services

The PHA's statutory audit was performed by Cooper Parry on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2026 was £30,600.

Statement on Disclosure of Information

All Directors at the time this report is approved can confirm:

- so far as each Director is aware, there is no relevant audit information of which the External Auditor is unaware;
- he/she has taken all the steps that he/she ought to have taken as a Director in order to make him/herself aware of any relevant audit information and to establish that the External Auditor is aware of that information; and
- the Annual Report and Accounts as a whole are fair, balanced and understandable and he/she takes personal responsibility for the Annual Report and Accounts, and the judgements required for determining that it is fair, balanced and understandable.

Statement of Accounting Officer's Responsibilities

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health has directed the Public Health Agency (PHA) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the PHA and of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FReM) and in particular to:

- Observe the HSC Manual of Accounts issued by the DoH including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements;
- Prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the PHA will continue in operation; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Aidan Dawson as the Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the regularity and propriety of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PHA's assets, are set out in the formal letter of appointment of the Accounting Officer issued by the Department of Health, Chapter 3 of Managing Public Money Northern Ireland (MPMNI) and the HM Treasury Handbook: Regularity and Propriety.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PHA's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

1. Introduction/Scope of Responsibility

The Board of the Public Health Agency (PHA) has overall accountability for the system of internal control. As Accounting Officer and Chief Executive of the PHA, I am responsible for maintaining a sound system of internal governance that supports the delivery of the organisation's policies, aims and objectives whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health (DoH).

As Accounting Officer, I ensure that effective arrangements are in place for the identification, assessment and management of risk. The PHA maintains a comprehensive suite of organisational controls, commensurate with officers' current assessment of risk, designed to ensure the efficient and effective discharge of the PHA's business in accordance with the law and Departmental direction. Every effort is made to ensure that the objectives of the PHA are pursued in accordance with the recognised standards of good governance and public administration.

A range of processes and systems including Service Level Agreements (SLAs), representation on PHA Board, Governance and Audit Committee, Planning Performance and Resources Committee and regular formal meetings between senior officers are in place to support the close working between the PHA and its partner organisations, primarily the Strategic Planning and Performance Group (SPPG) and the Business Services Organisation (BSO), as they provide essential services to the PHA and in taking forward the health and wellbeing agenda. Systems are also in place to support the inter-relationship between the PHA and the DoH, through regular meetings and by submitting regular reports.

During 2025/26, the PHA concluded its Refresh and Reshape Programme. This programme has established a strengthened and sustainable operating model designed to support the organisation's future functions and enhance its capacity to deliver high-quality public health outcome.

2. Compliance with Corporate Governance Best Practice

The board of the PHA applies the principles of good practice in corporate governance and continues to further strengthen its governance arrangements. The Board of the PHA does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by internal and external audits and through the operation of the Governance and Audit Committee, with regular reports to the PHA Board. The PHA Board also contributes to the strategic leadership of the organisation, ensuring that AMT are satisfactorily leading on the effectiveness, accountability, sustainability and progressing the vision for PHA. The board provides strategic support and challenge on and assesses

the appropriateness of delivery against the corporate plan and annual business plan which provide the vision for PHA and its key contribution to the wider HSC agenda. This includes risk identification, measurement and monitoring mechanisms and reviewing adequacy of policies to ensure ongoing legal, regularity and code of conduct compliance and ongoing adherence to section 75 equality and good relations requirements in the development of policies and delivery of services. The PHA Board is satisfied that the governance and risk management processes and overall control environment will enable successful delivery of its strategy, policy and objectives.

During 2025/26 the PHA Board completed a self-assessment against the DoH Arm's Length Bodies (ALB) Board Self-Assessment Toolkit relating to the 2024/25 financial year. Overall this shows that the PHA Board functions well, and identifies progress from the previous year. An action plan has been developed to take forward further improvements. Arrangements are in place for an annual declaration of interests by all PHA Board Members and staff; the register is publicly available on the PHA website. Members are also required to declare any potential conflict of interests at board or committee meetings, and withdraw from the meeting while the item is being discussed and voted on.

3. Governance Framework

The key organisational structures which support the delivery of good governance in the PHA are:

- PHA Board;
- Governance and Audit Committee;
- Remuneration and Terms of Service Committee; and
- Planning, Performance and Resources Committee

The PHA Board is comprised of a Non-Executive Chair, seven Non-Executive members, the Chief Executive and three Executive Directors. Two non-executive posts were vacant for the whole of 2025/26.

During 2025/26, the PHA Board met on 10 occasions. The board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are in place to appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. All board meetings were quorate.

PHA Board Meeting Attendance Register 2025/26 is summarised in the table below.

Name	Meetings Attended	Meetings Contracted to attend
Mr Colin Coffey (Chair)	10	10
Mr Aidan Dawson (Chief Executive)	10	10
Dr Joanne McClean*	9	10
Ms Heather Reid* (Resigned November 2025)	5	6
Ms Emily Roberts* (Commenced December 2025)	3	4
Ms Leah Scott*	9	10
Mr Craig Blaney**	9	10
Mr John Patrick Clayton**	7	10
Ms Anne Henderson**	10	10
Mr Robert Irvine**	8	10
Mr Joseph Stewart** (Resigned December 2025)	6	7

Executive Director* * Non-Executive Director*

The Governance and Audit Committee (GAC) was chaired by Mr Joe Stewart up to December 2025 and was succeeded by Ms Anne Henderson. The *Committee* gives an assurance to the PHA Board and Accounting Officer on the adequacy and effectiveness of the PHA's system of internal control. The GAC meets at least quarterly and comprises of four Non-Executive Directors. Representatives from Internal and External Audit are also in attendance. During 2025/26 the GAC met on 5 occasions and all meetings were quorate.

The Remuneration and Terms of Service Committee (chaired by Mr Colin Coffey) advises the PHA Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets at least once every 6 months. During 2025/26, the Committee met on one occasion and the meeting was quorate.

The Planning, Performance and Resources Committee is also chaired by Mr Colin Coffey and has responsibility to:

- keep under review the financial position and performance against key non-financial targets of the board;

- to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of all resources; and
- to ensure that corporate/business planning arrangements are working effectively.

The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets four times per year. During 2025/26, the Committee met on four occasions and the meetings were quorate.

4. Framework for Business Planning and Risk Management

Business planning and risk management are central to ensuring statutory obligations and ministerial priorities are embedded throughout the organisation.

The PHA launched its new Corporate Plan 2025-2030 at the start of 2025/26. The plan sets out the Agency's medium-term ambitions, informed by the new operating model and learning from the COVID-19 pandemic. The Corporate Plan has been approved by the Department of Health (DoH). The Annual Business Plan 2025/26, which translates the Corporate Plan into deliverable actions in line with DoH guidance and priorities, was approved by the PHA Board. Both documents were developed with input from the board, staff across all Directorates and engagement with external stakeholders.

The PHA's Risk Management Strategy and Policy clearly sets out the organisation's approach to risk management, based on a five-stage process: risk identification, risk assessment, risk appetite, addressing risk, and recording and reviewing risk.

The Corporate Risk register was kept under regular review by the Agency Management Team and the board. It incorporates the 3 Lines Model of Assurance (Assurance Mapping) which is now firmly embedded. The use of a Board Assurance Framework strengthens the evidence available to the Board regarding the effectiveness of controls and their role in managing identified risks.

During 2025/26, the Director of Finance and Corporate Services held responsibility for risk management at board level. The Corporate Risk Registers are reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). Directorate Risk Registers are also reviewed by AMT and the GAC on a rotational basis. The minutes of the GAC are brought to the following PHA Board meeting, and the Chair of the GAC also provides a verbal update on governance issues including risk. The Corporate Risk Register as at 31 March 2026 was most recently considered by GAC on 16 April 2026 and subsequently reviewed by the board on 23 April 2026.

In line with an Internal Audit recommendation, board members held a workshop during 2025/26 to consider their role and responsibilities in relation to risk management and to agree a risk appetite statement. This statement defines the PHA's risk appetite for each of the core business areas and provides direction on risk-taking within the PHA.

Guidance and support continued to be provided during the year to staff responsible for reviewing and coordinating Directorate and Corporate Risk Registers. All staff are required to complete the PHA risk management e-learning programme, alongside other mandatory and relevant training, including fire safety, health and safety, security and fraud awareness.

5. Information Risk

The PHA has robust measures in place to manage and control information risks. The designated Senior Information Risk Owner (SIRO) responsible for the management of information risk at board level is the Director of Finance and Corporate Services.

The Director of Public Health as the Personal Data Guardian (PDG) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. Assistant Directors/Deputy Directors and other identified senior staff, as Information Asset Owners (IAOs), are responsible for managing and addressing risks associated with the information assets within their function and provide assurance to the SIRO on the management of those assets. The Assistant Director of Finance and Corporate Services as the Data Protection Officer (DPO) has responsibility for monitoring and advising on data protection.

The PHA's Information Governance Steering Group (IGSG) has the primary role of leading the development and implementation of the Information Governance Framework across the organisation, including ensuring that IG action plans arising from Internal and External Audit reports and the Information Management Checklist are progressed. The Group is chaired by the SIRO and membership includes all the IAOs, PDG, a Non-Executive Board member or their representatives and relevant governance staff. The IGSG is scheduled to meet three times per year and provides a report to the GAC on a regular basis in addition to providing the IGSG Action Plan to GAC annually**.** During 2025/26 the IGSG met three times.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2023-2026 sets out the framework to ensure that the PHA meets its obligations in respect of information governance, embedding this at the heart of the organisation and driving forward improvements in information governance within the PHA.

Alongside this, a range of policies and procedures are in place to ensure compliance with legislation, including Data Protection/Confidentiality Policy, Data Breach Incident Response Policy and a Data Protection Impact Assessment Policy and Guidance.

Information asset registers are in place, and are kept under review. Information risks are assessed and control measures are identified and reviewed as required. Where appropriate, information risks are incorporated in the Corporate or Directorate Risk Registers.

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and Cyber Security continues to be rolled out to all staff. Specialised training for SIRO, PDG and IAOs also took place during 2025/26. Uptake of training is monitored by the IGSG. The PHA is represented on the regional HSC Cyber Security Programme Board, and works with BSO ITS, as its IT provider, to take necessary measures in relation to cyber security risks.

During 2025/26, no personal data incidents were reported to the Information Commissioner's Office.

6. Fraud

The PHA takes a zero-tolerance approach to fraud in order to protect and support our key public services. We have an Anti-Fraud and Anti-Bribery Policy and Response Plan in place which outlines our approach to tackling fraud, defining staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer promotes fraud awareness, coordinates investigations in conjunction with the BSO Counter Fraud and Probity Services team and provides advice to personnel on fraud reporting arrangements. All staff are supported in fraud awareness in respect of the Anti-Fraud and Anti-Bribery Policy and Response Plan, which are kept under review and updated as appropriate.

A fraud report is brought to the GAC on a regular basis. During 2025/26 there were no new cases of suspected fraud.

7. Public Stakeholder Involvement

Ensuring the voice of the service user and carer is heard, understood and integrated into the culture and practice of the PHA and indeed the wider HSC, is essential, if we are to ensure that what we are commissioning and delivering, is the truly person-centred, health and social care service we are committed to. There are two key ways in which this is achieved, one is through Patient & Client Experience (PCE) and the other is through the connected area of Personal & Public Involvement (PPI).

Through the PHA's Reshape and Refresh Programme, these two approaches, were brought under the auspices of a new integrated Partnership and Engagement team in 2025/26. This team works collaboratively, to advance patient experience and service user and carer involvement. The PHA actively considers Experience & Involvement in all aspects of the commissioning process, ensuring that the input of service users and carers, underpins the identification of priorities; in the development of service models and service planning and in the evaluation and monitoring of service changes or improvements.

The PHA Partnership & Engagement Team work to advocate for adherence to legislation, policy and best practice in regards to Patient Experience and Personal & Public Involvement, both within the PHA and across the wider HSC. The Change & Withdrawal of Services Circular (published by DoH in September 2025) is the most recent Circular

issued in reference to this area. It re-affirms HSC commitment to the active involvement of service users and carers in planning and decisions that affect care. It also references the role of the PHA in regards to the provision of PPI advice to the HSC in line with our leadership role.

The PHA provides leadership for the regional Patient Client Experience programmes, the on-line User Feedback System, (Care Opinion) and also the 10,000 More Voices Programme. These provide rich information sources and insights from the lived experience of those who use HSC services, informing and influencing commissioning, planning and delivery of services. Regular reports on these are produced for consideration by Trusts, PHA, SPPG, DoH and other partners.

The PHA has also developed and adopted an updated Involvement and Consultation Scheme (2025), which sets out:

- Organisational arrangements for Involvement;
- Mechanisms for involvement opportunities;
- Support for Service Users and Carers;
- Support for Staff in Involvement and Co-Production;
- How we work with partner organisations in Involvement matters;
- Processes for Public Consultation;
- Governance, reporting and monitoring arrangements for Involvement .

The PHA continues to lead and support cultural and practical change within the HSC, so that the voice of the service user and carer is heard, and the active involvement of and partnership working with people with lived and living experience can become the norm.

8. Assurance

The Governance and Audit Committee provides an assurance to the board of the PHA on the adequacy and effectiveness of the system of internal controls in operation within the PHA. It assists the PHA Board in the discharge of its functions by providing an independent and objective review of:

- all control systems;
- the information provided to the PHA Board;
- compliance with law, guidance, Code of Conduct and Code of Accountability; and
- governance processes within the PHA Board.

Internal and External Audit have a vital role in providing assurance on the effectiveness of the system of internal control. The GAC receives, reviews and monitors reports from Internal and External Audit. Internal and External Audit representatives are also in attendance at all GAC meetings. The PHA Assurance Framework sets out a systematic and comprehensive reporting framework to the board and its committees and is normally reviewed annually.

The PHA continues to ensure that data quality assurance processes are in place across the range of data coming to the PHA Board. Information presented to the PHA Board is quality assured through the Agency Management Team (AMT) and officers attend board meetings to support scrutiny.

The PHA has in place an effective Raising a Concern in the Public Interest (Whistleblowing) Policy based on the HSC Whistleblowing Framework and Model Policy (March 2023). During 2025/26 senior staff received bespoke whistleblowing training and a whistleblowing briefing session was made available to all staff. Both sessions were provided by Protect – Speak up, stop harm.

9. Sources of Independent Assurance

The PHA obtains Independent Assurance from the following sources:

- The Regulation and Quality Improvement Authority (RQIA); and
- Internal Audit.

In addition, the PHA receives an opinion on regularity from the External Auditor in the 'Report to those charged with Governance'.

RQIA

The PHA works closely with SPPG colleagues to continue to refine and improve governance reporting and assurance mechanisms to support the commissioning of safe services. An updated Safety and Quality framework for PHA/SPPG is under development which will, in part, incorporate the identification, co-ordination, dissemination and assurance on implementation of regional learning issued by the HSCB/PHA/DoH/ RQIA and other independent/regulatory bodies. Governance and reporting structures for this work sites with the Joint Assurance Group (JAG). Extant arrangements for the provision of professional public health advice remain in place.

Internal Audit

The PHA utilises an Internal Audit function through the Service Level Agreement with Business Services Organisation. Their work is informed by an analysis of the risk to which the agency is exposed and annual audit plans are based on this analysis. During 2025/26 the Internal Audit Charter was approved by GAC in February 2026 to set out the purpose of Internal Auditing in the PHA, a commitment to adhere to the Global Internal Audit Standards; the Mandate and the organisational position and reporting relationships, including independence. Internal Audit work in 2025/26 is outlined in the table below:

System Reviewed	Level of Assurance Received*
Financial Review	**Satisfactory**
Health Protection Surveillance	**Satisfactory**
Risk Management	**Satisfactory**
Research & Development	**Satisfactory**
Governance & Assurance	**Satisfactory**
Management of Screening Programmes	**Limited**

Internal Audit's definition of levels of assurance:

Satisfactory*: Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risks identified, this should not significantly impact on the achievement of system objectives.*

Limited*: There are significant weakness within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.*

Unacceptable: *The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.*

2025/26 Internal Audit Reports with a Limited Assurance

The PHA received a limited level of assurance in relation to one audit report. A summary of the significant findings identified in this report are provided below.

Screening

Internal Audit are providing limited assurance in relation to the Management of Breast Cancer, Abdominal Aortic Aneurysm (AAA) and Newborn Hearing Population Screening Programmes. It was noted that there were inadequate performance reporting and quality assurance arrangements in place for the delivery of screening programme services. Stakeholder roles and responsibilities are not defined in an agreed Service Level Agreement or Service Specification, making it difficult to hold parties to account for the delivery, performance management and quality assurance of screening programme services. There is no framework in place for commissioning of Screening Programmes.

Whilst providing limited assurance, it was noted that uptake rates for the screening programmes reviewed were meeting targets. Eligible Service Users are being contacted to attend screening services on an equitable basis. Actions taken as a result of intelligence received (via incidents, complaints etc.) was timely and effective at improving services.

Controls noted on the Public Health Directorate Risk Register in relation to the National Health Application and Infrastructure Services (NHAIS) IT platform were found to be in place.

Follow Up on Previous Recommendations

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued 03 April 2026, found that 86 (90%) of the outstanding 96 recommendations examined were fully implemented, a further 10 (10%) were partially implemented. Work will continue during 2026/27 to address those recommendations that have not yet been fully implemented.

Overall Opinion

In her Annual Report, the Head of Internal Audit provided the following opinion on the PHA's system of internal control: *Overall for the year ended 31 March 2026, I can provide* ***Satisfactory*** *assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.*

10. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the Internal Auditors and the executive managers within the PHA who have responsibility for the development and maintenance of the internal control framework, and comments made by the External Auditors in their Report to Those Charged with Governance (RTTCWG) and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governance and Audit Committee and a plan to address weaknesses and ensure continuous improvement to the system is in place.

11. Internal Governance Divergences

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

Financial Performance

The budget for Health and Social Care in Northern Ireland continues to be challenging. The PHA approved a financial plan in June 2025 on its financial position and direct resources. Financial performance has been monitored against this plan during the financial year and the PHA is currently projecting a breakeven financial position in

2025/26. On the basis that there are controls and assurances in place in respect of this risk and monthly monitoring reports produced and shared, the divergence is considered closed.

Pause on Campaign Programme

As a result of pressures on the HSC budget the DoH introduced a pause on campaign related mass advertising by its ALB's during 2023/24 which has continued into 2025/26.

Whilst other communication channels have been deployed the evidence base demonstrates that they are less effective in reaching population wide audiences therefore the PHA 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. As this is a directive from the DoH and mitigations are in place the divergence has now been closed.

PHA Staffing Issues/Staff Resilience

During the 2025/26 year the PHA continues to consider the workforce requirements both in terms of recruitment and retention in order to fully address the recommendations in the 'Rapid, focused external review' of the Public Health Agency's resource requirements conducted by Dr R Hussey in December 2020. While significant progress has been made to populate the new operating model through the Reshape and Refresh Programme, there remain a small number of key areas which present a risk to the fulfilment of the statutory functions of the Agency. As the issue has not stemmed from a failure in governance and is primarily due to supply and demand issues within the labour market the divergence is considered closed.

Recruitment – Consultant Workforce

PHA continues to face challenges in respect to consultant staffing. The permanent recruitment process undertaken in June 2025 for both Health Protection Consultants and Generic Public Health consultants was relatively successful and we have appointed 3 new permanent consultants. Three locum consultants also joined the PHA over the last 18 months through our rolling locum recruitment. Despite this success, consultant capacity remains constrained due to a mixture of vacant posts and staff not being available for work due to leave. The Agency continues to monitor the risk via the directorate risk register. As the issue has not stemmed from a failure in governance and is primarily due to supply and demand issues within the labour market the divergence is considered closed.

Hosting of SBNI

The PHA is the corporate host of the SBNI, via arrangements which are governed by a Memorandum of Understanding (MoU). As such, SBNI expenditure is recorded within the accounts of the PHA and whilst the PHA Chief Executive has no day to day responsibility for the operations or expenditure of SBNI, he is the de facto Accounting Officer for SBNI.

The SBNI has its own Board and the Chair of the SBNI provides an annual assurance statement to the PHA Chief Executive to attest to the effectiveness of internal control within SBNI. Additional controls are being put in place to oversee this arrangement, principally through a draft revised MOU, however, the ambiguity is unlikely to be fully mitigated and may remain. As the hosting arrangement does not reflect a failure in governance the issue is now considered closed.

Public Inquiries

The Agency continues to discharge its statutory responsibility to the UK Covid-19 Inquiry through the preparation of corporate witness statements and the delivery of oral evidence across the Inquiry's constituent modules. While the Agency's live engagement with the UK Covid-19 Inquiry is anticipated to conclude in-year, it will remain necessary to allocate resources to assess and respond to any recommendations arising from the Inquiry. In addition, the Agency will be required to dedicate further resourcing to consider the implications of recommendations emerging from the anticipated outcomes of both the Urology Services Inquiry and the Muckamore Abbey Hospital Inquiry. As the Agency are proactively managing the risk presented in meeting its overall objectives within a finite pool of resources the issue is now considered closed. An update will be reflected in the performance statement going forward.

Management of Contracts with the Community and Voluntary Sector

In 2023/24 internal audit made a number of recommendations aimed at strengthening the PHA control arrangements relating to procurement when contracting with Community and Voluntary Sector. The PHA has progressed these recommendations by working with providers to review contract activity, agree revised performance measures and consider changes in how services are targeted and delivered.

During 2024/25, the PHA Procurement Board completed a comprehensive review of all existing contracts and established a clear process for the systematic review of each contract, including the funding and award mechanisms likely to be used for securing new services. The priority one finding relating to the implementation of the PHA Social Care Procurement Plan was closed in 2025/26 following the approval of the PHA Operational and Procurement Plans.

Significant progress was also made during 2025/26 across the contract's portfolio. A detailed review of Key Performance Indicators (KPIs) and Progress Monitoring Returns (PMRs) was completed across a number of thematic areas, with updated templates and revised guidance issued to staff to support consistent completion and monitoring of PMRs. In addition, all new tender awards now include outcome-based KPIs within their PMRs.

Given significant progress in this area, the PHA now considers the control divergence to be closed. The remaining control issue will be progressed and monitored through established internal governance processes.

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

Cervical Screening

Following concerns about the performance of a small number of screening staff in the SHSCT laboratory the Trust asked the Royal College of Pathologists (RCPath) to: undertake a review of laboratory data; assess whether there were any issues with laboratory performance; undertake a risk assessment; and advise of actions that should be taken forward.

The RCPath report was published by the Southern Health and Social Care Trust (SHSCT) on 30 September 2023 and contained a number of critical findings relating to performance in the SHSCT laboratory and arrangements to identify and address underperformance within the laboratory over a protracted period of time from 2008 - 2021. The report also recommended that primary HPV screening be implemented as soon as possible.

Staff from the PHA worked intensively with the SHSCT to implement a Review exercise in order to identify women whose last screening samples were processed in the SHSCT by those screeners whose performance had been highlighted in the report. The review completed in autumn 2024 and the outcomes report was published in December 2024, alongside a companion report describing cervical cancer cases in the SHSCT during the affected time period. The review found that the vast majority of previous smear results were unchanged and were reconfirmed as normal. An external expert opinion on the findings of the review was commissioned with the report received in March 2025. This report endorsed the robustness of the review process and noted that the rate of abnormalities found at review indicated a relatively high sensitivity of the original result. This report was published in November 2025.

Primary HPV screening was introduced across Northern Ireland on 11 December 2023. As the next phase of this significant service change, the PHA led a reconfiguration of laboratory services during 2024/25. All cervical screening laboratory services were transitioned to one site within Belfast Trust from 1 November 2024. There has been ongoing work with the BHSCT to manage laboratory turnaround times as a result of this service change and to stabilise the service for the future with particular focus on the outsourcing of HPV testing due to an equipment failure earlier in the year.

A new regional contract for cellular pathology equipment was awarded in February 2026, following a protracted procurement process. This contract includes replacement of the processing and analytic equipment within the cervical screening laboratory. The PHA will continue to work with the Belfast Trust to ensure that this replacement is expedited over coming months with minimal disruption to the delivery of the service.

The PHA commissions the provision of three Cancer Screening Programmes and

oversees Quality Assurance for those programmes. Cervical screening is one of these programmes. There is a Quality Assurance Structure in place, led by the PHA, the core purpose of which is to maintain national standards and promote continuous improvement in the cancer screening programmes to ensure that all eligible people have access to a consistently high-quality of service wherever they live and in line with NI Department of Health's population screening policy.

While the RCPath Consulting report was commissioned by and focused on the Southern Trust laboratory, it was considered prudent to review the Quality Assurance function carried out by PHA and how the issues relating to underperformance were present in one of the laboratories carrying out cytology for the screening programme over a 13-year period. Screening experts from NHS England completed a detailed peer evaluation of our oversight and QA processes within the cervical screening programme laboratory service. The report of this evaluation was published in November 2025 and makes a number of recommendations for improvement. The PHA has developed an action plan to take forward these recommendations.

In response to a multi-patient SAI report in the SHSCT related to the audit of invasive cervical cancers (published November 2025), the DoH asked the PHA to lead a regional piece of work to improve and standardise the patient disclosures process associated with the audit. This is building on a quality improvement project already undertaken in the SHSCT. The PHA secured additional capacity from the HSC Leadership Centre to scope this work by end December 2025, which included engagement with all Trusts. This work looked at the whole audit and disclosure process in the context of the laboratory service reconfiguration and brought forward proposals for change. A pilot and implementation phase are in progress, to be completed by end June 2026.

In November 2025, the Minister announced the appointment of Professor Sir Frank Atherton to undertake an expert review of all published reports to date. This independent review assessed the findings of the existing reports and was submitted directly to the Minister. The review sought to address the key issues identified and to determine whether a statutory public inquiry was required. Following publication of the review in May 2026, it concluded that a statutory public inquiry was not necessary to provide a more comprehensive examination of the events in question. The PHA will collaborate with the Department of Health and the Southern Health and Social Care Trust to take forward any additional learning arising from this report.

Management of Vaccine Programme

During 2024/25 the PHA received limited assurance in relation to the management of vaccines where weaknesses in stock management issues, governance arrangements and contract spend oversight were identified.

The PHA immunisation team manages circa 30 public vaccine programmes across NI. One of the main systems used for administration and tracking of the vaccines is the

Vaccine Management System (VMS) which transferred to the PHA from the DoH during 2023. During the course of the audit, gaps were identified in the process used for the management and validation of stock levels. The main contributing factor identified was insufficient information being provided by the contracted supplier and the vaccine administrators e.g. GP Surgery. As the VMS system informs the setting of delivery quotas for the following year this is contributing to the level of vaccine which remain unused at the end of the season. The situation is also complicated by the current contractual arrangements in place.

The team have implemented a number of improvements to the programme following the internal audit:

- The appointment of a Band 6 Vaccine Logistics Coordinator to oversee the management of the PHA-owned vaccine stock. Stock is managed via an operational dashboard which displays vaccines ordered and vaccines administered.
- PHA uses this information to inform individual GP practices of their waste to raise awareness of their own ordering behaviour, vaccine waste and uptake. The team have developed new vaccine ordering forms which will ask practices to demonstrate their stock usage prior to placing a request for additional vaccine. GP practices are asked that they also declare any wasted vaccine prior to placing an uplift request.
- Furthermore, work is progressing to align GP payments to administrations recorded on VMS. This will facilitate better monitoring through improved data quality and therefore provides a more complete picture of vaccine usage and waste and may identify other measures that might support reduced waste.
- In terms of movement of vaccine stock regionally, PHA cross checks vaccine stock delivered in alignment with individual practice quotas. In addition, spot checks are now in place for the contracted distributer to provide delivery notes (with signed proof of delivery). Checks take place across all products, geographies and provider type. Presence of signature and job title of signatory are checked.
- The team have developed a new Memorandum of Understanding between SPPG, DoH, the Regional Pharmaceutical Procurement Service and PHA to formalise the roles and responsibilities relating to the strategic and operational implementation of vaccination programmes.

Trust Commissioned Services

During 2024/25 the PHA received limited assurance in relation to the audit of trust commissioned services where weaknesses in relation to performance management arrangements with HSC and the lack of a legacy business case register were identified.

The report highlighted the need to standardise and strengthen the approach to performance management with HSC Trusts and the need to develop a framework of accountability to ensure robust monitoring. The establishment of a formal review process by PHA to ensure services, currently commissioned, are sufficiently aligned to population needs was also identified. The report contains a priority one recommendation which

relates to a funding stream from PHA to HSC Trust which no longer falls within the PHA remit. This funding has now been transferred to SPPG who will monitor future performance of the initiative. PHA has established a project team to review Contract Management Processes. A key objective of this Team is to consider the audit recommendations and develop new performance management processes that will address the issues highlighted. The Project team has completed its work and will formally report in April 2026. During 2025/26 significant progress has been made to improve the performance management processes and accountability arrangements. Two of the four outstanding audit recommendations have now been fully implemented and it is anticipated that the remaining two will be fully implemented by the middle of 2026/27.

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

There have been no new issues identified in the current year.

12. Conclusion

The PHA maintains a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI (MPMNI).

Further to considering the accountability framework within the PHA and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the PHA has operated a sound system of internal governance during the period 2025/26.

Remuneration and Staff Report

Section 421 of the Companies Act 2006 requires the preparation of a Remuneration Report containing certain information about the Directors' remuneration in accordance with the requirements of Part 4 and Schedule 8 of Statutory Instrument 2008 No. 410.

Remuneration Policy

A committee of Non-Executive Board members exists to advise the full Board on the remuneration and terms and conditions of service for Senior Executives employed by the Public Health Agency (PHA).

While the salary structure and the terms and conditions of service for Senior Executives is determined by the Department of Health (DoH), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, in accordance with DoH policy, recommending progression through incremental pay scales subject to satisfactory performance.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the PHA received any other bonus or performance related pay in 2025/26. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts is normally for a term of four years. Details of newly appointed Non-Executive Directors or those leaving post have been detailed in the Non-Executive Directors Remuneration tables below. Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Senior Executive Pay

Following the introduction by the Department of Health (DoH) of the revised senior executive pay structures circular during 2025, a new pay framework was introduced for all Senior Executives who were in post at 1 April 2023. The revised framework introduced incremental pay scales, with progression subject to satisfactory performance. The impact of these changes is reflected in the Senior Employees' Remuneration disclosures in this report

The revised pay arrangements are subject to an ongoing legal challenge by Senior HSC Executives. A provision has therefore been retained in respect of former Senior Executives who were in post prior to 2023/24, with a value of £157k recognised in 2025/26.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2025/26 or 2024/25.

Membership of the Remuneration and Terms of Service Committee:

Mr Colin Coffey – Chair
Ms Anne Henderson – Non-Executive Director
Mr Craig Blaney – Non-Executive Director

The Committee is supported by the Director of Human Resources (BSO).

Non-Executive and Senior Employee's Remuneration and Pension Entitlement

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA are shown in the following table. It should be noted that there were no bonuses paid to any Director during 2025/26 or 2024/25.

Non-Executive Members (Table Audited)

Name	2025/26				2024/25			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Colin Coffey *(Chair)*	40-45	-	-	40-45	40-45	-	-	40-45
Professor Nichola Rooney *(Left 28 February 2025)*	0-5	-	-	0-5	10-15 (10-15 FYE)	-	-	10-15
Mr John-Patrick Clayton	10-15	-	-	10-15	10-15	-	-	10-15
Mr Joseph Stewart *(Left 31 December 2025)*	5-10	-	-	5-10	10-15	-	-	10-15
Mr Robert Irvine	10-15	-	-	10-15	10-15	-	-	10-15
Ms Anne Henderson	10-15	-	-	10-15	10-15	-	-	10-15
Mr Craig Blaney	10-15	-	-	10-15	10-15	-	-	10-15

FYE – Full Year Equivalent

Notes:

- *No Non-Executive Members have received benefits in kind below £50 which would have been rounded down to nil as specified in the second column of the table above.*
- *Payments to Non-Executive Members are based on DoH Circular HSC(F) 23-2024, with the most recent payments made being effective from 26 November 2024.*

Executive Members (Table Audited)

Name	2025/26				2024/25			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Aidan Dawson *Chief Executive*	180-185	-	105,000	285-290	160-165	-	31,000	190-195
Dr Aideen Keaney *Director of HSCQI (Ended 30 Sept 2024)*	-	-	-	-	60-65 (120-125 FYE)	-	58,000	115-120
Ms Leah Scott *Director of Finance & Corporate Services*	110-115	-	58,000	170-175	100-105	-	22,000	120-125
Dr Joanne McClean *Director of Public Health*	170-175	-	150,000	320-325	160-165	-	90,000	255-260
Emily Roberts *Interim Director of Nursing, Midwifery & Allied Health Professionals (Started 1 Dec 2025)*	40-45 (125-130 FYE)	-	134,000	175-180	-	-	-	-
Ms Heather Reid *Director of Nursing, Midwifery & Allied Health Professionals (Ended 30 Nov 2025)*	85-90 (135-140 FYE)	-	51,000	135-140	120-125	-	32,000	150-155

FYE – Full Year Equivalent

Notes:

- *No compensation for early retirement or loss of office was paid in the current year.*
- *The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation and any increase or decrease due to a transfer of pension rights.*

Salary

Salary includes gross salary and any other allowance to the extent that it is subject to UK taxation. This report is based on accrued payments made by the PHA and thus recorded in these accounts.

Benefits in Kind (Audited)

The monetary value of benefits in kind covers any benefits provided by the employer and treated by HM Revenue and Customs as a taxable emolument.

Pensions of Senior Management (Table Audited)

Name	2025/26				
	Real increase in pension and related lump sum at age 60 £000	Total accrued pension at age 60 and related lump sum £000	CETV at 31/03/25 £000	CETV at 31/03/26 £000	Real increase in CETV £000
Mr Aidan Dawson *Chief Executive*	5.5-6 pension 8-8.5 lump sum	70-75 pension 180-185 lump sum	1,270	1,762	149
Emily Roberts *Interim Director of Nursing & Allied Health Professionals*	6.5-7.0 pension 14-14.5 lump sum	40-45 pension 100-105 lump sum	-	1,086	181
Dr Joanne McClean *Director of Public Health*	7.5-8 pension 14-14.5 lump sum	55-60 pension 130-135 lump sum	955	1,176	171
Ms Leah Scott *Director of Finance & Corporate Services*	3.5-4 pension Nil lump sum	40-45 pension Nil lump sum	24	670	63
Ms Heather Reid *Director of Nursing & Allied Health Professionals*	3-3.5 pension Nil lump sum	55-56 pension Nil lump sum	1,124	1,293	15

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to transfer of pension rights, but include actuarial uplift factors and therefore can be positive or negative.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are a member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves the scheme and chooses to transfer their benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total service, not just their service in a senior capacity to which disclosure applies.

The CETV figures, and from 2003/04 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with The Occupational Pension Schemes (Transfer Values) Regulations 1996 (as amended).

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2026. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2025/26 CETV figures.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period (which therefore disregards the effect of any changes in factors).

Fair Pay Disclosures Tables (Audited)

The relationship between the remuneration of the highest-paid director and the lower quartile, median and upper quartile remuneration of the workforce is set out below.

Total remuneration includes salary, non-consolidated performance-related pay, and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

	2026	2025
Band of Highest Paid Director's Remuneration	£180-185k	£160-165k
Percentage Change of Highest Paid Director	11.41%	10%
Median Total Remuneration	£50,273	£48,526
Ratio	3.63	3.35

The remuneration of the highest paid Director has increased as a result of the Department of Health introducing a Senior Executive Pay Structure Reform in 2025 which impacts all Senior Executives in post at 1 April 2023. The estimated impact of these changes has been accrued at 31 March 2026. This has also resulted in an increase to the pay ratios in respect of the median remuneration, 25th and 75th percentiles.

The movement in ratio calculations for 2025/26 from 2024/25 is consistent with the pay, reward and progression policies for the PHA taken as a whole.

Further detail on pay ratio information is contained in the tables below;

	2025/26	25th Percentile	75th Percentile
Mid-Point of Top Salary	182,500	40,823	64,455
Ratio		4.47	2.83

	2024/25	25th Percentile	75th Percentile
Mid-Point of Top Salary	162,500	37,338	60,504
Ratio		4.35	2.69

In 2025/26, no employees received remuneration in excess of the highest paid director. Remuneration ranged from £7,626 to £180,451 in 2025/26 (£7,404 to £161,967 in 2024/25). The lowest salary relates to Safeguarding Board lay members.

For both 2025/26 and 2024/25, the 25th percentile, median and 75th percentile remuneration values consisted solely of salary payments.

Further detail on average salary is contained in the table below;

	2025/26 (£)	2024/25 (£)	Increase/ (Decrease) (£)	Change (%)
Average Salary	56,651	52,256	4,395	8.41%

Staff Report

Staff Costs (Table Audited)

PHA staff costs comprise:

	2026			2025
	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Wages and salaries	22,065	1,708	23,773	22,867
Social security costs	2,986	169	3,155	2,711
Other pension costs	4,666	266	4,932	4,837
Total staff costs reported in Statement of Comprehensive Net Expenditure	**29,717**	**2,143**	**31,860**	**30,415**
Less recoveries in respect of outward secondments			(488)	(582)
Total net costs			**31,372**	**29,833**

The PHA participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years.

The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2020 scheme valuation was completed by GAD in October 2023. The outcome of this valuation was used to set the level of contributions for employers from 1 April 2024 to 31 March 2027.

Pension benefits are administered by BSO HSC Pension Service. Two schemes are in operation, HSC Pension Scheme and the HSC Pension Scheme 2015. There are two sections to the HSC Pension Scheme (1995 and 2008) which was closed with effect from 1 April 2015 except for some members entitled to continue in this Scheme through 'Protection' arrangements. On 1 April 2015 a new HSC Pension Scheme was introduced. This new scheme covers all former members of the 1995/2008 Scheme not eligible to

continue in that Scheme as well as new HSC employees on or after 1 April 2015. The 2015 Scheme is a Career Average Revalued Earnings (CARE) scheme.

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy, known as the 'McCloud Remedy' puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Stage 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Stage 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

In complying with FReM, for 2025/26 pensions are being calculated using the rolled back opening balance, the rolled back closing balance, calculation of CETV by BSO HSC Pension Service on the rolled back basis and no restatement of prior year figures, where disclosed. All benefits accrued from 1 April 2022 onwards are calculated under the 2015 CARE Scheme. BSO HSC Pension Service will contact retirees with personalised information to assist in making their retrospective choice regarding the remedy period.

Following a public consultation, the DoH introduced changes to the amount members pay towards their HSC pension. The changes include the pensionable pay ranges used to decide how much members contribute to their pension and the percentage of members' pay to be a member of the scheme. The latter change means the amount payable will be based on a member's actual annual rate of pay, rather than their whole-time equivalent. For part-time staff, their contribution rate will now be based on how they are paid, instead of how much they would earn if they worked full-time.

The table below sets out the member contribution rates that apply in both the HSC Pension Scheme and the HSC Pension Scheme 2015 from 1 November 2022.

Pensionable salary range	Contribution rates (before tax relief & based on actual annual pensionable pay)
Up to £13,259	5.2%
£13,260 to £27,288	6.7%
£27,289 to £33,247	8.5%
£33,248 to £49,913	10.0%
£49,914 to £63,994	10.9%
£63,995 and above	12.7%

Average Number of Persons Employed (Table Audited)

The average number of whole time equivalent (WTE) persons employed during the year was as follows:

	2026			2025
	Permanently employed staff	Others	Total	Total
Commissioning of Health and Social Care	394	22	**416**	**409**
Less average staff number in respect of outward secondments	(6)	0	**(6)**	**(6)**
Total net average number of persons employed	**388**	**22**	**410**	**403**

Reporting of Early Retirement and other Compensation Schemes – Exit Packages (Audited)

There were no exit packages agreed and accounted for in 2025/26 or 2024/25. No exit costs were paid in 2025/26 (2024/25: nil).

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation (Northern Ireland) Order 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the PHA and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The PHA had no staff benefits in 2025/26 or 2024/25.

Retirements Due to Ill-Health

During 2025/26, there were two early retirements from the PHA on the grounds of ill-health (2024/25: nil). The estimated additional pension liabilities of these ill-health retirements will be £3.8k. These costs are borne by the HSC Pension Scheme.

Staff Composition

The staff composition broken down by male/female as at 31 March 2026 is illustrated in the table below:

	Male	Female	Total
Non-Executives	7	4	11
Chief Executive and Directors	1	3	4
Senior Management*	15	44	59
Other	73	283	356
Total	**96**	**334**	**430**

**Senior management is defined as staff in receipt of a basic whole-time equivalent salary of an Agenda for Change Band 8C or above and staff on Medical and Dental grades*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2025 to 31 March 2026 is 4.60% (2024/25, 4.02%).

There were 35,037 hours lost due to sickness absence (2024/25: 30,076 hours), or the equivalent of 84.22 hours (2024/25: 74.25 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 11.3 days per employee (2024/25: 9.9 days).

Staff Turnover Percentage

For a given period, the total turnover figure is calculated as the number of leavers within that period divided by the average employee headcount over the period. Voluntary turnover includes leavers classified under the categories of resignation, retirement or ill-health retirement. Involuntary turnover includes leavers classified under the categories of dismissal, end of fixed term contract or ill-health termination.

Staff Turnover %	2026	2025
Total Staff Turnover	6.96%	9.13%
Split between:		
Voluntary Turnover	5.04%	6.17%
Involuntary Turnover	1.92%	2.96%

Staff Policies / Employment and Occupation

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to promoting equality of opportunity and good relations for all groupings under Section 75 of the Northern Ireland Act 1998.

The PHA has a range of policies in place that serve to advance this aim, including, on the employment side, the Equality of Opportunity Policy. More information is available on the PHA's website at www.publichealth.hscni.net.

Where an employee has become disabled during the course of their employment with the PHA, the organisation works closely with Human Resources (BSO HR Shared Services) who are guided by advice from Occupational Health.

Subsequently, reasonable adjustments can be made to accommodate the employee such as reduced hours, work adjustments including possible redeployment, in line with relevant disability legislation. This legislation is incorporated into selection and recruitment training and induction training and is highlighted in relevant policies where necessary.

The PHA is fully committed to the ongoing training and development of all members of staff and through the performance appraisal system all staff are afforded this opportunity irrespective of ability/disability as well as having the same opportunities to progress through the organisation.

The PHA also participates in the Disability Placement Scheme which provides a six-month placement for those with a disability wishing to return to the workplace. During their placement they receive support and guidance – for example, guidance on the completion of application forms when applying for future posts.

Expenditure on Consultancy

The PHA had no expenditure on External Consultancy during 2025/26 (2024/25: nil).

Off-Payroll Engagements

The PHA is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed who earn more than £245 per day and lasted longer than 6 months during the financial year, which were not paid through the PHA Payroll. The PHA had two such 'off-payroll' staff resource engagements as at 31 March 2026 (2024/25: 2).

The following tables provide further analysis:

Temporary Off-Payroll Worker Engagements	**2026**	**2025**
Number of off-payroll workers engaged during the year ended 31 March	2	2
of which:		
Number determined as out-of-scope of IR35	2	2
Number determined as in-scope of IR35	0	0
Number of engagements reassessed for compliance or assurance purposes during the year	0	0

	2026	**2025**
Number of off-payroll engagements at 31 March	2	2
of which:		
Existed for less than one year at time of reporting	0	0
Existed for between one and two years at time of reporting	1	1
Existed for between two and three years at time of reporting	0	1
Existed for between three and four years at time of reporting	1	0

These engagements were via a contracted Recruitment Agency and comply with IR35 requirements. No penalty was imposed by HMRC resulting from non-compliance with off-payroll worker legislation.

Assembly Accountability and Audit Report

Funding Report

Regularity of Expenditure (Audited)

The PHA has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit. During 2025/26 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments (Audited)

Losses Statement	2025/26	2024/25
Total number of losses	1	1
Total value of losses (£)	£1,176k	£1,413k

Individual losses over £300k are shown in the table below:

	2025/26		2024/25
	Number	£'000	£'000
Fruitless Payments (PHA)			
Total number of losses	1	1,176	1,413

The loss disclosed above relates to flu vaccine purchased in the year that remained unused at year-end, which cannot be used in future years and so meets the definition of a fruitless payment. While ensuring sufficient supply means there will always be some level of unused vaccine stock, PHA have taken steps to minimise the level of this loss going forward.

Special Payments (Audited)

There were no special payments made during the year (2024/25: one, £85k).

Other Payments and Estimates

There were no other payments made during the year (2024/25: 0).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 19 of the financial statements, the PHA also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability. As at 31 March 2026, the PHA is not aware of any remote contingent liabilities, and there were none in 2024/25.

On behalf of the PHA, I approve the Accountability Report encompassing the following sections:

- Governance Statement.
- Remuneration and Staff Report.
- Assembly Accountability and Audit Report.

_____

Aidan Dawson
Chief Executive
Date: 18 June 2026

The Certificate and Report of the Comptroller and Auditor General to the Northern Ireland Assembly

Opinion on financial statements

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2026 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies.

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

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

In my opinion the financial statements:

- give a true and fair view of the state of Public Health Agency's affairs as at 31 March 2026 and of the Public Health Agency's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

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

Basis for opinions

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

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

Conclusions relating to going concern

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

The going concern basis of accounting for the Public Health Agency is adopted in consideration of the requirements set out in the Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

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

Other Information

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

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

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Department of Health directions issued under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

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

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

Matters on which I report by exception

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

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

Responsibilities of the Board and Accounting Officer for the financial statements

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

- maintaining proper accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud of error;
- ensuring the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with the applicable financial reporting framework; and
- assessing the Public Health Agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Public Health Agency will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

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

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

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

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Public Health Agency through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder;
- making enquires of management and those charged with governance on Public Health Agency's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of the Public Health Agency's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and the posting of unusual journals;
- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit

procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;

- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business.

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

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

Report

I have no observations to make on these financial statements.

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

26 June 2026

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2026

FOREWORD

These accounts for the year ended 31 March 2026 have been prepared in a form determined by the Department of Health (DoH) based on guidance in the Government Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

PUBLIC HEALTH AGENCY

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2026

This account summarises the expenditure and income generated and consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

	NOTE	2026 £000	2025 £000
Income			
Revenue from contracts with customers	4.1	628	728
Other operating income (excluding interest)	4.2	488	582
Total Operating Income		1,116	1,310
Expenditure			
Staff costs	3	(31,860)	(30,415)
Purchase of goods and services	3	(65,327)	(62,251)
Depreciation, amortisation and impairment charges	3	(1,458)	(1,639)
Provision expense	3	(99)	(698)
Other operating expenditure	3	(5,126)	(4,448)
Total Operating Expenditure		(103,870)	(99,451)
Net Operating Expenditure		**(102,754)**	**(98,141)**
Finance expense	3	(1)	(2)
Net Expenditure for the Year		(102,755)	(98,143)
Revenue Resource Limits (RRLs) and capital grants issued (to)			
Belfast Health & Social Care Trust		(19,515)	(17,372)
South Eastern Health & Social Care Trust		(5,793)	(6,363)
Southern Health & Social Care Trust		(8,682)	(9,123)
Northern Health & Social Care Trust		(10,008)	(10,476)
Western Health & Social Care Trust		(8,609)	(8,902)
NI Ambulance Service		(111)	(122)
Total RRL issued		(52,718)	(52,358)
Total Commissioner Resources Utilised		(155,473)	(150,501)
Adjustment to net expenditure for non cash items	22.1	10,290	9,125
Total Commissioner resources funded from RRL		(145,183)	(141,376)
Revenue Resource Limit (RRL) received from DOH	22.1	145,271	141,453
Surplus / (Deficit) against RRL		**88**	**77**

		2026 £000	2025 £000
OTHER COMPREHENSIVE EXPENDITURE			
Items that will not be reclassified to net operating costs			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/5.2/8	1	0
TOTAL COMPREHENSIVE EXPENDITURE for the Year Ended 31 March		**(102,754)**	**(98,143)**

The notes on pages 78 to 109 form part of these accounts.

PUBLIC HEALTH AGENCY

Statement of Financial Position for the Year Ended 31 March 2026

This statement presents the financial position of the Public Health Agency. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

	NOTE	2026 £000	£000	2025 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	362		90	
Right-of-use assets	5.1/5.2/16	60		162	
Intangible assets	6.1/6.2	1,425		2,821	
Total Non Current Assets			1,847		3,073
Current Assets					
Inventories	10	567		1,088	
Trade and other receivables	12	625		636	
Other current assets	12	311		274	
Cash and cash equivalents	11	435		417	
Total Current Assets			1,938		2,415
Total Assets			**3,785**		**5,488**
Current Liabilities					
Trade and other payables	13	(8,865)		(8,817)	
Other liabilities	13/16	(55)		(110)	
Provisions	14	(206)		(156)	
Total Current Liabilities			(9,126)		(9,083)
Total Assets less Current Liabilities			**(5,341)**		**(3,595)**
Non Current Liabilities					
Provisions	14	(1,006)		(909)	
Other liabilities	13/16	0		(55)	
Total Non Current Liabilities			(1,006)		(964)
Total Assets less Total Liabilities			**(6,347)**		**(4,559)**
Taxpayers' Equity and Other Reserves					
Revaluation reserve		5,325		5,321	
SoCNE Reserve		(11,672)		(9,880)	
Total Equity			**(6,347)**		**(4,559)**

The notes on pages 78 to 109 form part of these accounts.

The financial statements on pages 74 to 77 were approved by the Board on 18 June 2026 and were signed on its behalf by:

Signed (Chair) 18 June 2026

Signed (Chief Executive) 18 June 2026

PUBLIC HEALTH AGENCY

Statement of Cash Flows for the Year Ended 31 March 2026

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Public Health Agency during the reporting period. The statement shows how the Public Health Agency generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Public Health Agency. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Public Health Agency's future public service delivery.

	NOTE	2026 £000	2025 £000
Cash flows from operating activities			
Net operating expenditure	SoCNE	(102,755)	(98,143)
Adjustments for non cash transactions	3	1,740	2,475
(Increase)/decrease in trade and other receivables	12	(26)	3,668
(Increase)/decrease in inventories	10	521	(1,088)
Increase/(decrease) in trade and other payables	13	(62)	(6,938)
Less movements in payables relating to items not passing through the Net Expenditure Adjustment (NEA)			
Movements in payables relating to finance leases	13	110	109
Net cash inflow/(outflow) from operating activities		(100,472)	(99,917)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(382)	0
(Purchase of intangible assets)	6	0	(270)
Net cash outflow from investing activities		(382)	(270)
Cash flows from financing activities			
Grant in aid		100,932	100,320
Capital element of bringing lease onto Balance Sheet		(60)	(110)
Net financing		100,872	100,210
Net increase/(decrease) in cash & cash equivalents in the period		18	23
Cash & cash equivalents at the beginning of the period	11	417	394
Cash & cash equivalents at the end of the period	11	**435**	**417**

The notes on pages 78 to 109 form part of these accounts.

PUBLIC HEALTH AGENCY

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2026

This statement shows the movement in the year on the different reserves held by the Public Health Agency, analysed into the SoCNE Reserve (i.e. that reserve that reflects a contribution from the Department of Health). The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. The SoCNE Reserve represents the total assets less liabilities of the Public Health Agency to the extent that the total is not represented by other reserves and financing items.

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2024		**(12,086)**	**5,322**	**(6,764)**
Changes in Taxpayers' Equity 2024/25				
Grant from DOH		100,320	0	100,320
(Comprehensive expenditure for the year)		(98,143)	(1)	(98,144)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	29	0	29
Balance at 31 March 2025		**(9,880)**	**5,321**	**(4,559)**
Changes in Taxpayers' Equity 2025/26				
Grant from DOH		100,932	0	100,932
(Comprehensive expenditure for the year)		(102,755)	1	(102,754)
Transfer of asset ownership		0	3	3
Non cash charges - auditors remuneration	3	31	0	31
Balance at 31 March 2026		**(11,672)**	**5,325**	**(6,347)**

The notes on pages 78 to 109 form part of these accounts.

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

These financial statements have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2) (a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003 and the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Public Health Agency (PHA) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

In addition, due to the manner in which the PHA is funded, the Statement of Financial Position will show a negative position. In line with the FReM, sponsored entities such as the PHA which show total net liabilities, should prepare financial statements on a going concern basis. The cash required to discharge these net liabilities will be requested from the DoH when they fall due, and is shown in the Statement of Changes in Taxpayers' Equity.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and liabilities.

1.2 Currency and Rounding

These accounts are presented in UK Pounds (£) sterling. The figures in the accounts are shown to the nearest £1,000, which may give rise to rounding differences.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Buildings, Information Technology, Furniture & Fittings and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or operational potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation

All Property, Plant and Equipment are carried at fair value.

The PHA does not hold any land, and the buildings occupied by the PHA are held under lease arrangements.

Assets under Construction (AUC)

Assets classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid, or a liability has been incurred. They are carried at cost, less any impairment loss. Assets under construction are revalued and depreciation commences when that are brought into use.

Short Life Assets

Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where estimated life of fixtures and equipment exceed 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long-established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of "non-current assets held for sale" are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the PHA expects to obtain economic benefits or operational capacity from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

The following asset lives have been used.

Asset Type	Asset Life
Freehold Buildings	25 – 60 years
Leasehold property	Remaining period of lease
IT assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the

impairment in the revaluation reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the PHA's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible assets

Intangible assets include any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible assets under construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible non-current asset. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or operational capacity;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PHA's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or operational capacity be provided to, the PHA; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition may be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

The PHA had no non-current assets held for sale in either 2025/26 or 2024/25.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value and are included exclusive of VAT. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

Income relates directly to the activities of the PHA and is recognised on an accruals basis when, and to the extent that a performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised.

Where the criteria to determine whether a contract is in existence is not met, income is classified as Other Operating Income within the Statement of Comprehensive Net Expenditure and is recognised when the right to receive payment is established.

Income is stated net of VAT.

Grant in aid

Funding received from other entities, including the Department is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The PHA did not hold any investments in either 2025/26 or 2024/25.

1.12 Research and Development expenditure

Research and development (R&D) expenditure is expensed in the year it is incurred in accordance with IAS 38.

Following the introduction of the 2010 European System of Accounts (ESA10) and the change in the budgeting treatment (from the revenue budget to the capital budget) of R&D expenditure, additional disclosures are included in the notes to the accounts. This treatment was implemented from 2016-17.

1.13 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Under IFRS 16 Leased Assets which the PHA has use/control over and which it does not necessarily legally own are to be recognised as a ‘Right-Of-Use’ (ROU) asset. There are only two exceptions:

- short term assets – with a life of up to one year; and
- low value assets – with a value equal to or below the Department's threshold limit which is currently £5,000.

Short term leases

Short term leases are defined as having a lease term of 12 months or less. Any lease with a purchase option cannot qualify as a short-term lease. The lessee must not exercise an option to extend the lease beyond 12 months. No liability should be recognised in respect of short-term leases, and neither should the underlying asset be capitalised.

Lease agreements which contain a purchase option cannot qualify as short-term.

Examples of short-term leases are software leases, specialised equipment, hire cars and some property leases.

Low value assets

An asset is considered "low value" if its value, when new, is less than the capitalisation threshold. The application of the exemption is independent of considerations of materiality. The low value assessment is performed on the underlying asset, which is the value of that underlying asset when new.

Examples of low value assets are, tablet and personal computers, small items of office furniture and telephones.

Separating lease and service components

Some contracts may contain both a lease element and a service element. DoH bodies can, at their own discretion, choose to combine lease and non-lease components of contracts, and account for the entire contract as a lease. If a contract contains both lease and service components IFRS 16 provides guidance on how to separate those components. If a lessee separates lease and service components, it should capitalise amounts related to the lease components and expense elements relating to the service elements. However, IFRS 16 also provides an option for lessees to combine lease and service components and account for them as a single lease. This option should help DoH bodies where it is time consuming or difficult to separate these components.

The PHA as lessee

The ROU asset lease liability will initially be measured at the present value of the unavoidable future lease payments. The future lease payments should include any amounts for:

- indexation;
- amounts payable for residual value;
- purchase price options;
- payment of penalties for terminating the lease;
- any initial direct costs; and
- costs relating to restoration of the asset at the end of the lease.

The lease liability is discounted using the rate implicit in the lease.

Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the PHA's surplus/deficit.

The difference between the carrying amount and the lease liability on transition is recognised as an adjustment to taxpayer's equity. After transition the difference is recognised as income in accordance with IAS 20.

Subsequent measurement

After the commencement date (the date that the lessor makes the underlying asset available for use by the lessee) a lessee shall measure the liability by;

- increasing the carrying amount to reflect interest;
- reducing the carrying amount to reflect lease payments made; and
- re-measuring the carrying amount to reflect any reassessments or lease modifications, or to reflect revised in substance fixed lease payments.

There is a need to reassess the lease liability in the future if there is:

- a change in lease term;
- a change in assessment of purchase option;
- a change in amounts expected to be payable under a residual value guarantee; or
- a change in future payments resulting from change in index or rate.

Subsequent measurement of the ROU asset is measured in same way as other property, plant and equipment. Asset valuations should be measured at either 'fair value' or 'current value in existing use'.

Depreciation

Assets under a finance lease or ROU lease are depreciated over the shorter of the lease term and its useful life, unless there is a reasonable certainty the lessee will obtain ownership of the asset by the end of the lease term in which case it should be depreciated over its useful life.

The depreciation policy is that for other depreciable assets that are owned by the entity.

Leased assets under construction must also be depreciated.

The PHA as lessor

The PHA did not have any lessor agreements in either 2025/26 or 2024/25.

1.16 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2025/26 or 2024/25.

1.17 Financial instruments

A financial instrument is defined as any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

The PHA has financial instruments in the form of trade receivables and payables and cash and cash equivalents.

Financial assets

Financial assets are recognised on the Statement of Financial Position when the PHA becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. IFRS 9 requires consideration of the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the PHA's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument, where judged necessary.

Financial assets are classified into the following categories:

- financial assets at fair value through Statement of Comprehensive Net Expenditure;
- held to maturity investments;
- available for sale financial assets; and
- loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the PHA becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with the DoH, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the PHA is not exposed to the degree of financial risk faced by business entities.

The PHA has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the PHA in undertaking activities. Therefore, the PHA is exposed to limited credit, liquidity or market risk.

Currency risk

The PHA is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PHA therefore has low exposure to currency rate fluctuations.

Interest rate risk

The PHA has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

Credit and liquidity risk

Since the PHA receives the majority of its funding from the DoH, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when there is a present legal or constructive obligation as a result of a past event, it is probable that the PHA will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, it's carrying amount is the present value of those cash flows using the relevant discount rates provided by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.19 Contingent liabilities/assets

In addition to contingent liabilities disclosed in accordance with IAS 37, the PHA discloses for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the PHA discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA. A contingent asset is disclosed where an inflow of economic benefits is probable.

1.20 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2026. (Untaken flexi leave is estimated to be immaterial to the PHA and has not been included).

Retirement benefit costs

Past and present employees are covered by the provisions of the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the DoH.

The costs of early retirements, except those for ill-health retirements, are met by the PHA and charged to the Statement of Comprehensive Net Expenditure at the time the PHA commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years.

The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The scheme valuation data provided for the 2020 actuarial valuation will be used in the 2025/26 accounts. The 2020 valuation assumptions will be retained for demographic assumptions apart from the assumption for future longevity improvements, which are assumed to be in line with the 2022-based population projections for the United Kingdom published by the Office for National Statistics (ONS) on 28 January 2025. Financial assumptions are updated to reflect recent financial conditions. The 2024 valuation is underway but not sufficiently progressed to be used in the 2025/26 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.22 Value Added Tax (VAT)

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.23 Third party assets

The PHA had no third-party assets in 2025/26 or 2024/25.

1.24 Government Grants

The PHA had no government grants in 2025/26 or 2024/25.

1.25 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments.

They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the PHA not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.26 Accounting standards that have been issued but have not yet been adopted

IFRS 18 Presentation and Disclosure in Financial Statements:

IFRS 18 will replace IAS1 Presentation of Financial statements and is effective for annual reporting periods beginning on or after the 1 January 2027 in the private sector. The impact of IFRS18 on the Public Sector is still being assessed, and a decision has not yet been taken on an implementation date.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

IFRS 19 allows eligible subsidiaries to apply IFRS Accounting Standards with reduced disclosure requirements and is effective for annual reporting periods beginning on or after the 1 January 2027 in the private sector. The impact of IFRS 19 on the Public Sector is still being assessed, and a decision has not yet been taken on an implementation date.

Management currently assess that there will be minimal impact on application to the PHA's financial statements.

1.27 Changes in accounting policies

There were no changes in accounting policies during the year ended 31 March 2026.

NOTE 2 - ANALYSIS OF NET EXPENDITURE BY SEGMENT

The PHA has identified four segments: Commissioning, Family Health Services (FHS), Agency Administration, and Safeguarding Board NI - an independent body hosted by the PHA. Net expenditure is reported by segment as detailed below:

	NOTE	2026	2025
Summary		**£000**	**£000**
Commissioning	2.1	114,997	110,739
FHS	2.2	2,360	3,084
Agency Administration	2.3	37,405	35,759
Safeguarding Board NI	2.4	690	914
Total Commissioner Resources utilised		**155,452**	**150,496**

2.1 Commissioning

		2026	2025
Expenditure		**£000**	**£000**
Belfast Health & Social Care Trust	SoCNE	19,515	17,372
South Eastern Health & Social Care Trust	SoCNE	5,793	6,363
Southern Health & Social Care Trust	SoCNE	8,682	9,123
Northern Health & Social Care Trust	SoCNE	10,008	10,476
Western Health & Social Care Trust	SoCNE	8,609	8,902
NIAS	SoCNE	111	122
Other	3.1	62,907	59,109
		115,625	111,467
Income			
Revenue from contracts with customers	4.1	628	728
Commissioning Net Expenditure		**114,997**	**110,739**

2.2 Family Health Service (FHS)

FHS Net Expenditure	3.1	**2,360**	**3,084**

2.3 Agency Administration

		2026	2025
Expenditure		**£000**	**£000**
Salaries and wages	3.2	31,337	29,803
Operating expenditure	3.2	4,836	4,068
Non-cash costs	3.3	110	722
Depreciation	3.3	1,610	1,748
		37,893	36,341
Other Operating Income			
Staff secondment recoveries	4.2	488	582
Agency Administration Net Expenditure		**37,405**	**35,759**

2.4 Safeguarding Board NI

		2026	2025
Expenditure		**£000**	**£000**
Salaries and wages	3.2	522	612
Operating expenditure	3.2	168	302
Safeguarding Board NI Net Expenditure		**690**	**914**

NOTE 3 - EXPENDITURE

3.1 Commissioning	2026 £000	2025 £000
General Medical Services	2,360	3,084
Other providers of healthcare and personal social services	51,120	49,334
Research & development capital grants	11,787	9,775
Total Commissioning	**65,267**	**62,193**

3.2 Operating expenses are as follows:-

Staff costs[1]:		
Wages and salaries	23,773	22,867
Social security costs	3,155	2,711
Other pension costs	4,932	4,837
Supplies and services - general	60	58
Establishment	4,183	3,616
Transport	9	5
Premises	635	628
Rentals under operating leases	116	61
Interest charges under IFRS16	1	2
Total Operating Expenses	**36,864**	**34,785**

3.3 Non cash items

Depreciation	59	225
Amortisation	1,399	1,414
Depreciation charges under IFRS16	152	109
Increase / Decrease in provisions	79	693
Cost of borrowing of provisions (unwinding of discount on provisions)	20	5
Auditors remuneration	31	29
Total non cash items	**1,740**	**2,475**
Total	**103,871**	**99,453**

[1] Further detailed analysis of staff costs is located in the Staff Report within the Accountability Report.

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers

	2026 £000	2025 £000
R&D	504	290
Other income from non-patient services	124	104
Capital Grant Income	0	334
Total	**628**	**728**

4.2 Other Operating Income

	2026 £000	2025 £000
Seconded staff	488	582
Total	**488**	**582**

Total Income	**1,116**	**1,310**

NOTE 5.1 - Property, Plant & Equipment - Year Ended 31 March 2026

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2025	726	1,129	57	1,912
Indexation	8	0	4	12
Additions	49	333	0	382
Disposals	0	(49)	0	(49)
At 31 March 2026	**783**	**1,413**	**61**	**2,257**
Depreciation				
At 1 April 2025	562	1,050	48	1,660
Indexation	8	0	2	10
Disposals	0	(49)	0	(49)
Provided during the year	153	59	2	214
At 31 March 2026	**723**	**1,060**	**52**	**1,835**
Carrying Amount				
At 31 March 2026	**60**	**353**	**9**	**422**
At 31 March 2025	**164**	**79**	**8**	**251**
Asset financing				
Owned	0	353	9	362
Finance leased	60	0	0	60
Carrying Amount				
At 31 March 2026	**60**	**353**	**9**	**422**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £153k (2024/25: £109k).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2024/25: £nil).

NOTE 5.2 - Property, Plant & Equipment - Year Ended 31 March 2025

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2024	720	1,141	56	1,917
Indexation	6	0	1	7
Transfers	0	(7)	0	(7)
Disposals	0	(5)	0	(5)
At 31 March 2025	**726**	**1,129**	**57**	**1,912**
Depreciation				
At 1 April 2024	448	840	44	1,332
Indexation	5	0	1	6
Transfers	0	(7)	0	(7)
Disposals	0	(5)	0	(5)
Provided during the year	109	222	3	334
At 31 March 2025	**562**	**1,050**	**48**	**1,660**
Carrying Amount				
At 31 March 2025	**164**	**79**	**9**	**252**
At 1 April 2024	**272**	**301**	**12**	**585**
Asset financing				
Owned	0	79	9	88
Finance leased	164	0	0	164
Carrying Amount				
At 31 March 2025	**164**	**79**	**9**	**252**
Asset financing				
Owned	0	301	12	313
Finance leased	272	0	0	272
Carrying Amount				
At 1 April 2024	**272**	**301**	**12**	**585**

NOTE 6.1 - Intangible Assets - Year Ended 31 March 2026

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under Construction £000	Total £000
Cost or Valuation				
At 1 April 2025	343	6,921	196	7,460
Transfers	0	245	(196)	49
At 31 March 2026	**343**	**7,166**	**0**	**7,509**
Amortisation				
At 1 April 2025	317	4,322	0	4,639
Transfers	0	46	0	46
Provided during the year	17	1,382	0	1,399
At 31 March 2026	**334**	**5,750**	**0**	**6,084**
Carrying Amount				
At 31 March 2026	**9**	**1,416**	**0**	**1,425**
At 1 April 2025	**26**	**2,599**	**196**	**2,821**
Asset financing				
Owned	9	1,416	0	1,425
Carrying Amount				
At 31 March 2026	**9**	**1,416**	**0**	**1,425**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2024/25 - £nil).

NOTE 6.2 - Intangible Assets - Year Ended 31 March 2025

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under Construction £000	Total £000
Cost or Valuation				
At 1 April 2024	343	6,847	0	7,190
Additions	0	74	196	270
At 31 March 2025	**343**	**6,921**	**196**	**7,460**
Amortisation				
At 1 April 2024	242	2,983	0	3,225
Provided during the year	75	1,339	0	1,414
At 31 March 2025	**317**	**4,322**	**0**	**4,639**
Carrying Amount				
At 31 March 2025	**26**	**2,599**	**196**	**2,821**
At 1 April 2024	**101**	**3,864**	**0**	**3,965**
Asset financing				
Owned	26	2,599	196	2,821
Carrying Amount				
At 31 March 2025	**26**	**2,599**	**196**	**2,821**
Asset financing				
Owned	101	3,864	0	3,965
Carrying Amount				
At 1 April 2024	**101**	**3,864**	**0**	**3,965**

NOTE 7 - FINANCIAL INSTRUMENTS

As the cash requirements of PHA are met through Grant-in-Aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the PHA's expected purchase and usage requirements and the PHA is therefore exposed to little credit, liquidity or market risk.

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2025/26 or 2024/25.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

The PHA did not hold any assets classified as held for sale in 2025/26 or 2024/25.

NOTE 10 - INVENTORIES

	2026 £000	2025 £000
Vaccination Supplies	567	1,088
Balance at 31st March	**567**	**1,088**

NOTE 11 - CASH AND CASH EQUIVALENTS

	2026	2025
	£000	£000
Balance at 1st April	417	394
Net change in cash and cash equivalents	18	23
Balance at 31st March	**435**	**417**

The following balances were held at 31 March:

	2026	2025
	£000	£000
Commercial banks and cash in hand	435	417
Balance at 31st March	**435**	**417**

11.1 Reconciliation of liabilities arising from financing activities

			Non-Cash Changes		
	2025	Cash flows	Change in valuation	Other changes	2026
	£000	£000	£000	£000	£000
Lease Liabilities	165	(111)	1	0	55
Total liabilities from financing activities	**165**	**(111)**	**1**	**0**	**55**

			Non-Cash Changes (Prior Year)		
	2024	Cash flows	Change in valuation	Other changes	2025
	£000	£000	£000	£000	£000
Lease Liabilities	274	(112)	2	0	165
Total liabilities from financing activities	**274**	**(112)**	**2**	**0**	**165**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2026 £000	2025 £000
Amounts falling due within one year		
Trade receivables	240	187
VAT receivable	282	414
Other receivables - not relating to fixed assets	103	35
Trade and other receivables	**625**	**636**
Prepayments	311	274
Other current assets	**311**	**274**
TOTAL TRADE AND OTHER RECEIVABLES	**625**	**636**
TOTAL OTHER CURRENT ASSETS	**311**	**274**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**936**	**910**

The balances are net of a provision for bad debts of £nil (2024/25: £nil).

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2026 £000	2025 £000
Amounts falling due within one year		
Trade revenue payables	3,544	3,115
Payroll payables	2,465	1,652
BSO payables	904	946
Other payables	1,952	3,105
Trade and other payables	**8,865**	**8,817**
Current part of lease liabilities	55	110
Other current liabilities	**55**	**110**
Total payables falling due within one year	**8,920**	**8,927**
Amounts falling due after more than one year		
Finance leases	0	55
Total non current other payables	**0**	**55**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**8,920**	**8,982**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2026

	Holiday Pay	Other	Total
	£000	£000	£000
Balance at 1 April 2025	909	156	1,065
Provided in year	79	49	128
Cost of borrowing (unwinding of discount)	18	1	19
At 31 March 2026	**1,006**	**206**	**1,212**

Comprehensive Net Expenditure Account Charges

	2026	2025
	£000	£000
Arising during the year	128	693
Reversed unused	0	0
Cost of borrowing (unwinding of discount)	19	5
Total charge within Operating expenses	**147**	**698**

Analysis of Expected Timing of Discounted Flows

	Holiday Pay	Other	Total
	£000	£000	£000
Not later than one year	0	206	206
Later than one year and not later than five years	1,006	0	1,006
Later than five years	0	0	0
At 31 March 2026	**1,006**	**206**	**1,212**

Provisions have been made for a Holiday Pay legal case, Senior Executives Pay award and dilapidations costs associated with end of a lease. The latter two provisions are within the *Other* category.

Holiday and Sick Pay Provision

On 4 October 2023, the Supreme Court handed down the decision in the case of the Chief Constable of the PSNI v Agnew and others. The judgement confirmed that the claimants are able to bring their claims under the 'unlawful deductions' provisions of the Employment Rights (Northern Ireland) Order 1996 and can thus claim in respect of a series of deductions potentially going back to the beginning of their employment or the implementation of the Working Time Regulations in 1998.

The judgement accepted the principle, established by a number of cases in both the European and domestic courts that the claimants were entitled to be paid their normal pay during periods of annual leave, and that "normal pay" is not limited to basic pay but could include elements such as overtime, commission and allowances. The outcome of this case has widespread implications for all public sector bodies in Northern Ireland in respect of both the pay elements that must be included in holiday pay calculations and the period of retrospection which means that some employees may be able to bring claims to be rectified as far back as 1998.

With effect from 1 April 2025, HSC employers have implemented an interim arrangement to ensure employees are paid appropriately for periods of annual leave. This interim arrangement has been agreed with trade unions pending the introduction of the new HR and payroll system in 2026/27. A provision in respect of the retrospective payment is still required for the period 1998/99 to 2024/25. The PHA's provision at 31 March 2026 reflects this retrospective timeframe. In calculating the provision, the PHA has used payroll data available, for all eligible staff, within the current HRPTS system back to 2015, with averaging applied for the prior years and changes in staff numbers. Revised Working Time Directive (14.5%) and Employer costs rates have been factored in, and 8% compound interest applied. A settlement year of 2028/29 has been used and as such the overall value of the provision has been discounted to determine the net present value.

A number of key areas of uncertainty which may impact on the value of the provision remain including:

- The reliability of the data used;
- The terms of settlement is subject to the determination in cases lodged by employees to the Industrial Tribunal;
- The resolution of grievances lodged by employees and any settlement negotiations with trade unions;
- The uptake rate for current or past employees;
- The extent of attrition in the workforce;
- Delays in the time it will take to administer the payments, once agreed; and
- The extent to which interest will apply.

A sensitivity analysis was undertaken to assess the impact of changes in key assumptions on the value of the provision. This analysis supports management judgement in relation to estimation uncertainty, but given the relatively small value of the provision in the context of the overall financial position, management do not consider it necessary to disclose it.

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2025

	Holiday Pay £000	Other £000	2025 £000
Balance at 1 April 2024	233	134	367
Provided in year	671	22	693
Cost of borrowing (unwinding of discount)	5	0	5
At 31 March 2025	**909**	**156**	**1,065**

Analysis of Expected Timing of Discounted Flows

	Holiday Pay £000	Other £000	2025 £000
Not later than one year	0	156	156
Later than one year and not later than five years	909	0	909
Later than five years	0	0	0
At 31 March 2025	**909**	**156**	**1,065**

NOTE 15 - CAPITAL AND OTHER COMMITMENTS

The PHA did not have any capital or other commitments as at 31 March 2026 or 31 March 2025.

NOTE 16 - LEASES

16.1 Quantitative Disclosures around Right of Use Assets

	Land and Buildings	Other	Total
Cost or Valuation	**£000**	**£000**	**£000**
At 1 April 2025	489	0	489
Additions	49	0	49
As at 31 March 2026	**538**	**0**	**538**
Depreciation Expense			
At 1 April 2025	326	0	326
Charged in year	152	0	152
At 31 March 2026	**478**	**0**	**478**
Carrying Amount at 31 March 2026	**60**	**0**	**60**
Interest charged on IFRS 16 leases	**1**		**1**

16.2 Quantitative Disclosures around Lease Liabilities

Maturity Analysis

	2026	2025
	£000	**£000**
Buildings		
Not later than one year	55	111
Later than one year and not later than five years	0	55
Later than five years	0	0
	55	**166**
Less interest element	0	(1)
Present Value of Obligations	**55**	**165**
Total Present Value of Obligations	**55**	**165**
Current Portion	55	110
Non-Current Portion	0	55

16.3 Quantitative Disclosures around Elements in the Statement of Comprehensive Net Expenditure

	2026 £000	2025 £000
Other lease payments not included in lease liabilities	66	61
Sub-leasing income	0	0
Expense related to short-term leases	0	0
Expense related to low-value asset leases	0	0
	66	**61**

16.4 Quantitative Disclosures around Cash Outflow for Leases

	2026 £000	2025 £000
Total cash outflow for lease	121	172

NOTE 17 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENTS

17.1 Off balance sheet PFI contracts and other service concession arrangements

The PHA had no commitments under PFI or service concession arrangements in either 2025/26 or 2024/25.

NOTE 18 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2026 or 31 March 2025.

NOTE 19 - CONTINGENT LIABILITIES

The PHA has no contingent liabilities (2024/25: £5k).

Clinical negligence

	2026 £000	2025 £000
Total estimate of contingent clinical negligence liabilities	0	5
Amount recoverable through non cash RRL	0	(5)
Net Contingent Liability	**0**	**0**

Other litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

Holiday Pay and Sick Pay Liability

The PHA has made provision of the potential liability, back to 1998, for claims for shortfalls to staff in holiday pay, and for breach of contract in relation to sick pay. However, the extent to which the liability may exceed this amount remains uncertain as the calculation will rely on the outworkings of the Supreme Court judgment, and will be agreed as part of any negotiated settlement with Trade Unions.

NOTE 20 - RELATED PARTY TRANSACTIONS

The PHA is an arms length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts.

During the year, none of the board members, members of the key management staff or other related parties have undertaken any material transactions with the PHA.

NOTE 21 - THIRD PARTY ASSETS

The PHA had no third party assets in 2025/26 or 2024/25.

NOTE 22 - FINANCIAL PERFORMANCE TARGETS

22.1 Revenue Resource Limit

The PHA is given a Revenue Resource Limit which it is not permitted to overspend.

The Revenue Resource Limit (RRL) for PHA is calculated as follows:

	2026	2025
	£000	£000
Revenue Resource Limit (RRL)		
RRL Allocated from:		
DoH (excludes non Cash)	144,773	140,962
Other Government Departments - NIMDTA	498	491
Total RRL Received	145,271	141,453
Less RRL Issued To:		
RRL Issued	(52,718)	(52,358)
Total RRL issued	(52,718)	(52,358)
RRL to be Accounted For	**92,553**	**89,095**
Revenue Resource Limit Expenditure		
Net Expenditure per SoCNE	102,755	98,143
Adjustments to remove items not funded via RRL		
Capital Grants for R&D	0	(334)
Research and Development under ESA10	(8,550)	(6,314)
IT purchase not capitalised	0	(2)
Depreciation	(59)	(226)
Depreciation - IFRS 16	(152)	(109)
Amortisation	(1,399)	(1,414)
Notional Charges	(31)	(29)
Movements in Provisions	(99)	(698)
Total Adjustments	(10,290)	(9,125)
Net Expenditure Funded from RRL	**92,465**	**89,018**
Surplus/(Deficit) against RRL	88	77
Break Even cumulative position (opening)	2,313	2,236
Break Even cumulative position (closing)	**2,401**	**2,313**

Materiality Test:

	2026	2025
	%	%
Break Even in year position as % of RRL	0.06%	0.05%
Break Even cumulative position as % of RRL	1.65%	1.64%

The PHA has met its requirements to contain Net Resource Outturn to within +/- 0.25% of its agreed Revenue Resource Limit (RRL), as per DoH circular HSC(F) 37/2023.

22.2 Capital Resource Limit

The PHA is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2026 £000	2025 £000
Capital Resource Limit (CRL)		
CRL Allocated from:		
Department of Health - Investment Directorate	8,883	6,920
Total CRL received	8,883	6,920
Total CRL Issued	0	0
Net CRL position	**8,883**	**6,920**
Capital Resource Limit Expenditure		
Capital expenditure per additions in asset notes	382	270
Adjustments to remove items not funded via CRL	(49)	0
Adjustments to add items not capitalised in accounts (i.e. expensed through SoCNE) but funded via CRL		
Capital grants for R&D	0	334
Research and Development under ESA10	8,550	6,314
IT purchase not capitalised	0	2
Net Capital Expenditure Funded from CRL	**8,883**	**6,920**
Surplus/(Deficit) against CRL	**0**	**0**

NOTE 23 - EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period having a material effect on the accounts.

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 26 June 2026.