HSC Public Health Agency

Meeting agenda

PHA Board Meeting

Date and time	Venue
27 August 2026 at 1.30pm	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Item	Topic and details	Presenter
1 1.30	Welcome and Apologies	Chair
2 1.30	Declaration of Interests	Chair
3 1.30	Minutes of Previous Meeting held on 18 June 2026	Chair
4 1.30	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reports of New or Emerging Risks **[PHA/01/08/26]**	Chief Executive
6 1.50	Raising Concerns	Chief Executive
7 1.55	Updates from Committees: • Governance and Audit Committee **[PHA/02/08/26]** • Remuneration Committee • Planning, Performance and Resources Committee **[PHA/03/08/26]** • Screening Programme Board • Procurement Board • Information Governance Steering Group	Committee Chairs
8 2.10	Chief Executive and Directors' Report	Chief Executive
9 2.20	Finance: • Financial Plan 2026/27 **[PHA/04/08/26] (For approval)**	Mrs Scott

- Finance Report **[PHA/05/08/26] (For noting)**

10 2.45	Annual Progress Report 2025-26 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order **[PHA/06/08/26] (For approval)**	Mrs Scott
11 3.00	Performance Management Report **[PHA/07/08/26] (For noting)**	Mrs Scott
12 3.15	Complaints, Compliments and Claims Quarterly Report **[PHA/08/08/26] (For noting)**	Mr Wilson
13 3.20	Presentation by Living Well Public Health Planning Team	Dr McClean
14 3.35	Gifts and Hospitality Policy **[PHA/09/08/26] (For noting)**	Mrs Scott
15 3.40	Health and Safety, Fire Safety and Security Annual Report 2025/26 **[PHA/10/08/26] (For noting)**	Mrs Scott
16 3.50	Infectious Diseases in Pregnancy Report **[PHA/11/08/26] (For noting)**	Dr McClean
17 4.00	Chair's Remarks	Chair
18 4.05	Any Other Business	Chair
19	Details of next meeting: *Thursday 24 September 2026 at 1.30pm* *Board Room, Gransha Park House, L'derry*	Chair

PHA Board Meeting Minutes

Date and Time	Venue
18 June 2026 at 1.30pm	Fifth Floor Meeting Room, 12/22 Linenhall Street

Member	Title	Attendance status
Mr Colin Coffey	Chair	Present
Mr Aidan Dawson	Chief Executive	Present
Dr Joanne McClean	Director of Public Health	Present
Ms Emily Roberts	Interim Director of Nursing, Midwifery and Allied Health Professionals	Present
Mrs Leah Scott	Director of Finance and Corporate Services	Present
Mr Craig Blaney	Non-Executive Director	Present
Mr John Patrick Clayton	Non-Executive Director	Present
Ms Anne Henderson	Non-Executive Director	Present
Mr Robert Irvine	Non-Executive Director	Present
Ms Patricia Kelly	Non-Executive Director	Present
Mr Tom Wright	Non-Executive Director	Present
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Mr Robert Graham	Secretariat	In attendance
Mr Michael Gibbs	Non-Executive Director	Apologies
Ms Meadhbha Monaghan	Chief Executive, Patient Client Council	Apologies

76/26 - Item 1 – Welcome and Apologies

76/26.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr Michael Gibbs and Ms Meadhbha Monaghan.

77/26 - Item 2 – Declaration of Interests

77/26.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

78/26 - Item 3 – Minutes of previous meeting held on 2 June 2026

78/26.1 The Chair advised that an issue had been raised by a member of the public with regard to the draft minutes, and in particular Item 14 relating to the update given by Dr David Cromie on cancer clusters in the mid-Ulster area and the reassurance that was given to the Board. He noted that this item was designed to be an update for the Board in the light of recent media activity on this issue and that the Board was content with the work that PHA is undertaking in this area.

78/26.2 The Chair said that issues had also been raised with regard to PHA's governance processes and in his view, elements of this clearly constituted a complaint and therefore fell within the context of the complaints process.

78/26.3 The Chair asked Dr McClean about the data for the period 2023-25. Dr McClean replied that PHA is in constant contact with the clinical team in the Belfast Trust and the Northern Ireland Cancer Registry and any matters that are flagged will be looked at. She noted that this is a technical activity and not one that would normally be brought to the Board. Mrs Henderson asked if an analysis will be undertaken once the data has been verified and validated and Dr McClean confirmed this would be the case and would be reported back to the Board **(Action 1 – Dr McClean)**.

78/26.4 Mr Clayton asked if the Board would have a sufficiently detailed review of the information and if the Board can be satisfied that there are governance systems in place to ensure that issues like this are dealt with appropriately. The Chair said that this would be picked up as part of the Complaints Process and he suggested that a small number of Non-Executive Directors would be involved in this.

78/26.5 Ms Kelly said that there are three elements to be considered. She said that the first element is the medical aspect and for the period covered within Dr Cromie's presentation, she felt assured. She advised that the second element which relates to the complaint should be dealt with on its own. In terms of the third element, governance, she suggested that there is merit in a paper being prepared to outline the process undertaken to bring the update to the Board and ensure that it was fit for purpose.

78/26.6 The Chief Executive said that this type of work is "business as usual" for the PHA and therefore in order to provide assurance, it is about showing that PHA has the

proper suitably qualified staff to undertake this work and that staff are validated and undertaking their professional requirements in terms of CPD. He also noted that there is an algorithm for clusters designed by the UK Health Security Agency which PHA followed. He said that PHA brought this matter to the attention of the Board because there had been media interest.

78/26.7 The Chief Executive advised that Dr McClean and he will prepare a report to the Board to provide the necessary assurance **(Action 2 – Chief Executive/Dr McClean)**. He added that PHA has offered to meet with a local MLA and the Minister and that he has already spoken to the Permanent Secretary regarding this matter.

78/26.8 The minutes of the Board meeting held on 2 June 2026 were **APPROVED** as an accurate record of that meeting.

79/26 - Item 4 – Actions from Previous Meeting / Matters Arising

79/26.1 The Chair noted that some of the actions from the previous meeting had been completed while other actions remained ongoing.

80/26 - Item 5 – Reports of New or Emerging Risks

80/26.1 The Chief Executive advised that there were no new or emerging risks and that the Corporate Risk Register is due to be reviewed at the end of June.

81/26 - Item 6 – Raising Concerns

81/26.1 The Chief Executive advised that there were no new concerns to report on.

82/26 - Item 7 – Updates from Board Committees

Governance and Audit Committee ***[PHA/01/06/26]***

82/26.1 Mrs Henderson reported that the Governance and Audit Committee had met on 11 June and welcomed Mr Wright to his first meeting as a member. She said that the Committee had reviewed the Annual Report and Accounts which had received an unqualified opinion from the Northern Ireland Audit Office. She noted that there was a Priority 2 finding in relation to the £1.1m loss on vaccines, but there had been a full report on this at a previous meeting.

82/26.2 Mrs Henderson advised that the Head of Internal Audit had given PHA an overall satisfactory level of assurance and that all of the Internal Audit reports for the year had been satisfactory, except one. She said that there is a need to have a Non-Executive Director in attendance at the Information Governance Steering Group and the Procurement Board. She added that the Committee approved the Gifts and Hospitality Policy.

82/26.3 Mrs Henderson reported that Internal Audit highlighted two areas. She noted that all screening audits have resulted in a limited level of assurance, but said that the follow up work undertaken by the Finance and Corporate Services team on outstanding audit recommendations was commended.

82/26.4 Mr Clayton declared an interest in the Report to those Charged with Governance referencing the pay situation for 2025/26. Mr Clayton expressed concern regarding the limited assurances in screening audits and requested further action by the Agency Management Team (AMT). Dr McClean said that PHA is well aware of the challenges around screening and outlined the additional management arrangements now in place. She added that a work had commenced to review the governance arrangements and added oversight of this would be reported to AMT and the Screening Programme Board. It was agreed that Dr McClean would provide a further report to the Board. **(Action 3 – Dr McClean)**.

84/26 - Item 9 – Presentation on Neighbourhood

Mr Paul Cavanagh joined the meeting for this item

84/26.1 Mr Cavanagh delivered a presentation updating the Board on work in relation to Neighbourhood. He began by outlining the changing demographic of the Northern Ireland population and the impact this will have on healthcare demand and the healthcare budget. He explained that 17 Integrated Neighbourhood Teams (INTs) are being set up to look at need and having more person-centred support nearer to home which will in turn reduce health inequalities and demand on services. He added that these will be multi-disciplinary teams which will be co-terminus with the GP Federation Areas.

84/26.2 Mr Cavanagh outlined how the first priority of this initiative will focus on older people and in terms of expected outcomes, he hoped this would see a reduction in attendances at Emergency Departments and non-elective admissions among other benefits.

84/26.3 Mr Cavanagh went through the approach for how this initiative will work commencing with the identification of patients. In terms of resources, he advised that there will be realignment of HSC services to community settings of approximately 2%. He added that HSC will link with other public bodies and also explore partnerships with external bodies and seed funding, for example with pharmaceutical companies like Astra Zeneca.

84/26.4 Mr Cavanagh set out the next steps and advised that once the target group has been refined and the budget identified, there will be presentation of the model at the development day scheduled for the end of June. He added that there will be discussions with Trusts about service realignment with the initiative beginning in September 2026, at which point there will be a further workshop to begin winter planning. He added that there will be further work in aligning Area Integrated Partnership Boards (AIPBs) with the Community Planning Partnerships.

84/26.5 The Chair said that there was no reference to the Northern Ireland Fire and Rescue Service (NIFRS) and the work they do with older people. Mr Cavanagh said that there is no reason not to work with them and this work presents that opportunity.

84/26.6 Mr Clayton noted the reference to alignment with AIPBs. He said that prior to Neighbourhood, PHA had a role in the development of the Integrated Care System (ICS) and also contributed to the Live Better initiative. He asked where Neighbourhood fits in terms of ICS. He also asked about seed funding and more information about the funding Astra Zeneca is providing for respiratory care. With regard to the rollout of MDTs, he said that any changes in terms and conditions of staff would require proper engagement with Trade Unions.

84/26.7 Mr Cavanagh replied that with regard to staffing, this is not about transferring staff as the Trusts are part of the INTs. He added that MDTs benefit patients and benefit GP services. He explained that in terms of the work with Astra Zeneca, a respiratory hub was developed in the Moy area and two further hubs have also been developed. He said that this is a new way of using professional skills and suggested that about a dozen hubs would be required. Mr Clayton asked about Astra Zeneca's intentions. Mr Cavanagh replied that the company provides drugs, but it also has a social responsibility. He noted that previously HSC was previously reluctant to work with drugs companies, but now it has started working with them.

84/26.8 Mr Cavanagh said that in the HSC there needs to be an improved focus on dealing with problems in the service and that by working with the AIPBs and having that connection with community planning there should be more benefits. Mr Clayton asked what PHA's future role in this work will be, given its role in looking at health inequalities. He noted the references to work being undertaken by Dr Declan Bradley in providing data. Mr Cavanagh replied that all of this professional advice comes from the PHA and that the work that Dr Bradley is doing will be key in identifying the first cohort of patients. He stated that Neighbourhood is about fixing problems within the health and social care system. Ms Roberts advised that her team is also supporting this work.

84/26.9 Ms Kelly noted that a big element of social care is currently provided in the private sector at a huge cost and asked how Neighbourhood would work with this being the case. She asked if the resources could be reclaimed and used in health. Mr Cavanagh explained that there are things happening in care homes which are leading to people ending up in hospital and this needs to be challenged. He stated that the system is not quick enough in discharging people from hospital and providing them with a domiciliary care package. He said that how social care is delivered in future is being debated at the highest levels as there is not enough money to deliver social care.

84/26.10 The Chief Executive commented that there has been a number of iterations of AIPBs and their relationship with Local Councils. He noted that NIFRS carries out checks in people's homes, but added that there are other groups who look at falls prevention so this work could be done better. He said that Neighbourhood is part of a spectrum where it is easier for people to stay in their homes.

84/26.11 Mr Blaney expressed surprise at the scale of domiciliary care in the private sectors and asked what would happen if one of the large providers were to fail given the current issues around National Living Wage and increased National Insurance contributions. Mr Cavanagh acknowledged that there are vulnerabilities and that staff

turnover in these organisations is high. He said that he did know if bringing the service within the HSC would help. He added that there is a big challenge in rural areas.

84/26.12 Mr Wright said that the NIFRS is a different organisation to what it was previously in that it carries out safety checks in homes and he agreed that it would be worthwhile having that conversation. He asked what would be envisaged as quick wins. Mr Cavanagh replied that this work needs to make a contribution to winter pressures. He outlined that if a significant number of people are targeted, e.g. 10,000 and each of those people has one less attendance at an Emergency Department, that would make a profound difference. He said that the focus is on making this simple and that it has to be the way to work in the future. He acknowledged that there is work to do to change people's attitudes, but everything will be done to make it work as the Minister and Permanent Secretary are both committed. Mr Wright asked what impact there would be if there was a different political party overseeing health after the next election. Mr Cavanagh said that whatever party oversees health, the same challenges will remain.

84/26.13 Mrs Henderson sought clarity as to whether the 10,000 people being targeted are real people and Mr Cavanagh explained that they are and will be identified by GPs and others. Ms Kelly asked about individuals who may not be registered. Mr Cavanagh replied that Inclusion Health sits within his team so these individuals will not be overlooked.

84/26.14 The Chair thanked Mr Cavanagh for attending the meeting and delivering this presentation.

82/26 - Item 7 – Updates from Board Committees (ctd.)

Remuneration Committee

82/26.6 The Chair advised that the Remuneration Committee had not met since the last Board meeting.

Planning, Performance and Resources Committee

82/26.7 The Chair advised that the Planning, Performance and Resources Committee had not met since the last Board meeting.

Screening Programme Board

82/26.8 The Chair noted that the Screening Programme Board had not met since the last Board meeting.

Procurement Board

82/26.9 The Chair noted that there is a need for a new Non-Executive Director to attend the Procurement Board.

82/26.10 Mrs Scott provided a verbal report on the last meeting which took place on 2 June. Mrs Scott said that the last meeting was a useful one and there was an update on the Procurement Plan for 2026/27. She advised that there is a new dashboard in

place. She noted that there are still some delays in scoping phase of procurement while there is still some alignment to be done with the different public health planning teams. The Chair said that the planning teams will be critical in terms of the savings plans. He said he would like to meet Mrs Scott to further discuss this **(Action 4 – Chair/Mrs Scott)**.

Information Governance Steering Group

82/26.11 The Chair noted that the Information Governance Steering Group had not met since the last Board meeting.

Public Inquiries Programme Board

82/26.12 Mr Wilson advised that the report following the Muckamore Abbey Hospital Public Inquiry has been published and that PHA has been named in three of the 106 recommendations, with a further 20/30 recommendations having some relevance to PHA.

82/26.13 The Chief Executive said that he wished to take this opportunity to acknowledge the hurt that has been caused to families. He said that a review of the Report will be undertaken and an update brought to the Board in August **(Action 5 – Chief Executive)**. Mr Clayton declared an interest as his organisation had been engaged with the Inquiry.

82/26.14 Mr Wilson advised that the report of Module 4 of the COVID Inquiry, which related to vaccines and therapeutics has been published and while there are some recommendations aimed at Northern Ireland, the Department will be leading on their implementation. He added that PHA has received a warning learning from the Inquiry indicating that it will be cited in the report for Module 6, which relates to the care sector. He said that there are a few areas that PHA has been given the opportunity to comment on and it will address those in the next 10 days.

82/26.15 Mr Wilson said that the report on the Urology Inquiry is due to be published next week.

82/26.16 Mr Wilson advised that the Coroner is holding an inquest into two deaths relating to cervical screening and that PHA has been asked for a range of information.

82/26.17 The Chief Executive said that PHA has received a query from the House of Lords Childhood Vaccinations Committee and is assisting with a response.

83/26 - Item 8 – Chief Executive and Directors' Report

83/26.1 The Chair acknowledged the PHA staff who had won awards at the recent Royal College of Nursing event.

83/26.2 Mr Clayton asked if any concerns had been raised by staff following the recent disorder. Mrs Scott replied that Directors had worked with affected staff within Directorates and noted that Line Managers and Directors had been keeping in close contact with staff. Mr Clayton said that he welcomed the statement that had gone out from the Chair and Chief Executive. The Chair stated that he was keen to ensure that

staff were supported, and he would wish to ensure that this support is reiterated and not seen as a one-off. The Chief Executive advised that he is about to undertake his next series of visits around the local offices and he would reiterate Boards position in relation to support.

83/26.3 Ms Kelly suggested that there should be a message from the Board **(Action 6 – Chief Executive)**. She noted that the community and voluntary sector helps to support those individuals who are most impacted.

85/26 – Item 10 – PHA Annual Compliments and Complaints Report [PHA/02/06/26]

85/26.1 Mr Wilson advised that the Annual Report on Compliments and Complaints had been considered by the Governance and Audit Committee. He said that during 2025/26 PHA had received ten complaints and nine compliments. Of the ten complaints, he reported that six were not upheld, two were partially upheld and two were upheld.

85/26.2 Mr Wilson explained that from January 2026, PHA has moved to reporting against the new model complaints handling procedure.

85/26.3 The Board **APPROVED** the PHA Annual Compliments and Complaints Report.

86/26 - Item 11 – PHA Annual Report and Accounts 2025/26 [PHA/03/06/26]

86/26.1 Mrs Scott presented the Annual Report and Accounts for 2025/6 and reported they had been scrutinised by the Governance and Audit Committee and were presented for approval. Following approval, she explained that it will be sent to the Northern Ireland Audit Office for certification and would be laid before the Assembly within the agreed timescales.

86/26.2 Mr Clayton sought clarity in a number of areas and information was provided as appropriate.

86/26.3 Ms Kelly asked if PHA produces an easy read version. Mr Wilson replied that the report is published on the PHA website and it could do this if asked. Ms Kelly asked if an Executive Summary could be produced. Mrs Scott agreed to take this query back to her team for further consideration **(Action 7 – Mrs Scott)**.

86/26.4 The Chair said that he wished to put on record that the team has undertaken great work as shown in the Report.

86/26.5 The Board **APPROVED** the PHA Annual Report and Accounts

87/26 - Item 12 – PHA Five Year Review of Equality Scheme [PHA/04/06/26]

87/26.1 Mrs Scott outlined that this review, which is for the whole of the HSC, has been prepared by the Equality Unit in BSO, in consultation and collaboration with PHA. She said that PHA is a starting point in this area having established a new Equality Forum. She recommended the approval of the review as presented for the period 2021/26.

87/26.2 Mr Clayton asked what this is a joint review instead of each organisation conducting their own given that they each have their own equality obligations. He highlighted some limitations of the report which covered work over the last 5 years. He felt that something is missing from the report if it not specifically about PHA. He added that there does not seem to have been any input from external stakeholders, but maybe this would be picked up through the Annual Report. Mrs Scott acknowledged Mr Claytons points.

87/26.3 Ms Kelly noted PHA;s statutory duty to report and noted in her view the review inward looking document. She added that there appears to a conflation of the different legislation around disability, equality and Section 75. She noted that the PHA website has information on equality but it is out of date and should be urgently updated. She referenced the Equality Coalition's model Equality Scheme as a good example of stakeholder engagement.

87/26.5 The Chief Executive said that he viewed this document as a review of the Equality Scheme and not about the outputs. It was agreed that the report would be sent and then PHA would work with BSO to review future years approach. **(Action 8 – Mrs Scott)**.

87/26.5 The Board **APPROVED** the Five Year Review of the Equality Scheme.

88/26 - Item 13 – Update on Financial Plan 2026/27

88/26.1 Mrs Scott gave a verbal update on the status of the preparation of the Financial plan for 2026/7. She reported that PHA has received a draft allocation for 2026/27 which reflecting a 6% reduction in its baseline revenue budget. She said that PHA is awaiting clarity from the Minister on the implementation of savings proposals which had been submitted to the Department of Health and which would achieve the equivalent to 5% savings to baseline revenue costs. She reported her team will be able to finalise a Financial Plan which will be brought to the Board in due course.

89/26 - Item 14 – Chair's Remarks

89/26.1 The Chair said that he and the Chief Executive had attended the PHA Accountability Review meeting with the Permanent Secretary earlier this week and that the meeting went well with very positive discussion.

90/26 - Item 15 – Any Other Business

90/26.1 There was no other business.

91/26 - Item 16 – Details of Next Meeting

Thursday 27 August 2026 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

Signed by Chair:

Date:

item 5

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Corporate Risk Register as at 30 June 2026
Reference	PHA/01/08/26
Prepared by	Karen Braithwaite
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to bring the Corporate Risk Register, as at 30 June 2026, to the Board for approval.

2 Background Information

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the corporate register is to provide assurances to the Chief Executive, AMT, the Governance and Audit Committee and the PHA board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The previous review was undertaken as at 31 March 2026 and the Corporate Risk Register was approved by AMT on 30 March 2026 and forwarded to the Governance and Audit Committee for approval at its meeting which took place on 16 April 2026.

The attached Corporate Risk Register reflects the review as at 30 June 2026 and has been carried out in conjunction with individual directorate register reviews for the same period.

The next review will be undertaken as at 30 September 2026.

The Corporate Risk Register was approved by the Agency Management Team at its meeting on 3 August 2026, and by the Governance and Audit Committee at its meeting on 13 August 2026.

3 Outcome

- One new risk has been added to the register this quarter:
  CR 78: Right Care, Right Person (RCRP)

- One risk has been removed from the register this quarter and de-escalated to the Public Health Directorate Risk Register
  CR 55: Shortage of staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / organisational change

- One risk has had its rating altered this quarter:
  CR 71: Public Inquiries – PHA ability to respond to requests from various Public Inquiries (rating reduced from Medium to Low)

4 Next Steps

The next review of the Corporate Risk Register will be undertaken after 30 September 2026.

PHA Corporate Risk Register

Date of Review:
30 June 2026

Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has a systematic and unified process in place to ensure a fully functioning risk register at both corporate and directorate levels as set out in the PHA Risk Management Strategy and Policy.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DoH guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
1 – Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Overview of Risk Register Review as at 30 June 2026

Number of new risks identified	**1** **CR 78:** Right Care, Right Person (RCRP)
Number of risks removed from register	**1** **CR 55:** Shortage of Staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / Organisational Change (de-escalated to PHD Directorate Risk Register)
Number of risks where overall rating has been reduced	**1** **CR 71**: Public Inquiries – PHA ability to respond to requests from various Public Inquiries (rating reduced from Medium to Low)
Number of risks where overall rating has been increased	0

CONTENTS

APPENDICES

Appendix 1	Risks added to the Corporate Risk Register
Appendix 2	Risks removed from the Corporate Risk Register
Appendix 3	Public Health Agency Risk Appetite Statement

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Control Effectiveness RAG Rating:	
GREEN	High: Controls in place assessed as adequate/effective and in proportion to the risks
AMBER	Medium: Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
RED	Low: Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
WHITE (not identified)	Insufficient information at present to judge the adequacy/effectiveness of controls

1st, 2nd & 3rd Lines of Assurance:	
1st	Department / Directorate
2nd	Organisational Oversight
3rd	Independent Assurance

Corporate Risk 39					
RISK AREA/CONTEXT: Cyber Security					
DESCRIPTION OF RISK: Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure (including those used by the PHA, as well as Trusts providing services for the PHA) may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in significant business disruption. It could also lead to unauthorised access to any of our systems or information, theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage. Whilst the BSO is primarily responsible for managing this system wide risk as IT lead for HSC, the Agency has a key responsibility to safeguard against any actions by its staff that could compromise IT security.				**DATE RISK ADDED:** June 2017 **REVISED:** June 2024 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
CORPORATE OBJECTIVE: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target Risk Score	Possible	Moderate		MEDIUM	
Risk Appetite Category & Level: Security - Averse		Risk within identified risk appetite? YES If no, add comment:			
LEAD OFFICER: Director of Finance and Corporate Services					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**
Technical Infrastructure: • HSC security hardware (eg firewalls); • HSC security software (threat detection, antivirus, email & web filtering);	1st and 2nd line Technical risks assessments and penetration tests; 1st and 2nd line Reports to GAC/PHA board on	Gaps in Assurance: • Level of corporate recognition and ownership of cyber security threat as a service delivery risk.		BSO ITS provides PHA IT services. PHA will continue to work with BSO ITS, DHCNI and through the HSC Cyber Security Programme Board.	~~June~~ Sept 2026

• Server/client patching; • 3rd party Secure Remote Access; • Data & system backups **Policy, Process:** • Regional & local ICT/information security policies; • Data protection policy; • Change Control Processes; • User Account Management processes; • Disaster Recovery Plans; • Emergency Planning & Service/Business Continuity Plans; • Corporate Risk Management Framework, processes & monitoring; • Regional & local incident management & reporting policies & procedures; **User Behaviours – influenced through:** • Induction/ Annual Appraisal • Mandatory Training; • HR Disciplinary Policy; • Contract of employment; • 3rd party contracts/data access agreements • Metacompliance monthly training now operational	reported incidents as appropriate. 1st & 2nd line PHA represented on cyber programme board 1st & 2nd line External security review carried out by ANSEC (external security company) 3rd line Internal Audit/BSO ITS self-assessment against 10 Steps towards NCSC; 3rd line: An HSC Cyber Gap analysis (ISO 27001) was carried out (externally carried out by DXC)	• An HSC Cyber Gap analysis (ISO 27001) was carried out. (external carried out by DXC Technology) -need to work through the recommendations • External security review carried out by ANSEC (ext security co) <u>Gap in Controls</u>: – • Cyber security programme not fully delivered yet (all bar SOC/SIEM). • Strategic outline Case sent to DoH for consideration which shows gaps: A SIEM (security incident and event management system) Privileged accounts management (PAM) to be carried forward to ~~26/27~~ 27/28 due to affordability and ccapacity within the BSO Project Team. • BSO led Cyber strategic plan developed for implementation over next 4 years to deliver outputs of the cyber security strategy, however funding via DHCNI not yet secured.	Work has continued in a number of priority work streams including Incident response and third party management. Further cyber projects are being undertaken to enhance capabilities across the region, under 3 key work streams. • Communications and culture which contains Cyber training for all staff, Senior Teams, ICT, Department specific • Strategy and Policy, the development and implementation of HSC wide Cyber Security policies, standards and processes and Supplier Management • Technical and Infrastructure including a HSC Network Security Review, Implementation of Network Discovery and vulnerability Management Tools and Incident Response management See below for update on key projects ongoing under these workstreams Targeted training and 'all users' training (Metacompliance) (monthly) to be provided. New schedule from March 26 – Feb 27 to run during year 26/27	

PHA member of the Regional HSC Cyber Security Business Continuity Group BSO cyber project manager co-ordinating regional cyber security work. Regional cyber security programme board (BSO representing PHA) taking forward actions arising from DXC Technology report and recommendations. Ongoing work being taken forward and overseen by the Regional Cyber Security Programme Board. A regional cyber Incident Response Plan has been developed to effectively manage a cyber incident within the HSC. Cyber Incident Response Action Plan finalised and launched. Reviewed Feb 25. A baseline audit against ISO27001 across all ICT Departments and Internal audits against NSCS Cyber Essentials 10 steps have been completed and recommendations accepted			(complementary to the mandatory eLearning cyber security training).	

Several Business Cases have been approved and implemented re ongoing resource funding for Cyber staff across HSC this includes: (i) Cyber Resource for one year (ii) Tactical Business Case for resource to implement the tactical recommendations from the network security review. Full HSC-wide cyber incident response test - Incident response plan completed on 1 June 2023 and May 2025 (Dir Fin & Corp Serv attended) Targeted training and 'all users' training (Metacompliance) provided during years 2022/23 (May-Mar) and 2023/24 (Apr-Mar) and 2024/25 and on target for continuation during 26/27. HSC cyber elearning material current review completed June 2024 including Management review of compliance. Review of Incident Response Plan finalised – being issued				

to Programme Board members 5/12/24- now approved and tested in May 25. Revised (in June 24) HSC cyber elearning material launched 2 Dec 24. Quarterly updates provided to IGSG on completion of mandatory training across PHA. PHA Business Continuity Plan test carried out 6 May 2025 with emphasis on cyber security. Training programme for Board members (3 attended training on 16/4/25). Business Case completed and submitted to DoH (Sept 25) for SOC/SIEM (Security Operation Centre / Security Incident and Event Management System) Training for PHA Board Members, facilitated by Regional Cyber Security Programme Board, completed 6 November 25.				

Corporate Risk 55

RISK AREA/CONTEXT: Shortage of Staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / Organisational Change

DESCRIPTION OF RISK:

The Public Health Agency does not currently have the appropriate retained staffing capacity / skill mix in order to be able to safely and sustainably discharge all of its statutory responsibilities pertaining to protecting and improving the health of the population of Northern Ireland. In particular, it is currently unable to fill full Public Health Consultant positions due to the unavailability of suitably qualified people in the labour market. Whilst this has been managed to date through use of Retire & Return and locum recruitment as well as some reprofiling of skill mix this is not sustainable in the medium to longer term. There is therefore a risk that the absence of core public health services in key areas such as Health Protection and preventing the transmission of communicable diseases could directly impact the health of the population.

A number of specific staffing-related risks have been identified in the organisation including:

- A number of consultant in public health posts are vacant. Recent recruitment exercises for both locum and permanent HP and PH consultants has had some success. The team have recruited 4 permanent Public Health Consultants (2 Service Development/Screening and Health Protection) and two locum consultants (1 Service Development/Screening and one Health Protection). since January 2025.

- A draft Professional Governance Framework for Healthcare Registrants employed by the PHA is being finalised after being issued to all registrant PHA staff for comment. The framework will outline governance structures for all professional staff in relation to responsibilities for maintaining registration and supervision.

Reshape Refresh risk details removed for Population Health and Wellbeing, the programme is near completion and structures are in place.

DATE RISK ADDED:
June 2020

REVISED:

August 2020 - HSCQI Risk added.

June 2022 - Merged.

September 2023 - Updated to cover all Directorate risks.

March 2024 - Updated to detail specific high impact staffing risks at March 2024

June 2024 – Redrafted to reflect core risk.

Updated March 2024

CLOSED:

N/A

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension and Operational Performance and Service Improvement Dimension			
CORPORATE OBJECTIVE: O1 Develop a new HR Strategy 'Beyond the People Plan'			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Likely	Moderate	**MEDIUM**
Target Risk Score	Possible	Moderate	**MEDIUM**
Risk Appetite Category & Level:		Risk within identified risk appetite? YES NO If no, add comment:	
LEAD OFFICER: All Directors			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
Organisation structure at Tier 4 and below approved by AMT & Senior Leaders Forum (31 August 2025) **Public Health** Two operational Assistant Directors have been appointed to strengthen leadership arrangements to ensure a safe high quality service is being provided. 2 new operational and governance HOS appointed Dec 2025 to directorate through R&R. 3 Deputy Director posts appointed since April 23 to	1st & 2nd line: • Reports to CEx and AMT. • Staff in post position kept under regular review • Updates to GAC via Corporate Risk register • Briefings provided to PHA Board. 3rd line: • Vacancy updates provided to Sponsor Branch via Ground clearance process.	**Gap in Controls** • Ability to recruit to consultant posts is constrained currently due to a number of external factors including availability of suitably qualified professionals pay and conditions and market forces. **Gaps in Assurance:** • Deficits in the PHA workforce across a range of functions compromising the performance of the organisation and ability to deliver statutory functions.		Reshape and Refresh – Management of Change: • Level 2 Job Descriptions (Director level) 2 have been finalised and have been submitted to DoH for evaluation. Review progress by December 2025. • Level 3 (AD level) recruitment programme substantively complete with one outstanding position to be filled in Q4. 2025/6. **Public Health -** Continued advertisement of Consultant Posts.	June 2026

~~support DPH in providing leadership across the directorate.~~ ~~These will focus on~~ ~~• Governance and standards~~ ~~• Training and workforce~~ ~~• Epidemiology and public health science~~ ~~Ongoing implementation of the workforce plan which includes:~~ ~~**Recruitment:**~~ ~~4 permanent consultant posts recruited and 2 locum consultants recruited since January 2025.~~ ~~Consultants on retire and return have been consolidated to permanent appointments.~~ ~~Recruitment of 2 permanent and 2 temporary specialty doctor to support health protection and screening services.~~ ~~**Strengthen Consultant led MDT in Health Protection**~~ ~~Recruited 6 x programme managers posts established in Health Protection team.~~ ~~Informal MDTs established in areas of GI and Zoonosis, TB~~	~~• Link with DOH Safety and Quality Standards branch.~~		~~Locum Consultant posts are advertised on a rolling basis.~~ ~~Plans to go out for permanent PH and HP consultant recruitment in March 2026.~~ ~~Discussions have commenced with the Faculty of Public health about supporting experienced staff in PHA to receive additional training and support with a view to specialist registration in the future. Revisit June 2026.~~	

~~and Resp, Sexual Health, BBV, AMR with input from HP/PH consultant, prog manager, surveillance and HP nursing.~~ ~~Bank staff are trained and able to provide support to acute health protection service both in hours and out of hours.~~ **~~Staff development~~** ~~Introduction of SpR rota for acute response (Delegated responsibility) to release Consultant capacity.~~ ~~Upskilling nursing workforce – 1 completed MSc in PH, 2 senior nurses undertaking MSc in PH to complete 2026/27.~~ **~~CEO Office~~** ~~Reshape and Refresh Management of change process designed (end of Mar 24)~~ ~~New operational structure and model has been approved by board.~~ ~~Interviews for Tier 2 and 3 positions are progressing.~~ ~~Director of Finance appointed.~~				

~~First Tuesday events continue~~ ~~Regular staff meetings, job planning and review of work prioritisation.~~				

Corporate Risk 59

RISK AREA/CONTEXT: Quality Assurance and Commissioning of Screening

DESCRIPTION OF RISK:
The commissioning and quality assurance of population screening programmes is a core PHA function.

Screening programmes are delivered within complex systems, involve a number of organisations and are supported by a range of bespoke IT systems. The population demographics platform (NHAIS), used by a number of screening programmes including cervical, is being decommissioned and core functionality moved to NIDIS.

As well as maintaining the core PHA functions associated with the programmes, the PHA is increasingly leading on complex change and development projects for the screening programmes in response to policy changes or the impact of wider HSC IT or service changes. Additionally, the screening digital modernisation intent is to move all screening programmes onto a single digital platform which, during the design and implementation, will increase capacity demands requiring dedicated input and management from screening, service and digital leadership.

There is a risk that PHA will not have the systems, capacity and digital expertise to manage and maintain comprehensive and robust provision of all of these functions for all screening programmes, especially during the transition phase to a new screening platform envisaged by the screening digital modernisation programme – whereby maintenance of the systems to be replaced and the introduction of the new systems will need be managed in parallel . This may result in a failure to deliver safe and effective screening programmes to the population, an inability to monitor, identify and respond to concerns regarding quality and performance, adversely impact public confidence in participating in screening programmes and negatively impact the reputation of the PHA.

DATE RISK ADDED:
November 2020

REVISED:
Dec 2023 - Risks revised (CR61 closed and integrated into CR 59)
June 2024

CLOSED:
N/A

LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension

CORPORATE OBJECTIVE: Corporate Objectives 1 – 4

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	**HIGH**
Target Risk Score	Possible	Major	**MEDIUM**
Risk Appetite Category & Level: Operational - Averse		Risk within identified risk appetite? YES If no, add comment:	

LEAD OFFICER: Director of Public Health	

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
Screening Programme Board re-established to provide broader oversight (at CEx/Director level across regional organisations) **IT systems** • Project structure for implementation of Breast Screening Select has been established, business case approved and implementation ongoing. • Processes are in place within each programme to attempt to manage any identified current risk – manual processes / reporting /monitoring/failsafe systems. • Technical review of screening IT systems completed by BSO ITS • PHA has acquired strategic digital expertise from DHCNI	**1st and 2 line assurance** • Reports to AMT and briefing/updates to PHA Board; • Report on screening internal audit follow-up to GAC. • Quality assurance site Quality assurance site visits re-established in breast and cervical • Desktop QA reviews in bowel screening • Ongoing meetings between the Encompass team and screening leads to ensure integrity of interfaces is maintained with Encompass going live. • PHA CEX represented on encompass Programme Board • A programmed series of messaging to media/ public is ongoing to ensure that public confidence is maintained in the cervical screening	Gaps in Controls: • Commissioning and delivery of screening programmes is a HSC wide system based approach (i.e. a number of partners). PHA relies upon each part of the system having appropriate controls in place • Funding insufficient to meet delivery needs within some screening programmes • Funded staffing levels in PHA are insufficient to provide a robust and responsive QA infrastructure for all programmes (Newborn and IDPS) • Limited technical and information governance expertise available to support the screening programmes Gaps in Assurances:		Roles and Responsibilties (R&R) documents are being developed for each programme which will outline R&R of each planning/delivery partner. These will be produced on a phased basis and is commencing in year for 3 programmes (AAA, Cervical, Newborn Hearing). **Southern Trust Cervical Cytology Review**: Continue to manage and respond to public and political interest relating to the cervical screening programme. Remaining reports published November 2025: Independent Expert Opinion of SHSCT review; NHS England report of PHA QA (review completed April 2025) of CSP and SHSCT SAI report • Ongoing funding pressures in Diabetic eye, and the call recall functions of bowel, and cervical screening programmes continue to be a	~~June 2026~~ September 2026

• A screening digital modernisation programme board has been established with SRO representation from key regional digital programmes, as well as, clinical, digital and screening leadership. • £200K has been allocated to support digital resourcing until March 26 with a Proof of Concept project ongoing with Epic **Screening programmes –** Consultant screening group providing cross-programme oversight; regular updates provided to DoH Sponsorship branch. Ongoing monitoring of uptake, activity and capacity within each programme with escalation of risks and concerns as required. Baseline screening budget reviewed and recurrent inescapable funding needs have been highlighted. **Staffing** New post of AD for commissioning public health	programmes as a result of the Southern Trust Review. • Separate workstream established within the NIDIS project to extend the scope to replace the NHAIS functionality for cervical screening and business case submitted to DHCNI . • Regular communication with finance regarding budgetary pressures within programmes to ensure that the need for non-recurrent funding is flagged early in the year and can be considered as part of the wider financial planning process. **3rd line assurance:** • Regular updates provided to DoH through sponsorship arrangements • Reporting to regular meetings of the DoH Cervical Screening Oversight and Assurance Group	• Limited resources (staffing, financial and technical) particularly to establish and support an enhanced QA structure for the newborn and antenatal screening programmes. • Limitations to core QA work as prioritisation given to responding to significant and urgent issues • Absence of cross organisation strategic approach to screening IT systems	feature. Need for additional recurrent funding continue to be raised as inescapable into 2026/27/ June 2026. • A business case to secure reccurent funding for DESP is being developed in year. In the interim finance colleagues have earmarked nonreccurent funding to support programme. • Screening Digital Modernisation Programme Board has been established, a proof of concept to understand if Screening Programmes can be facilitated within Encompass has been completed. This has been successful and DHCNI colleagues are exploring an approach to implement new screening IT systems through Encompass. ~~**Staffing**~~ ~~Recruitment of Band 8B commissioning lead for screening in progress part of Reshape and Reform.(ITM process unsuccessful)~~ ~~To explore options for recruitment of a quality manager~~	

screening and immunisation recruited under Reshape and Refresh. Will provide additional expertise in PHA to support commissioning of screening programmes. Appointment of new post of Head of Service for screening (band 8B) from 1 December will support and provide additional oversight of operational functions across the screening programmes. **Programme specific issues:** • Cytology review completed - SHSCT review report and SHSCT cancer report published 11/12/24. • NHS England commissioned to undertake a review of QA process relating to cervical screening laboratories. Action plan developed against recommendations • Quarterly performance management meetings established with BSO for bowel and cervical screening delivery - with review of progress against audit action plan and SLA.			~~across the screening programmes.~~	

• Final phase decommissioning of NHAIS and move to NIDIS is underway.				

Corporate Risk 64					
RISK AREA/CONTEXT: Cyber Security - compromise of HSC network due to cyber-attack on a supplier or partner organisation					
DESCRIPTION OF RISK: There is a risk to the HSC network and organisations in the event of a cyber-attack on a supplier or partner organisation resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. The risks and consequent impacts include the ability of the HSC to continue to deliver services to patients/service users/clients and therefore, potential harm to patients/service users/clients, compromise or loss of personal and organisational information, and loss of public confidence.				**DATE RISK ADDED:** September 2021 **REVISED:** June 2024 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension					
CORPORATE OBJECTIVE: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Likely	Major		**HIGH**	
Target Risk Score	Possible	Moderate		MEDIUM	
Risk Appetite Category & Level: Security - Averse		Risk within identified risk appetite? YES If no, add comment:			
LEAD OFFICER: Director of Finance and Corporate Services					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**
BSO Cybersecurity Strategy, Programme & Workplan (via Regional Cyber Security Programme Board)	1st & 2nd line: Assistant IG Manager appointed to support Service Leads in a review of new and existing contracts in line with UK	Gaps in Control: • Business continuity plans to be up to date in relation to a cyber incident,		PHA Business Continuity Plan, BIAs and Directorate Business Continuity Plans kept under continual review (live documents) but next review scheduled for	~~June~~ Sept 2026

Information Governance Team support & advisory services Info Gov Advisory Group (regional) Corporate Risk Management framework PHA BCP tested and updated February 2018 with a focus on cyber security PHA member of the Regional HSC Cyber Security Business Continuity Group Regional cyber security programme board led by programme manager – PHA representation on board Cyber Incident Response Action Plan finalised and launched Regional IT Security/cyber security training is now mandatory for all staff. Information Governance Team support & advisory services Info Gov Advisory Group (regional) available Cyber Incident Response Supplier on Retainer contract established to provide further	GDPR (working with Cyber Security colleagues, PaLS and DLS as appropriate). 1st & 2nd line: Technical risks assessments and penetration tests; 1st & 2nd line: HSC SIRO Forum for shared learning and collaborative action planning and delivery; 1st & 2nd line: IGAG oversight 1st & 2nd line: Reports to GAC/PHA board on reported incidents as appropriate. 1st & 2nd line: HSC Supplier framework developed for contractors who provide any service to HSC (approved by SIRO as part of Programme Board). Worked with PALS, Legal & CPD. 3rd line: IA report on 3rd party suppliers undertaken 2022	implemented and regular testing • Develop and test an Information Governance emergency plan in response to a Cyber attack • Legal binding agreements are in place where contracts not required • Lack of a PHA Incident Response Plan for IG <u>Gaps in Assurance</u>: • PHA does not have in-house ICT systems expertise and is reliant on BSO partner to provide expert analysis of cyber related issues with PHA contracted orgs.	completion Q1 26/27. This work being taken forward by PHA Business Continuity Plan Project Team. With the QUB and other cyber incidents, HSC SIROs are commissioning, through the Information Governance Advisory Group, a Regional IG Task & Finish Group to address the risks/review data flows from HSC/Partner organisations and issues associated with data loss by a partner organisation. Proposal considered at IGAG 27/5/21. This action currently with DHCNI for decision/funding, etc. Ongoing – lack of funding is holding up progress. Review again Sept 2026 (as per below) Development and testing of IG emergency plan in response to cyber attack being led by IGAG. Currently with DHCNI to support financially. IGAG regularly seek input from DoH/DHCNI. – Currently not happening – no funding identified by DHCNI and no one identified to take it forward. Agreed to keep on risk register as an action and review in 6 months if there has been any change. (Review Sept 26). (but as	

cyber incident preparedness support in the event of an incident. HSC Supplier framework – to include Security and IG clauses, risk assessment and security management plans, approved by Cyber Security Programme Board in June 2022 now being implemented. Amended Supplier Framework signed off by Cyber Security Programme Board 24 Oct 2025 (and BSO ELT Nov 2025.) Revised framework in place & being used since Nov 25. Report to PHA IGSG at March 24 meeting re review of new and existing contracts in line with UK GDPR (working with Cyber Security colleagues, PaLS and DLS as appropriate) and IG awareness raising re data sharing and other IG documentation to be considered/completed as required. Existing contracts reviewed for Security and Data Protection clauses – correspondence prepared & forwarded to H Imp for issue to contractors (June			Mar 26 no update – sitting with IGAG and DHCNI). Need for wider HSC discussion in independent sector social care contracts. IG awareness raising ongoing across PHA in relation to data sharing and other IG documentation to be considered/completed as required (ongoing). Standing item at PHA IGSG agenda – further update will be given at next meeting ~~April~~ Sept 2026 (no meeting in April).	

2025). Standardized clauses documentation issued by PHA Health Improvement July 25 and signed contracts returned during July/August 25. PHA Business Continuity Plan, reviewed during 25/26. Business Impact Analysis undertaken and Directorate BCPs developed. BCP test in May 25. Report of test completed and circulated Sept 25.				

Corporate Risk 71			
RISK AREA/CONTEXT: Public Inquiries - Reputational damage to the PHA as a result of criticism received from any of the statutory public inquiries around the Agency's ability to respond to the requests made of it by each Public Inquiry.			
DESCRIPTION OF RISK: There is a risk that the PHA may suffer reputational damage and loss of professional credibility if the outcome of any public inquiry results in criticism of the PHA. The PHAs ability to adequately respond to Public Inquiries in a timely and complete manner is critically important. Factors such as loss of corporate memory with many key members of staff no longer in PHA employment, capacity of current staff to devote the time required to input into responses, and no corporate document retrieval system to readily locate relevant files are relevant. There is also the risk of adverse impacts on other significant PHA deliverables, if key staff are required to reallocate their time to input into the work of ongoing Public Inquiries. There has been no dedicated support / increase in core funding for staff from DoH. The PHA is actively involved in three open public inquiries alongside a requirement to review the work undertaken in respect of the now closed Hyponatraemia, Neurology and Infected Blood Inquiries			**DATE RISK ADDED:** 30 April 2023 **REVISED:** June 2024 Mar 2025 **June 2026** **CLOSED:** N/A
LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension			
CORPORATE OBJECTIVE: Our Organisation Works Effectively			

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	~~Possible~~ Unlikely	~~Moderate~~ Minor	~~MEDIUM~~ LOW
Target Risk Score	Unlikely	Minor	LOW

Risk Appetite Category & Level: Reputational - Cautious	Risk within identified risk appetite? YES If no, add comment:

LEAD OFFICER: Head of Chief Executive's Office and Strategic Engagement

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date

When required, the Agency has the ability to stand up its PI Programme Management Board chaired by the CEXE. On a day to day basis, work aligned to the Agency's PI response is managed through the wider portfolio of a small team aligned to the Chief Executive's Office. When required, the Agency can rely on dedicated legal support for its PI work through a named Solicitor Consultant.	1st & 2nd line - Resourcing available at AfC Band 8A and Band 6 level to co-ordinate any live work stemming from PIs. - Dedicated input by DLS Solicitor Consultant - Escalation to a PI Programme Management Board chaired by CEXE and containing Director representation. - Update reports and escalation pathway to PHA board as appropriate. 3rd line - None Identified	Gaps in Assurance: Gaps in Control: • No dedicated financial support from DoH (i.e. no increase in core funding) • Although the psychological impact of the Covid-19 response may have left an indelible mark upon staff, it is hoped that the tangible acts of recognition and engagement stemming from ODEF are helping to address this legacy of the pandemic.	Update as at June ~~March~~ 2026 The Agency's proposed safety and quality framework has now been discussed at AMT and is under implementation. ~~Alongside existing PI structures,~~ tThe framework will provide a mechanism through which the Agency can manage and progress learning in relation to inquiries and other concerns aligned to SAI, audit, reviews etc. ~~The Agency awaits publication of both the Muckamore Abbey Hospital Public Inquiry and the Urology Services Inquiry during quarter four of 2025/26 – any recommendations from these inquiries will be progressed through the revised structure.~~ Final reports for both the Muckamore Abbey Hospital Public Inquiry and the Urology Services Inquiry were published in June 2026 each identifying a range of recommendations relating to quality improvement, patient safety, safeguarding, governance, learning and the development of a more open and responsive culture across the HSC. As the recommendations	~~June 2026~~ Sept 26

			are formally considered, the full impact on the Agency will become clearer and will inform a future assessment of the ongoing score and wider lifespan of this corporate risk. Furthermore, with only a couple of inquiries ongoing and still to report our current assessment is that the likelihood and impact of this risk has been diminished.	

Corporate Risk 73

RISK AREA/CONTEXT: Financial Planning Context 26/27
Finance / Operational Performance and Service Improvement Dimensions

DESCRIPTION OF RISK:

The Department of Health (DoH) indicative opening allocation for 2026/27 reflects a 6% reduction to the Public Health Agency's baseline funding (£5.046m). However, following engagement with DoH and the wider HSC planning assumptions, the PHA financial plan has been developed on the basis of delivering savings of £3.3m (4%), resulting in a residual funding gap of approximately £1.7m.

In the absence of an approved Northern Ireland Executive Budget, confirmed DoH allocations, written Ministerial direction regarding implementation of the full 6% reduction and longer-term funding certainty, there is a risk that PHA may be required to implement additional recurrent savings during 2026/27 and beyond. This could result in reductions or cessation of programme expenditure, contracts and services, particularly within prevention, early intervention, health protection and health improvement programmes. Consequently, PHA may be unable to fully deliver the priorities and outcomes as set out in the PHA Corporate Plan 2025-30, fulfil its statutory public health functions or maintain planned investment in prevention, early intervention and health improvement services across Northern Ireland.

DATE RISK ADDED:
June 2024

REVIEWED:
June 2026

CLOSED:

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension

CORPORATE OBJECTIVE: Our Organisation Works Effectively

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Possible	Major	**HIGH**
Target Risk Score	Possible	Moderate	**MEDIUM**

Risk Appetite Category & Level: Finance - Averse

Risk within identified risk appetite? ~~YES~~ NO

If no, add comment: The risk exceeds the Agency's financial risk appetite due to the uncertainty surrounding the final 2026/27 funding settlement, the potential requirement for additional savings beyond those currently planned, and the possible impact on delivery of statutory functions, commissioned services and Corporate Plan objectives

LEAD OFFICER: Director of Finance and Corporate Services	

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
PHA approach will be guided by AMT and PHA board direction Scenario planning undertaken assessing the operational and financial impact of 4%, 5%, 10% & 15% savings options and submitted to DoH Development of Financial plan in advance of agreement of budgets. Monthly financial monitoring and reporting through AMT and Board Engagement at highest level with DOH Sponsor Branch, Finance Directorate, Permanent Secretary and Director of Health regarding funding assumptions and service impacts. Development of PHPT investment and disinvestment plans to identify sustainable	1st and 2nd line assurances AMT/ PHA board to be updated on budget position on a regular basis. Formal allocation letter from the DoH provides assurance over the level of funding available to the PHA. Final allocation confirmation remains outstanding. PHA staff to continue to engage with DoH Finance and Policy colleagues to ensure impact of the indicative allocation is understood and any additional savings going forward are clearly communicated.	<u>Gaps in Controls</u> Absence of confirmed final 26/27 allocation No written Ministerial direction regarding implementation of the full 6% savings requirement with limited ability to achieve further savings without impacting commissioned services and programme delivery. Lack of multi-year funding settlement to support strategic planning and transformation <u>Gaps in Assurances</u> No approved NI Executive Budget. Continued uncertainty regarding HSC funding position and reported system wide funding gap		The DoH have noted a significant funding gap of circa £1bn across HSC for 2627 requiring a reduction of 10-14% on the current rate of expenditure. The PHA responded to a request from DoH for detailed financial planning information based on proposed savings of 5%,10% & 15%. The PHA highlighted the counter-strategic and counter-productive impact of reducing early intervention and prevention spend. PHA is currently forecasting a breakeven position at 31 March 2027 based on delivery of the planned 4% savings target. This remains subject to confirmation of the final DoH allocation and any requirement to deliver additional savings beyond those currently reflected in the draft financial plan. *Engag*ement will continue with DoH, Permanent Secretary and	~~June 2026~~ Sept 2026

recurrent savings from April 2027. Engagement with Minister and SPAD on importance of PHA to the public health outcomes.		Reliance on indicative allocations and planning assumptions Uncertainty regarding future DoH expectations for savings delivery beyond 26/27	the ministers office to secure clarity regarding funding allocations and savings expectations.	

Corporate Risk 74					
RISK AREA/CONTEXT: ICS: Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA.					
DESCRIPTION OF RISK: A new system for the planning, delivery and performance management of health and social care is being designed and implemented in Northern Ireland. Integrated Care System (ICS) is the overall title for this. The primary risk is that the design and implementation of this new system and consequent legislation does not fully recognise the importance of public health in the role of planning and delivering better health for the population of Northern Ireland. The delay in the full programme of legislative instruments may mean that the PHA is at risk of operating 'ultra vires' in relation to accountability arrangements at an operational level with regard to joint planning and commissioning teams.				**DATE RISK ADDED:** June 2024 **REVIEWED:** **CLOSED:**	
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension					
CORPORATE OBJECTIVE: Potentially all corporate objectives; particularly corporate objectives 4 (working together to ensure high quality services) and 5 (our organisation works effectively).					
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**		
Current	Possible	Moderate	**MEDIUM**		
Target Risk Score	Unlikely	Minor	**LOW**		
Risk Appetite Category & Level: Security - Cautious		Risk within identified risk appetite? YES If no, add comment:			
LEAD OFFICER: Chief Executive					

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating (RED)**	**Action Plan/Comments/ Timescale**	**Review Date**
~~The Agency Chair and Chief Executive sit on the group led by the permanent secretary tasked with the design elements of the new~~	1st and 2nd lines - PHA Multi Disciplinary SPTs - Multi Disciplinary Planning and	Control gaps: - Clarity around PHA role and resourcing - PHA does not currently have the planning capacity to support the anticipated requirements of		The following actions were agreed at an PHA/SPPG workshop in June 2025 • New timeline and plan template to be produced	~~June 2026~~ Sept 26

~~planning and governance approach~~. The Chief Executive sits on the regional project board for ICS and AIPBs The senior officers of the PHA were involved in developing the SOPs for ~~how~~ the systems of governance ~~of planning will run~~ at SPPG and PHA ~~level.~~ PHA /SPPG workshop held on 23 June agreed actions on the following objectives relating to the new JPPTs: • Review the core functions, range and remit of the new teams. • Consider the governance and accountability arrangements • Agree the structure, shape and support Joint PCT workshop held June 25. Actions taken forward includes: - SPPG and PHA have confirmed Co chairs and reviewed JPPT membership	Commissioning teams - Regular reporting into JAM (PHA/SPPG joint assurance meetings) 3rd line - Internal Audit programme - Reporting to PTEB	joint commissioning and Planning bodies. - This is being developed in parallel to the Reshape and Refresh programme. Assurance: - There is no legislative framework currently underpinning the Governance arrangements for the PHA - PHA ICS hub in place to oversee the exchange of information and development of appropriate actions - PHA CEO is engaged with SPPG interim Chief Operating Officer to develop a partnership approach to establishing and agreeing oversight arrangements for the new Planning and Commissioning Teams	• Joint PPT development and governance arrangements to follow • SLT will work to ensure coherence and alignment between joint performance and planning teams and public health planning teams – issues identified at JAG meeting on 11 November to be taken forward through COO/CEO discussion. Work remains underway around addressing the issues identified in the context of both the Neighbourhood model policy development and Ministerial Reset plan. ~~Updates will be sought on action progress and the wider corporate risk during quarter 1 26/27~~ Although this risk remains live within the Agency work is now required to reframe the content to ensure that it adequately addresses the Agency's statutory responsibilities in respect of join commissioning – this work will take place during quarter two.	

- Joint Assurance meeting (Senior Leaders) 11 November discussed progress to date and agreed governance issues that remain outstanding.				

Corporate Risk 75					
RISK AREA/CONTEXT: Pandemic Preparedness					
DESCRIPTION OF RISK: There is a risk that the PHA may be unable to deliver a timely, coordinated and scalable public health response to a largescale infectious disease outbreak or pandemic due to insufficient surge staffing capacity, lack of an operational staff mobilisation framework, and absence of a modern, scalable digital contact tracing solution. This could result in delayed detection and management of cases and contacts, compromised surveillance capability, reduced ability to implement national guidance, and significant impact on public health outcomes and organisational reputation. There may also be a negative impact on the organisation's responsibility to establish and resource and Emergency Operation Centre (EOC) as part of the wider regional co-ordination of the response to a pandemic or public health incident.				**DATE RISK ADDED:** June 2024 **REVIEWED: March 2026** **CLOSED:**	
LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension					
CORPORATE OBJECTIVE: Our Organisation Works Effectively					
GRADING	**LIKELIHOOD**	**IMPACT**		**RISK GRADE**	
Current	Possible	Major		**HIGH**	
Target Risk Score	Possible	Moderate		**MEDIUM**	
Risk Appetite Category & Level: Operational - Adverse		Risk within identified risk appetite? ~~YES~~ NO If no, add comment: Due to unresolved issues relating to HPZone replacement and available access to a surge response service there is a risk that the Agency will not be in a position to effectively manage a large-scale infectious disease outbreak or pandemic. Absence of an approved staff mobilisation policy and supporting operational arrangements will contribute to delays in establishing a planned response to a new and emerging infectious disease with potential for pandemic.			
LEAD OFFICER: Director of Public Health					
Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating**	**Action Plan/Comments/ Timescale**	**Review Date**

		(RED)		
~~Establishment of PHA; SPPG and BSO Joint Pandemic Planning Preparedness Group (June 2023)~~ Establishment of the DoH Pandemic Preparedness Oversight Group and supporting planning structures (ref DoH correspondence 16.06.26). these arrangements supersede the previous Regional Pandemic Preparedness Planning Board Completion table top exercises: (completed in 2023/24/25). ~~Representation on the NI Regional Pandemic Preparedness Planning Board – June 2024~~ PHA representation on UKHSA 4 Nations planning groups as appropriate. PHA represented as observers on RoI National co-ordinating Group for HPAI. In preparation for exercise Pegasus, PHA pandemic	Submission of draft plans to DoH assurance (Complete October 2024 with updates provided July 2025). Business impact analysis completed in August 2025. Development of a staff mobilisation policy to be progressed via Protecting Health PHPT and Senior Leaders Forum. The Corporate business continuity plan review completed March 2025 and tested on 6th May 2025. There is regular liaison with UKHSA, other UK DA's and RoI on operational health protection matters. These can include cross border issues which are addressed on case by case basis while longer term solutions are worked through. The Common Framework is the statutory agreement which underpins co-	• Resources (capital and human) required to deliver a surge response for the required time period. • Ability to deliver a proportional contact tracing service to meet the requirements of the specific guidance with respect modelling assumptions as reflected in the UK National Risk Register. HP escalation plan limited in resource - allows for increase in capacity from 185 hours per week (BAU) to 264 hours per week. Requirement for wider PHA staff mobilisation plan within 48hours. As part of the staff mobilisation plan, staff should be preidentified, undergo regular training and be part of an organisational staff call out list • Existing BIAs were completed based on previous PHA structures and will need reviewed based on new structures. • Identification and funding of a digital solution for contact tracing is required. Submission to DOH in Oct 2024 and July	**DoH Policy / Funding requirements *(No timescales included as outside the PHA's control)*** - Meetings that were convened by DoH in January 2025 to review October 2024 Pandemic submissions are currently on hold due to exercise Pegasus, urgent need to re-establish. - Opportunity for NI to be factored into development of the UK wide Single Service Centre/ Surge Response service. This requires DoH policy and funding. - Development of business cases to be informed following further discussions with UKHSA re the proposed solution for a Single Service Centre/ Surge Response Service. - Business case for resilience workforce to support enhanced HP responses complete and submitted to ~~with~~ DoH, permanent funding required to progress.	June 2026

plans were submitted to DOH in October 2024 and resubmitted in July 2025. National Pandemic Exercise, exercise Pegasus Phase 1, 2 and 3 completed in September to November 2025. PHA;SPPG;BSO exercise Pegasus debrief completed November 25. Report circulated January 2026 Staff Mobilisation T&F group established through the Protecting Health PHPT (April 2026) PHA table top exercise to test our ability to deliver a co-ordinated response to a public health incident (Meningitis Outbreak Response- surge) was delivered – June (Part 1) and September (Part 2) 2026	operation and joint working across UK administrations. This agreement does support sharing of information across DA's. The WHO international health regulations are implemented at UK level and these underpin working with RoI, EU and other countries. These strategic frameworks are not a substitute for DSAs which are the responsibility of the relevant services. -	2025 to outline IT requirements to support pandemic response – awaiting feedback on options re: availability of funding to progress. There is a cost associated with maintaining MS Dynamics as a standby and a significant cost to reactivating the system and developing it to meet the needs of a new pathogen. • Absence of a 5 Nations approach to a border response for pandemic presents a disproportionate risk to NI. • Government led (Home Office and Health Depts) ~~joint planning with RoI and rest of UK~~ in relation to border response for a pandemic including a ~~5~~ 4 nations approach for the management of travel with respect to data sharing around passenger locator forms. ~~PHA will provide input / expertise to this as appropriate.~~ • Review of data sharing agreements for pandemic response including border health security and travel (Passenger Locator Forms PLFs).	- IT Systems – ongoing discussion with UKHSA re opportunity to utilise their new system (MAVEN) as a jurisdiction of UKHSA. This will require DoH support and funding to proceed. **PHA Actions** - ~~Establish~~ Staff Mobilisation T&F group which was established in April 2026 through the Protecting Health PHPT ~~(March 2026)~~ to: - Explore the requirement for PHA Staff Mobilisation Policy and supporting operational plan. - Link with each AD to identify staff available for mobilisation to support the immediate and protracted response to a pandemic (based on outputs of BCP and BIAs) - Develop PHA wide staff mobilisation plan where each position is identified, detailing clear roles and responsibilities,	

			training needs identified and provision of training, and clear understanding of change of role as part of any emergency response for the organisation. in pandemic response. March 2027 - Absence of 5 Nations approach to Border Health Security including data sharing with respect to PLFs has been raised with DoH.	

Corporate Risk 76

RISK AREA/CONTEXT: The Child Health System is used by all 5 HSC Trusts and is used to record and manage the information needed to plan, oversee and deliver Child Health services to the children and young adults. This includes;

Scheduling & Surveillance e.g. Healthy Child Healthy Future and immunisation programmes

Monitoring e.g. New born blood spot screening failsafe

Production of Quality and Performance Management Statistics: including

- Births, breastfeeding data and infant mortalities

CHS is the driver for the Child Health Programme which is comprised of a number of complex processes and supporting algorithms that help ensure the right children are called for the right treatment / surveillance at the right time and that any significant results or outcomes are suitably followed up. Failure in any part of this has potential for serious adverse patient impact.

The Child Health System is not currently live on Encompass, Encompass intends to replace the Child Health System (CHS) regionally. The process of transitioning CHS workflows to Encompass, including engagement with relevant stakeholders, has commenced the proposed Go Live date has been proposed to be extended to a phased approach from August 2026

(Linked to Risk 59 Quality Assurance and Commissioning of Screening).

DESCRIPTION OF RISK:

- The complexity of the system build
- Confidence that it can be completed in the revised time scale
- Ability to replicate the full functionality of the current system
- Rigorous testing and the time it will take to ensure
- Loss of data if it not migrated in respect of record retention schedule
- Litigation if children and young people are not scheduled for; screening or the provision of results following screening, immunisations and developmental reviews
- Lack of interface between Encompass and GP systems which may impact on scheduling and recording of childhood immunisations
- Efficiency of order comms (labels) due to requirement from Clinisys (lab supplier) for technical solution

DATE RISK ADDED:
December 2024

REVISED:
CLOSED:
N/A

LINK TO ASSURANCE FRAMEWORK: Safety and Quality Dimension

CORPORATE OBJECTIVE: Protecting Health / Starting Well; Drive and support the transfer of the NI Child Health system onto Encompass including supporting the build for the system with EPIC developers.			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
Current	Possible	Major	**HIGH**
Target Risk Score	Unlikely	Major	**HIGH**
Risk Appetite Category & Level: Information - Cautious		Risk within identified risk appetite NO If no, add comment: Preference for safe delivery options but high degree of inherent risk for safe delivery of services for children	
LEAD OFFICER: Interim Director Population Health			

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating AMBER**	**Action Plan/Comments/ Timescale**	**Review Date**
Existing Controls – IT Programme Board for CHS and Encompass. Extension to CHS contract sought and granted to March 2027 Working group aware of interface challenges of write back between GP systems and Encompass Dedicated project group led by PHA to progress. ~~High profile projects /enhancements needed to continue have been identified e.g. changes to child health vaccination programme (Phase 1 Jul 25). CHS are progressing with changes in preparation for changes to the childhood vaccine schedule Phase 2 implemented Jan 26. All changes built into Encompass.~~	1st– Early Years and Family Nurse Partnership Nurse Consultants, CHS Encompass Senior Project Manager AD SPH Starting Well and Interim Director from Population Health. 2nd – Subgroups include, Screening and Service Development Nurse Consultant and Senior Systems and Business Analysts and Operations Service Manager.	**Gaps in Control:** CHS will run in parallel for a short post go live period with the encompass system until all functionality and data flows have been tested and assurance has been sought that it replicates the CHS functionality. Gaps in interface between GP interface and Encompass, relating to Pre-School Vaccination Programme **Gaps in Assurance:** ~~Unconfirmed Go Live Date, should be in place by end of Q4.~~		Ongoing review of the work by all stakeholders will inform a Go Live date. ~~At present it is proposed that it will be phased in from August 2026.~~ The Vaccination & Immunisation Focus Design Group, Working Group and Steering Group will have to approve as this holds a high risk for children. Once build is complete ~~Q4~~ business change management, training, provisioning, roles and responsibilities, manual data migration and reporting will	~~Apr~~ Sep 26

Additional resource has been provided by Encompass to support CHS managers and BSO programme manager support. Extended until September. Dedicated Senior Project Manager now in place in PHA and as a result there is significant positive improvement Further GP representation secured A full revision of the project has been carried out and detailed scoping documents provided to Encompass. This informed the project plan and will allow progress to be monitored. These are under review at present ~~Following the Risk Summit at end Sep 25 a proposal was made to extend go live date to Aug 2026~~. ~~A full review has taken place in relation to governance structures which have now been tightened up, with clear paths for escalation.~~ ~~9~~ 8 focus design groups, a working and steering group who report through the delivery readiness group supporting the governance structure. The project is now a standing agenda item on Regional Programme Board which will provide oversight at senior level.	3rd – Encompass, trusts, labs, BSO, NIGPC, SPPG medical advisors	Delay in 10th Aug go live date due to lack of readiness assurance.	become a focus. Review progress September 26 Senior Leadership from PHA, encompass and Trusts to discuss and agree a new go live date and approach CHS Go Live further delayed without an agreed date. Core build is complete however testing and build continuing at present on vaccine and immunisation workflow review progress Sep 26 A full review is underway in relation to governance structures with clear paths for escalation. Review progress Sep 26.	

Representation from five trusts and other organisations to inform and support the testing ~~build~~ across all 8 FDGs and working group. Encompass delivered a demonstration for ~~the~~ scheduling and booking of pre school vaccinations for GP clinics to the Focus Design Group on 8.12.25. ~~It provided a much improved technical solution.~~ Regular workshops being held to quality assure and test, ~~positive feedback received.~~ ~~A further options review was carried out in December. No agreement at this stage regarding a Go Live Date of August 2026. Agreed to work towards completion of build by end of Q4.~~ ~~Further obstacles to go live date highlighted in January regarding School Nursing i.e. non-term time. A risk analysis was carried out and a suitable solution approved which should allow for Aug 26.~~ Request submitted to Clinisys (lab supplier), an alternative solution is now in place ~~being progressed in absence of response.~~ This is still an improvement from current process. Additional piece maybe considered as part of optimization				

Corporate Risk 77					
RISK AREA/CONTEXT: Safety and Quality					
DESCRIPTION OF RISK: The 2011 Department of Health Framework document is out of date, specifically the section on Safety and Quality which outlines roles and responsibilities. Since the migration of HSCB to SPPG governance arrangements around Safety and Quality are unclear. PHA requires separate internal structures and policies to be identified in relation to the management of to Safety and Quality processes including but not limited to: SAI's, early alerts, CMRs, Child Deaths, development of clinical guidance.				**DATE RISK ADDED:** December 2025 (after GAC meeting) Escalated from PHWB Directorate RR (SQ10). **REVISED:** March 2026 **CLOSED:** N/A	
LINK TO ASSURANCE FRAMEWORK: Effective Quality, Safety and Governance Arrangements					
CORPORATE OBJECTIVE: Finalise a framework to support Quality and Safety corporate processes for PHA					
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**		
Current	Possible	Major	**HIGH**		
Target Risk Score	Unlikely	Moderate	High		
Risk Appetite Category & Level: Operational (Safety and Quality/Patient Safety) – AVERSE		Risk within identified risk appetite? **NO** If no, add comment: The risk remains outside appetite due to ongoing governance, assurance and resource gaps, together with reliance on an outdated regional framework.			
LEAD OFFICER: Director of Population Health Directorate					

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG**	**Action Plan/Comments/ Timescale**	**Review Date**
Input from Safety and Quality team and escalation to Safety Brief, AMT and JAM (on matters of joint working).	1st Line Assurance – establishment of Oversight & Surveillance arrangements, lead by PHA to oversee interim.	**Gap in Controls** • Ability to update the HSC Framework 2011 remains with the DoH as outlined in the 2009 Health & Social Care Act.		~~A joint PHA/SPPG Quality and Safety framework has been developed and approved at Joint Assurance Group on 10th March 2026.~~	~~June~~ Sept 2026

DoH HSC Framework 2011 outlines PHA roles and responsibilities – whist this remains extant guidance, content is significantly out of date. PHA have escalated to DoH areas for review. Requirement for PHA to provide assurance on safety and quality of Trust services for Population Health is undeliverable (governance of these services rests with HSC Trusts). A joint PHA/SPPG Quality and Safety framework has been developed and approved at Joint Assurance Group on 10th March 2026. The intention is for this framework to be delivered under the 4 pillars of - Information - Triangulation - Risk management - Escalation/ improvement Regular monthly update review meetings are now established (Safety Brief).	2nd Line Assurance – escalation arrangements in place via Safety Brief (Director led) and via Joint Assurance Group (Chief Executive lead). Interim Framework to be kept under review. 1st & 2nd line assurance – yearly assurance reports to PHA Board. 3rd Line assurance – risk associate with outdated 2011 Framework raised with Sponsor Branch 3rd Line assurance - Link with DOH Safety and Quality Standards branch.	• Limited technical and analytical expertise available to support the PHA responsibilities in relation to surveillance, anticipated within the new Patient Safety Incident Framework. • Current arrangements for Safety & Quality of HSC Services is a HSC wide system based approach with oversight arrangement responsibilities aligned to both PHA and SPPG. PHA relies upon each part of the system having appropriate controls in place **Gaps in Assurance:** • PHA does not have in-house access to DATIX system, platform which holds information relating to adverse incidents. PHA is reliant on SPPG partner to provide information to support the Safety & Quality arrangements. • Limited resources (staffing, financial and technical) particularly to establish and support a regional surveillance system relating to Quality & Safety.	~~The intention is for this framework to be delivered under the 4 pillars of~~ ~~- Information~~ ~~- Triangulation~~ ~~- Risk management~~ ~~- Escalation/ improvement~~ Whilst approved at JAG the framework will continue to be subject of review given the emerging landscape in relation to Safety & Quality, including further development of JPPTs, introduction of new PSI framework, launch of Being Open Framework & Being Human Framework and the recently issued HSC Planning Guidance. All changes will be formally shared through PHA / SPPG governance structures. ADs for Systems Transformation and Learning will continue to work with other PHA Directorates to secure input to the PHA review of Safety and Quality, agree priorities to update existing processes for internal governance and link with partners on the safety and quality agenda.	

			~~Regular monthly update review meetings are now established (Safety Brief).~~ This will be an ongoing area of work and until a new Framework is issued by the DoH this will continue to be a risk as the previous one is significantly out of date and has asks that are no longer relevant The System Learning, Transformation and Governance ADs continue to work with other Directorates and organisations to update internal proceses. However due to long term sick leave capacity within the team is very depleted and this will lead to some areas of work having to be deferred. The team will at all times prioritise based on safety and quality needs.	

APPENDIX 1

RISKS ADDED TO CORPORATE RISK REGISTER AS AT 30 June 2026

Corporate Risk 78

RISK AREA/CONTEXT: Introduction of Right Care, Right Person (RCRP) initiative by PSNI

DESCRIPTION OF RISK:

A multi-agency forum has been established by the PSNI and the Department of Health to oversee the development and implementation of new PSNI arrangements called 'Right Care Right Person' (RCRP). RCRP is a national policing model introduced across the UK to ensure that incidents primarily involving a health or social care need, particularly those related to mental health, are responded to by the most appropriate agency. Under this model, police attendance should be limited to situations where there is a clear and necessary policing purpose. The PSNI is introducing this process as they feel they are currently responding to many health related incidents and their limited capacity is not being used appropriately.

The health and social care experience elsewhere in the UK has highlighted risks and extra burden on services following implementation of RCRP. Again acknowledging the significant pressures on all aspects of health and social care provision in NI, it is likely that RCRP implementation will exacerbate these pressures, particularly in the absence of the additional funding for implementation that was provided elsewhere in the UK

There is a risk that implementation of Right Care Right Person (RCRP) in Northern Ireland may outpace the development of alternative health and social care pathways and crisis response capacity. This could result in delayed or inappropriate responses to people experiencing mental health, substance use or other health and social care crises, increased demand on already stretched health and social care services, unclear accountability and decision-making between agencies, and an increased risk of adverse outcomes for service users, carers and staff. Failure to mitigate these risks could impact patient safety, service performance, organisational reputation and the delivery of the Mental Health Strategy.

Rapid implementation of this proposal in Northern Ireland without adequate planning and in the context of current service challenges brings risks for both the HSC sector and for the population of Northern Ireland.

DATE RISK ADDED:
22 July 2026

REVISED: N/A

CLOSED: N/A

LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement & Safety and Quality

CORPORATE OBJECTIVE: Protecting from serious health threats e.g. infectious disease or major incidents

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Major	HIGH

Target Risk Score	Likely	Minor	**Medium**
Risk Appetite Category & Level: **Governance; Cautious** **Reputational; Cautious** **Operational; Open/Averse**		Risk within identified risk appetite? **No** If no, add comment: Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks	
LEAD OFFICER: Interim Director of Population Health and Wellbeing			

Existing Controls	**1st, 2nd & 3rd lines of Assurance**	**Gaps in Controls and Gaps in Assurances**	**Control Effectiveness RAG rating**	**Action Plan/Comments/ Timescale**	**Review Date**
PHA are involved in groups with other HSC partners re planning for implementation of RCRP. Current operational interfaces exist between PSNI, NIAS, ED's, mental health services including social services and Primary Care. Existing safeguarding, Serious Adverse Incident, AWOL, missing person and lone worker policies remain in place. The Mental Health Strategy 2021-2031 commits to regionally, consistent urgent emergency and crisis services (action 12) and a fully integrated Regional Mental Health Crisis Service (Action 27). The plan emphasizes a "right person,	**1st and 2nd line of assurance** ▪ Internal RCRP meetings within MHSULD ▪ PHWB and PHS directorate discussions to share information from various RCRP subgroups and identify any concerns which need escalated ▪ SAI audit/review process to identify incidents related to RCRP ▪ AMT kept informed of progress with implementation **3rd level assurances** ▪ PHA involved in multiagency Gold / Strategic Group ▪ Regular RCRP Silver meetings between PSNI, DoH, SPPG, PHA and HSC stakeholders	Commissioning: Limited assurance within PHA and SPPG across all relevant directorates/commissioning teams regarding awareness of potential impact and consideration of mitigations required. Limited assurance regarding the impact on vulnerable and high-risk groups including frequent presenters, people with co-occurring mental health and substance use needs, children and young people, older adults and people with learning disabilities Operational: Variation across Trusts regarding mental health crisis provision. Out of hours Crisis Response Home Treatment Team and Mental Health Liaison not consistent with some services not providing 24/7 crisis services.		PHA will continue to be involved as appropriate at Strategic Group, Silver Group and subgroups and raise any concerns within these as required. PHA internal RCRP group to continue to meet regularly following roll out of RCRP. Need for wider involvement across agency and awareness among senior team The Mental Health (Northern Ireland) Order 1986- Code of Practice launch on 9th July 2026 which clarifies responsibilities of HSC professionals, PSNI and other agencies when responding to people experiencing mental ill health. Go live planned for	September 2026

right place and right time" approach and a two-hour emergency response for people in crisis. Escalation routes exist between mental health crisis teams, ED, NIAS, PSNI and senior managers on call. PHA are involved in working groups with other HSC partners to consider the consequences of RCRP. NIAS Hear and Treat model currently operational in BHSCT and SEHSCT. NIAS Hear & Treat model provides an opportunity to develop a more scalable and sustainable crisis triage model (subject to funding) aligned to the objectives of RCRP Ongoing pilot between NHSCT and NIAS facilitating direct referrals from NIAS into Crisis Home Treatment Team. This will continue to be monitored as data becomes available. Existing mental health and suicide prevention services	▪ Regular RCRP sub group meetings between Trusts, NIAS, SPPG and PHA ▪ SPPG establishing Operational Readiness group and arranging meetings with senior leaders within Trusts to ensure 'operational readiness' and provide assurances re same before implementation. PHA to be involved in these meetings. ▪ When operational there will be Regional and Local RCRP groups in each of the 5 areas to monitor implementation and detect and resolve issues emerging	Alternative crisis response pathways are not yet available at sufficient scale across Northern Ireland and would require investment. Lack of clarity of impact on HSC for activity displaced by PSNI. Training for staff for the revised Code of Practice has not commenced. Unclear ownership for Welfare Checks, self-harm threats without immediate danger, ED walkouts, AWOL patients and transport and conveyance. Regional arrangements for monitoring, evaluation and reporting outcomes are still in development. Limited evidence that all relevant HSC services are ready for implementation of RCRP MOU between PSNI and NIAS still not agreed and signed off. Limited assurance that operational staff realise the impact of RCRP and roles and responsibilities within same.	1 Sept when training delivered.	

such as Lifeline, SHIP, C&V sector and Mental Health Crisis and Liaison Teams continue to support people at risk.		Limited assurance on interface with NIAS control and PSNI call management Limited assurance regarding consistent application of RCRP thresholds across agencies.		

APPENDIX 2

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 30 June 2026

Corporate Risk 55 – de-escalated to PHD Directorate Risk Register

RISK AREA/CONTEXT: Shortage of Staff across particular areas, impacting the ability to discharge full range of public health statutory responsibilities / Organisational Change

DESCRIPTION OF RISK:

The Public Health Agency does not currently have the appropriate retained staffing capacity / skill mix in order to be able to safely and sustainably discharge all of its statutory responsibilities pertaining to protecting and improving the health of the population of Northern Ireland. In particular, it is currently unable to fill full Public Health Consultant positions due to the unavailability of suitably qualified people in the labour market. Whilst this has been managed to date through use of Retire & Return and locum recruitment as well as some reprofiling of skill mix this is not sustainable in the medium to longer term. There is therefore a risk that the absence of core public health services in key areas such as Health Protection and preventing the transmission of communicable diseases could directly impact the health of the population.

A number of specific staffing-related risks have been identified in the organisation including:

- A number of consultant in public health posts are vacant. Recent recruitment exercises for both locum and permanent HP and PH consultants has had some success. The team have recruited 4 permanent Public Health Consultants (2 Service Development/Screening and Health Protection) and two locum consultants (1 Service Development/Screening and one Health Protection). since January 2025.

- A draft Professional Governance Framework for Healthcare Registrants employed by the PHA is being finalised after being issued to all registrant PHA staff for comment. The framework will outline governance structures for all professional staff in relation to responsibilities for maintaining registration and supervision.

  Reshape Refresh risk details removed for Population Health and Wellbeing, the programme is near completion and structures are in place.

DATE RISK ADDED:
June 2020

REVISED:

August 2020 - HSCQI Risk added.

June 2022 - Merged.

September 2023 - Updated to cover all Directorate risks.

March 2024 - Updated to detail specific high impact staffing risks at March 2024

June 2024 – Redrafted to reflect core risk.

Updated March 2024

CLOSED:

N/A

LINK TO ASSURANCE FRAMEWORK: Corporate Control Arrangements Dimension and Operational Performance and Service Improvement Dimension

CORPORATE OBJECTIVE: O1 Develop a new HR Strategy 'Beyond the People Plan'

GRADING	LIKELIHOOD	IMPACT	RISK GRADE
Current	Likely	Moderate	MEDIUM
Target Risk Score	Possible	Moderate	MEDIUM
Risk Appetite Category & Level:		Risk within identified risk appetite? YES NO If no, add comment:	
LEAD OFFICER: All Directors			

Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating AMBER	Action Plan/Comments/ Timescale	Review Date
Organisation structure at Tier 4 and below approved by AMT & Senior Leaders Forum (31 August 2025) **Public Health** Two operational Assistant Directors have been appointed to strengthen leadership arrangements to ensure a safe high quality service is being provided. 2 new operational and governance HOS appointed Dec 2025 to directorate through R&R. 3 Deputy Director posts appointed since April 23 to support DPH in providing leadership across the directorate.	1st & 2nd line: • Reports to CEx and AMT. • Staff in post position kept under regular review • Updates to GAC via Corporate Risk register • Briefings provided to PHA Board. 3rd line: • Vacancy updates provided to Sponsor Branch via Ground clearance process. • Link with DOH Safety and Quality Standards branch.	**Gap in Controls** • Ability to recruit to consultant posts is constrained currently due to a number of external factors including availability of suitably qualified professionals pay and conditions and market forces. **Gaps in Assurance:** • Deficits in the PHA workforce across a range of functions compromising the performance of the organisation and ability to deliver statutory functions.		Reshape and Refresh – Management of Change: • Level 2 Job Descriptions (Director level) 2 have been finalised and have been submitted to DoH for evaluation. Review progress by December 2025. • Level 3 (AD level) recruitment programme substantively complete with one outstanding position to be filled in Q4. 2025/6. **Public Health -** Continued advertisement of Consultant Posts. Locum Consultant posts are advertised on a rolling basis. Plans to go out for permanent PH	June 2026

~~These will focus on~~ ~~• Governance and standards~~ ~~• Training and workforce~~ ~~• Epidemiology and public health science~~ ~~Ongoing implementation of the workforce plan which includes:~~ **~~Recruitment:~~** ~~4 permanent consultant posts recruited and 2 locum consultants recruited since January 2025.~~ ~~Consultants on retire and return have been consolidated to permanent appointments.~~ ~~Recruitment of 2 permanent and 2 temporary specialty doctor to support health protection and screening services.~~ **~~Strengthen Consultant led MDT in Health Protection~~** ~~Recruited 6 x programme managers posts established in Health Protection team.~~ ~~Informal MDTs established in areas of GI and Zoonosis, TB and Resp, Sexual Health, BBV, AMR with input from HP/PH consultant, prog~~			~~and HP consultant recruitment in March 2026.~~ ~~Discussions have commenced with the Faculty of Public health about supporting experienced staff in PHA to receive additional training and support with a view to specialist registration in the future. Revisit June 2026.~~	

~~manager, surveillance and HP nursing.~~ ~~Bank staff are trained and able to provide support to acute health protection service both in hours and out of hours.~~ **~~Staff development~~** ~~Introduction of SpR rota for acute response (Delegated responsibility) to release Consultant capacity.~~ ~~Upskilling nursing workforce – 1 completed MSc in PH, 2 senior nurses undertaking MSc in PH to complete 2026/27.~~ **~~CEO Office~~** ~~Reshape and Refresh Management of change process designed (end of Mar 24)~~ ~~New operational structure and model has been approved by board.~~ ~~Interviews for Tier 2 and 3 positions are progressing.~~ ~~Director of Finance appointed.~~ ~~First Tuesday events continue~~				

~~Regular staff meetings, job planning and review of work prioritisation.~~				

APPENDIX 3

Public Health Agency Risk Appetite Statement 2026/27

Introduction

The Public Health Agency (PHA) is committed to improving and protecting the health and social wellbeing of the population of Northern Ireland. Achieving these outcomes requires us to take informed, balanced risks while maintaining public trust, complying with statutory requirements, and ensuring the safety of our people and the public.

As a progressive and collaborative organisation, the PHA embraces innovation and continuous improvement. We recognise the need to adapt, evolve, and, where appropriate, experiment within clearly defined risk parameters and supported by robust controls. Managing risk is an integral part of how we operate and how we deliver meaningful impact.

Our risk appetite defines the level and types of risk the PHA is willing to accept in pursuit of its strategic objectives. It supports proportionate decision-making, encourages responsible, and ensures that risks are managed within acceptable boundaries. This Risk Appetite Statement applies across the organisation and supports the PHA's strategic priorities, corporate plan, and internal control framework.

Definition of Risk Appetite and Tolerance

Risk appetite represents the amount and type of risk an organisation is willing to accept in pursuit of its objectives. Risk tolerance reflects the acceptable variation from that appetite during the active management of risk. Where a risk exceeds the defined appetite or tolerance level, it must be escalated through the agency's established governance mechanisms.

Appetite Levels

The PHA has applied the following risk appetite levels which are based on the UK Government's Orange Book, Management of Risk – Principles and Concepts[1] and its supporting Risk Appetite Guidance Note, 2021[2]:

[1] The Orange Book – Management of Risk – Principles and Concepts (publishing.service.gov.uk)

[2] 20210805_-_Risk_Appetite_Guidance_Note_v2.0.pdf

Appetite level	Definition
Averse	All precautions and mitigations in place with very low appetite for risk (likelihood of risk is rare but not impossible).
Cautious	Preference for safe delivery options that have a low degree of inherent risk, and which may only have limited potential for reward.
Open	Receptive to activities which carry a degree of risk where these will result in successful delivery and measurable improvements while also providing value for money.

Risk Appetite by Category

The PHA's appetite varies across different types of risk, reflecting the nature of our statutory responsibilities and operational environment.

1. **Strategy – Open**.
   We are willing to take considered risks to pursue strategic ambitions, improve population health, and maximise impact for the public.

   example: Implementing innovative digital health platforms to enhance public engagement or adopting novel approaches for reducing health inequalities even where evidence is emerging.

2. **Governance - Cautious**
   We expect robust oversight, assurance, and governance arrangements to be in place, but accept some limited risk where benefits justify the approach.

   example: Robust process in place to oversee Performance Monitoring Returns

3. **Operational – Open (General Operations) Averse (Staff/Public Safety**)
   We encourage innovation and new approaches in delivering core services and partnership work. However, we are **averse** to risks that compromise staff safety or wellbeing.

   example: Introducing new models of partnership commissioning with Trusts/C&V organisation.

4. **Security - Averse**
   We have no tolerance for significant information security breaches or cyberrelated threats that could lead to data loss, legal breach, or public harm.

   example: Data breaches; unencrypted device loss; non-compliance with UK GDPR

5. **Legal and Regulatory Compliance – Averse to breaches**
   We have adopted a minimal risk approach in complying with regulatory and statutory obligations.

   example: GDPR, FOI or procurement compliance risks; statutory reporting duties.

6. **Commercial – Cautious**
   We implement safe, wellcontrolled approaches to procurement, contract management and supplier engagement to ensure continuity, value, and compliance.

   example: Procurement award: contracting with maturing providers; single-supplier dependence.

7. **People and Workforce Development – Open**
   We are willing to invest in our people, support professional development, and encourage innovation in workforce planning that enhances organisational capability.

   example: Leadership programmes; research support; robust skills assessment tool.

8. **Finance – Cautious / Averse to statutory financial breach**
   We take a cautious approach to ensure safe financial delivery and prudent management of public resources accepting minimal residual risk where it could yield upside opportunities. That said we are **averse** to breaching statutory financial obligations.

   example: Implementing savings plans that involve service redesign; intolerance for break-even risk.

9. **Information - Cautious**

We support appropriate information sharing to deliver effective services, while maintaining strong safeguards and adhering to information governance standards.

example: Use of data-sharing agreements; new projects/analytics tools requiring DPIAs.

10. **Reputational risks - Cautious**

We adopt approaches that protect public confidence, while recognising that some reputational risk is inherent in delivering public health functions and speaking transparently about emerging issues.

example: Public Health Guidance and Public Inquiries.

11. **Project/Programme - Open**

We support innovation in change programmes aligned to strategic priorities, provided these do not compromise client or population safety.

example: Transformation programmes; testing new models of early intervention and prevention

PHA Governance and Audit Committee Meeting Minutes

Date and Time	Venue
11 June 2026 at 10.00am	Fifth Floor Meeting Room, 12/22 Linenhall Street

Member	Title	Attendance status
Ms Anne Henderson	Non-Executive Director (Chair)	Present
Mr Robert Irvine	Non-Executive Director	Present via Teams
Mr Craig Blaney	Non-Executive Director	Present via Teams
Mr Tom Wright	Non-Executive Director	Present
Ms Leah Scott	Director of Finance and Corporate Services	In attendance
Ms Helen O'Hare	Assistant Director of Finance and Corporate Services	In attendance
Mr Stephen Wilson	Head of the Chief Executive's Office	In attendance
Ms Catherine McKeown	Internal Audit, BSO	In attendance
Mr Ryan Falls	Cooper Parry	In attendance
Ms Suzanne Murphy	Northern Ireland Audit Office	In attendance
Mr Robert Graham	Chief Executive Office Manager	In attendance
Ms Aisling Smyth	Secretariat	In attendance

1/26 - Item 1 – Welcome and Apologies

1/26.1 Ms Henderson welcomed everyone to the meeting and noted apologies. She introduced Mr Tom Wright as a new Non-Executive Director for the PHA, who will also serve as a member of the Governance and Audit Committee. She noted that Mr Irvine and Mr Blaney are attending via Teams.

2/26 - Item 2 – Declaration of Interests

2/26.1 None to declare.

3/26 - Item 3 – Minutes of previous meeting held on 16 April 2026

3/26.1 The minutes of the previous meeting, held on 16 April 2026, were **APPROVED** as an accurate record of that meeting subject to an amendment requested by Ms McKeown.

4/26 - Item 4 – Matters Arising

4/26.1 Ms Henderson noted that an Action Log had been circulated in advance of the meeting and noted all matters arising were captured within it. Ms Scott provided an update on the Cyber Security action, advising that the next Cyber Security Programme Board meeting is scheduled to take place shortly, which she plans to attend and once she has a response to the ISO standards from the Cyber Security Programme Board, she will come back with the detail.

4/26.2 Ms Henderson requested that an action be added to the Action Log to review the SBNI Memorandum of Understanding (MoU) and provide an update. Ms Scott advised that the MoU has been in development and that engagement with the Department is ongoing. She noted an intention to progress this further once the SBNI appoints its new Chair in July. Mr Wright highlighted that ambiguity remains regarding the relationship between the PHA and SBNI, and that there is currently a lack of an assurance statement. While acknowledging positive working relationships, he advised that this should remain on the watch list. **(Action 1 – Ms Scott)**

5/26- Item 5 – Chair's Business

5/26.1 No Chair's Business to report.

6/26 - Item 6 – Internal Audit

Internal Audit Progress Report [GAC/01/06/26]

6/26.1 Ms McKeown presented the Internal Audit Progress Report, noting that it was a brief update outlining the 2026/27 plan. She advised that the Duty Room Audit Assignment has been completed, with fieldwork concluded on 22 April and the exit meeting held on 29 May. She further advised that fieldwork for the Information Governance Audit Assignment is currently ongoing. In response to a query from Ms Henderson regarding any emerging issues, Ms McKeown confirmed that no issues have been identified to date.

6/26.2 Members Noted the Internal Audit Progress Report.

Shared Services Update [GAC/02/06/26]

6/26.3 Ms McKeown presented the Shared Services update, providing a summary of the BSO Shared Services position. Ms Henderson queried whether the ITS audit had been completed. Ms McKeown confirmed that it had, noting that as ITS forms part of BSO Shared Services, the outcome is incorporated into the overall Shared Services assurance process. She advised that an assurance letter would be issued to the Chief Executive. Ms Henderson commented that it would be useful to review this report. Ms McKeown advised that, as it is issued to the Chief Executive, access should be sought through that route.

6/26.4 Members Noted the Shared Services Update.

Head of Internal Audit Annual Report [GAC/03/06/26]

6/26.5 Ms McKeown presented the Head of Internal Audit Annual Report. She began by drawing members' attention to the opening acknowledgement, recognising and thanking management and staff for their support and engagement in facilitating Internal Audit. She advised that all key performance indicators had been achieved during the period. Summarising the report, she noted that six audits were completed in 2025/26, of which five received Satisfactory Assurance, with Limited Assurance provided in respect of Screening Programmes. She also provided an overview of the Shared Services audit outcomes. Ms McKeown highlighted key themes arising from the 2025/26 audit work. In particular, she noted that Limited Assurance has been reported across the last three Screening audits, and emphasied the importance of strengthening controls in this core area. She further highlighted the improved coordination and follow-up of audit recommendations by the Finance and Corporate Services Directorate, which has resulted in a more proactive approach to implementation and a high rate of completion of recommendations by year end (2025/26).

6/26.6 Ms McKeown further advised that the overall Internal Audit opinion is that Satisfactory Assurance can be provided on the adequacy and effectiveness of the

organisation's governance, risk management and control framework. She noted that Satisfactory Assurance was achieved across the majority of audits conducted in 2025/26, supported by a high rate of implementation of Internal Audit recommendations during the year. However, she highlighted that Limited Assurance continues to be reported in relation to the Management of Screening Programmes.

6/26.7 Ms Henderson thanked Internal Audit for their recognition and noted that the points raised regarding the Management of Screening Programmes were well made. She added that, overall, she was content with the Satisfactory Assurance opinion provided.

6/26.8 Mr Wright welcomed the overall Satisfactory Assurance, noting that it reflects the significant work undertaken by both Internal Audit and PHA staff. In relation to Screening Programmes, he queried whether an action plan was in place to address the identified issues and the planned approach going forward.

6/26.9 Ms McKeown advised that a summary of the position has been presented to management. Ms Scott confirmed that management has accepted the findings, with actions in place and these are subject to ongoing monitoring. She noted that Internal Audit conducts six monthly follow-up reviews, with a robust process now established, and updates are reported to the GAC.

6/26.10 Ms Henderson reiterated that the Management of Screening Programmes is a significant area for the PHA. While acknowledging that further work is required, she welcomed the progress made to date and expressed her thanks to all involved.

6/26.11 Mr Irvine welcomed the report, noting that, aside from Screening Programmes, it was positive to see Satisfactory Assurance across the remaining audits and a reduction in the number of outstanding recommendations. He extended his congratulations to Ms Scott and her team, emphasising the importance of ensuring that improvements are embedded going forward.

6/26.12 Members Noted the Head of Internal Audit Annual Report.

7/26 - Item 7 – Corporate Governance

Annual Compliments & Complaints Report 25/26 [GAC/04/06/26]

7/26.1 Mr Wilson presented the Annual Compliments and Complaints Report. He noted that this year's report is more extensive due to the transition to a new complaints process, with the report covering both the previous process and the new arrangements implemented from January 2026. He advised that, for the period 1 April 2025 to 31 March 2026, a total of 10 complaints and 9 compliments were received. The report outlines the source and nature of compliments, as well as a breakdown of complaints by Directorate and category. Mr Wilson provided an overview of the range of complaints received and outlined performance in relation to timeliness of responses. He noted that some cases exceeded standard timescales due to their complexity but confirmed that

efforts are made to meet targets, which are subject to ongoing review. He emphasised that complaints are welcomed as an important source of learning and highlighted that the report includes measures taken to implement corrective actions and prevent recurrence.

7/26.2 Ms Henderson welcomed the comprehensive nature of the report and the emphasis on learning from complaints.

7/26.3 Members Noted the Annual Compliments & Complaints Report.

Gifts and Hospitality Policy [GAC/05/06/26]

7/26.4 Miss Scott presented the PHA Gifts and Hospitality Policy, advising that it was approved by AMT in May 2026.

7/26.5 Ms Henderson noted that she had reviewed the policy and sought clarification on whether there were any significant changes from the previous version.

7/26.6 Ms Scott outlined the key updates, including: the requirement for Director-level approval; the need to raise a purchase order for all external venue hire and hospitality; the introduction of a £50 threshold for gifts; the general rule prohibiting hospitality for internal-only meetings; the use of external venues only as a last resort; and the requirement to record all offers of gifts and hospitality in the Gifts and Hospitality Register.

7/26.7 Mr Irvine requested that, where policies are refreshed or reviewed, changes should be clearly highlighted for members to easily identify amendments. He further suggested that the AMT cover paper should be included alongside such policies. Request was made for the AMT cover paper to be sent out for this policy.
(Action 1 – Ms Smyth)

7/26.8 Members Approved the PHA Gifts and Hospitality Policy

8/26 - Item 8 – Finance

Annual Report and Account incorporating Governance Statement and Letter of Representation [GAC/06/06/26]

8/26.1 Ms Scott presented the Annual Report and Accounts, incorporating Governance Statement and Letter of Representation, for the year ending 31 March 2026. She noted that the report reflects many weeks of collaborative work between staff and audit colleagues.

8/26.2 Providing a summary of key highlights, Ms Scott noted that the organisation received an Unqualified Opinion from External Audit and a Satisfactory Assurance opinion from Internal Audit, providing confidence in the organisation's governance and control arrangements. She also reported a £88,000 surplus, in line with financial targets.

Ms Scott concluded that the report demonstrates a positive year for the organisation and recommended that it be approved for submission to the PHA Board.

8/26.3 Ms Henderson confirmed that she was content to approve the report, noting the positive outcome.

8/26.4 Mr Wright advised that he was content for the report to go to the Board for Approval, recognising the significant time, effort and collaboration involved. He highlighted the strong working relationship between staff and auditors, noting that this effective approach has delivered positive results. He extended his congratulations to all involved.

8/26.5 Members Approved the Annual Report and Accounts, incorporating Governance Statement and Letter of Representation.

9/26 - Item 9 – Information Governance

Information Governance Action Plan 2025/26 [GAC/07/06/26]

9/26.1 Ms Scott presented the Information Governance Action Plan for 2025/26. She advised that all actions have been completed, with no outstanding items. She highlighted that ongoing focus continues to be placed on training and awareness, ensuring that training remains up to date and is delivered within required timescales. She noted that good progress has been made throughout the year.

9/26.3 Ms Henderson welcomed the update, acknowledging the strong emphasis on training. She also queried which Non-Executive Director will join the Information Governance Steering Group moving forward.

9/26.3 Members noted the positive position and the completion of all actions.

9/26.4 Members Noted the Information Governance Action Plan for 2025/26.

Information Governance Action Plan 2026/27 [GAC/08/06/26]

9/26.5 Ms Scott presented the Information Governance Action Plan for 2026/27, advising that it has been developed based on experience to date. She highlighted that key areas of continued focus will include training and awareness, data sharing, new systems/projects, standards and legislation, information requests, records management, and data breaches. She also noted that Information Governance responsibilities are shared with BSO, in particular ITS and DLS for various programmes / areas as and when required.

9/26.6 She summarised the main priorities for the year ahead, noting that training and awareness will remain central. Data sharing continues to be an area of focus, particularly in relation to systems such as Encompass and Equip, as well as new systems being introduced for Child Health Services and Screening Programmes. She

emphasised the importance of ensuring robust governance arrangements, data sharing agreements, and staff awareness in these areas.

9/26.7 Ms Scott further advised that both the volume and complexity of Information Governance work has increased over the past year, placing additional pressure on the Team. Records Management remains a key area of focus, with a need to ensure consistent use of organisational systems, such as SharePoint, and adherence to established controls and policies. She also noted that data breaches are managed in partnership with BSO, as required, and highlighted the Information Governance Steering Group (IGSG) as an effective oversight mechanism.

9/26.8 Ms Henderson suggested that Mr Tom Wright be nominated to join the Information Governance Steering Group and that this be recommended to the Board. Mr Wright confirmed he would be content to take on this role, noting his relevant experience in GDPR and organisational governance. Mr Irvine and Mr Blaney supported this proposal.

9/26.9 Further discussion took place regarding formal systems for information and records management. Ms Henderson queried whether this area required more exploration. Ms Scott confirmed that while policies are in place, there remains scope for improvement and further development, and emphasised the importance of ensuring Information Governance considerations are fully embedded.

9/26.10 Members Noted the Information Governance Action Plan for 2026/27.

10/26 - Item 10 – External Auditor's Report to those Charged with Governance (Draft)

External Auditor's Report to those Charged with Governance (Draft) [GAC/09/06/26]

10/26.1 Ms Murphy presented the External Auditor's Report to Those Charged with Governance, noting that it remains in draft form. She advised that External Audit is proposing to issue an Unqualified Audit opinion. She expressed her thanks to Ms Scott and her team, as well as Mr Falls and his team, for their support and engagement throughout the audit process.

10/26.2 Ms Murphy then invited Mr Falls to provide a high-level overview of the report. Mr Falls confirmed that the report is still in draft, pending finalisation of the BSO Shared Services report, on which PHA places reliance. He advised that there were no findings in respect of significant risks and no significant risks identified in relation to the break-even position, noting that additional funding had been received. Mr Falls did, however, raise an observation regarding the timing of the Annual Report and Accounts, which were presented to the Audit and Risk Committee on 16 April for scrutiny, however it was incomplete. He advised that in future years, the Public Health Agency may wish to consider reviewing its processes and timings of future Committee dates to ensure that the draft Annual Report can be adequately scrutinised by the Committee.

10/26.3 Mr Falls also highlighted Vaccine losses, acknowledging that while mitigating actions have been taken, the level of loss remains significant.

10/26.4 Mr Falls concluded by noting that this was a positive, clean audit outcome and reiterated his thanks to Ms Scott and her team, adding that the organisation is currently in a strong position.

10/26.5 Ms Henderson thanked Ms Murphy and Mr Falls for their work on the External Auditor's Report. In relation to Vaccine losses, she noted that a full report had been presented to both the Governance and Audit Committee and the Vaccination and Immunisation Board. Regarding the timing of the draft Annual Report and Accounts, Ms Henderson advised that she and Ms Scott would discuss this further to consider potential improvements to the timeline.

10/26.5 Mr Irvine concurred with the comments made, including those relating to Vaccine losses. He acknowledged that this remains a complex area, noting the challenges in balancing public engagement with managing stock effectively. He welcomed the Unqualified Audit opinion and stated that he had no further comments, adding that progress is evident and that the organisation appears to be in a positive position moving forward.

10/26.5 Members Noted the External Auditor's Report to Those Charged with Governance.

11/26 - Item 11 – Any Other Business

11/26.1 There was no other business.

12/26 - Item 12 – Annual Meeting with Auditors (External and Internal) without Officers present

13/26 - Item 13 – Details of Next Meeting

Thursday 13th August 2026 at 10am

Fifth Floor Meeting Room, 12/22 Linenhall Street

Signed by Chair:

Anne Henderson

Date: 13 August 2026

PHA Planning, Performance and Resources Committee Minutes

Date and Time	Venue
14th May 2026 10am	5th Floor Meeting Room, Linenhall Street

Member	Title	Attendance status
Mr Colin Coffey	Chair	Present
Mrs Anne Henderson	Non-Executive Director	Present
Ms Patricia Kelly	Non-Executive Director	In attendance
Dr Joanne McClean	Director of Public Health	In attendance
Mrs Leah Scott	Director of Finance and Corporate Services	In attendance
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Mr Stephen Murray	Assistant Director of Planning and Performance	In attendance
Mrs Helen O'Hare	Assistant Director of Finance	In attendance
Mr Kevin Bailey	Senior Planning Manager	In attendance
Ms Julie Mawhinney	Senior Planning Manager	In attendance
Mr Robert Graham	Chief Executive Office Manager	In attendance
Mr Craig Blaney	Non-Executive Director	Apologies
Mr Aidan Dawson	Chief Executive	Apologies
Ms Emily Roberts	Interim Director of Nursing, Midwifery and AHPs	Apologies

10/26 - Item 1 – Welcome and Apologies

10/26.1 The Chair welcomed members and acknowledged apologies from Mr Craig Blaney, Mr Aidan Dawson and Ms Emily Roberts. He gave a particular welcome to Ms Patricia Kelly who has recently joined the PHA Board.

11/26 - Item 2 – Declaration of Interests

11/26.1 The Chair asked if any members had any declarations of interest. No declarations were made.

12/26 - Item 3 – Minutes of previous meeting

12/26.1 The minutes of the previous meeting held on 19th February 2026 were **APPROVED** as an accurate record of that meeting.

13/26 - Item 4 – Matters Arising

13/26.1 The Chair noted that the actions from the previous meeting had either been completed or were in progress.

14/26 - Item 5 – Planning

Procurement Update

14/26.1 Mr Murray presented an overview of the developments in Procurement outlining the delays in tenders as a result of revisions required to terms and conditions due to the new Procurement Act. He advised these delays were likely to be close to 6 months and will have a corresponding delay to other areas of procurement. He advised that a meeting of the Procurement Board is due to take place within the next few weeks.

14/26.2 Mr Murray said that the Procurement Plan for 2026/27 is being reviewed and that the team is looking at the timelines and capacity to drive procurement work forward, particularly the pre-planning stage. Mrs Henderson noted that the pre-planning stage is where there appears to be a bottleneck and PHA needs to put its resources there. The Chair said that he is content that there is a plan, but he would like to see the timelines and to get a better understanding the causes of delay. He asked on how procurement exercises are being prioritised. Mr Murray clarified the process for prioritising contracts and agreed to provide a timeline **(Action 1 – Mr Murray)**.

Public Health Planning Teams Action Plans ***(PPR/01/05/26)***

14/26.3 Mr Murray presented the Draft action plans for each of the Planning teams and outlined the considerable progress made to set out the annual plans for each team. He noted that the indicators and the actions are all linked to the Corporate Plan. The Chair asked why the number has reduced to five and Mr Murray explained that this is to ensure alignment with the new PHA structure and the Corporate Plan, and to ensure that the focus of the plans looks at a population level rather than at a thematic level.

14/26.4 Mr Murray advised that the five teams are all at different stages as some have been in place longer than others. He said that these drafts will be further refined and he acknowledged the work of Mr Bailey and Ms Mawhinney in helping the teams to get to this stage.

14/26.5 The Chair stated that from the perspective of the Board, he would like to see regular updates from planning teams during the year to help the Board to monitor PHA progress against its strategic plan as well as the outworking of the Reshape and Refresh programme. It was agreed that a plan would be presented to the Board setting out a timetable for presentation **(Action 2 – Mrs Scott)**.

14/26.6 Mrs Henderson commended the work noting that each report was in a different format, giving each team its own identity. She asked if PHA would be sharing the charts in the plans with the Department and with Trusts and asked how indicators which were not available would be developed. Dr McClean acknowledged some issues with data particularly relating to Healthcare Acquired Infections (HCAIs) and Anti-microbial Resistance (AMR). She also noted opportunity for some further indicators in areas including wastewater and cancer diagnosis, where data is available. Mrs Henderson asked if this helps PHA get the understanding it needs in relation to protecting health. Dr McClean said that work is ongoing in many areas, and noted some of the work was beyond the control of the Agency.

14/26.7 The Chair noted the importance of working with the Department of Health, particularly in relation to This Is Our Health and Neighbourhood, and highlighted that it would be useful to reference these in the Plans. The Chair also noted that PHA will be undertaking stakeholder engagement to increase the profile and awareness of the Agency across other public sector partners. Mr Wilson commented that it is good to see that within the plans, stakeholders have been identified upfront.

14/26.8 The Chair asked Mr Bailey and Ms Mawhinney for their views. Mr Bailey said that from his perspective, work is now becoming much more streamlined and having the 3-year plans will make it much better, but now it needs to be delivered. He added that there has been a lot of investment in the operating model, and while it will take time to be established, he would wish to see improved collaboration. Ms Mawhinney acknowledged progress with more integration and collaboration and observed there would be a required cultural change to ensure success of the plans.

14/26.9 The Chair asked if the learning is being captured and if for example, a team is doing something well, this learning is being transferred to other teams. Ms Mawhinney replied that each team has its own Senior Planning Manager associated with it and these managers are meeting, and similarly there is now a Planning Teams Chairs Forum which has met on a couple of occasions. The Chair welcomed that SPPG are also involved and noted the excellent presentation that was given at the last Board

meeting. He added that he would like to see more presentations to the Board. Ms Mawhinney said that work is ongoing on a reporting schedule for this Committee.

15/26 - Item 6 – Performance

Quarter Four Performance Report ***(PPR/02/05/26)***

15/26.1 Mr Murray presented the Quarter 4, year-end performance report advising that of the 56 actions, 41 are rated "blue", therefore fully complete, 7 are rated "amber" and 11 are rated "red".

15/26.2 The Chair sought for clarification on KPI 24 on the Safety and Quality Framework. Mrs Scott explained that this is linked to the development of a new process for Serious Adverse Incidents (SAIs) which the Department is leading on.

15/26.3 The Chair sought further information about KPI 20 on the framework for the planning teams. Mr Murray explained that it has been drafted and is pending Board approval subject to further clarification in relation to Joint Planning Teams with SPPG.

15/26.4 The Chair asked about KPI 25 on the Reshape and Refresh programme as he felt that the programme had been concluded. Mr Wilson explained that there is one final piece of work, which is to undertake an evaluation of the programme, and Ms Grainne Cushley is taking this forward.

15/26.5 The Chair acknowledged the work that has been undertaken to achieve this outcome.

15/26.6 Mrs Henderson noted that KPI 5 in relation to bowel screening is rated "blue", but the programme has not yet been extended. Mrs Scott explained that PHA has submitted the business case to the Department which is pending a decision.

15/26.7 The Chair asked if there is going to be a mid-year review of the Corporate Plan undertaken. Mr Murray replied that this could take place at the end of this 2026/27. Ms Mawhinney noted the restrictions around upcoming elections and possibly a new Programme for Government and recommended undertaking a review in the autumn.

15/26.8 Mrs Henderson asked if this Report is shared with staff. Mr Murray agreed to consider communication with staff to recognise achievements .

16/26 Item 7 – Resources

2026/27 Financial Update Position

16/26.1 Mrs Scott updated members on the outturn for 2025/6 and that the financial year has been finalised with the accounts submitted to the auditors. She reported that PHA ended the year with a surplus of £88k.

At this point Dr McClean left the meeting

16/26.2 In relation to 2026/27, Mrs Scott advised that she attended a Finance Summit meeting on Tuesday where attendees were informed that no budget has yet been agreed by the Assembly and that there remains an £800m deficit in the health budget. She added that the Department of Health hoped to present a 3 year recovery plan which would require 6% savings in 2026/7 with a further 3% in each of the following two years. She said that PHA is expecting an allocation letter from the Department of Health which would include a 6% reduction. She added that PHA had submitted a savings plan in response to requests for 5% savings and had been instructed to implement the proposals. However due to discussion around funding for Community and Voluntary Sectors clarification is now being sought.

16/26.3 Mrs Scott said that there was discussion at the summit about the need for all HSC organisations to have a co-ordinated approach to implementing the savings, including Equality impact and Rural Needs assessment. The process for which has to be worked through. Mrs Scott also emphasised that PHA has also has a statutory responsibility to break even and without intervention and as the year goes on, there will be an increased pressure to achieve the level of savings.

17/26 Item 8 – Terms of Reference [PPR/04/05/26]

17/26.1 Mrs Scott advised that the terms of reference have been updated to remove any elements relating to Human Resources.

17/26.2 Ms Kelly queried the quorum and the reference to “Officers” and if this should read, “Executive Directors”. The Chair agreed that this should be amended.

17/26.3 Members **APPROVED** the updated terms of reference.

15/26 - Item 6 – Performance (ctd.)

Corporate Plan Indicator Progress Summary ***(PPR/03/05/26)***

15/26.9 Mr Murray presented the dashboard, the work for which he said has been led by Ms Mawhinney and Ms Marie-Thérèse Higgins. Ms Mawhinney acknowledged the work of Ms Higgins in compiling this, but she caveated that it is not intended to be a statistical analysis, but more about ensuring that PHA has some level of awareness of the direction the indicators are going. She said that the aim was to get as much information as possible, but in some cases the information is not available. She added that going forward the team will link with Mr Paul Barber to take this work forward and to have an improved document that looks at data modelling. She said that this would be shared with members when available.

15/26.10 Mrs Henderson asked if these indicators are the ones that are being used by the planning teams. Ms Mawhinney replied that they have been shared with the planning teams to ensure that there is no duplication. Mrs Scott added that these indicators were set when the Corporate Plan was developed and the aim is to ensure that the team works to these and acknowledged the amount of work invested to get the report to this stage . Mr Murray said that once all of the senior planning managers were

in place, it was intention to be able to produce this information and going forward the team with work with the new digital directorate.

15/26.11 Ms Kelly asked if there were any other organisations that held the data that PHA is looking for, thus easing the burden on PHA. She asked about disaggregation of the data to look at, for example, is it a higher percentage of young men from certain socio-economic areas who smoke. Mrs Scott replied that health inequalities sits across all of the planning teams and is an important aspect of their plans. She added that PHA is also establishing an Equality Forum. With regard to the information, Mr Wilson said that it is PHA's aim to have updated indicators on the new PHA website which was under development.

15/26.12 The Chair indicated the opportunity for other organisations to track some of these areas and integrate with PHA's stakeholder engagement work.

15/26.13 The Chair asked for this update to be reported to the Board would for interest. Mr Murray said that the indicators will form part of the updates that the planning teams will bring when they present to the Board. Mrs Henderson asked if there could be an update for the Board on the work of the Equality Forum **(Action 3 – Mrs Scott)**.

Item 9 – Any Other Business

18/26.1 There was no other business.

Item 10 – Details of Next Meeting

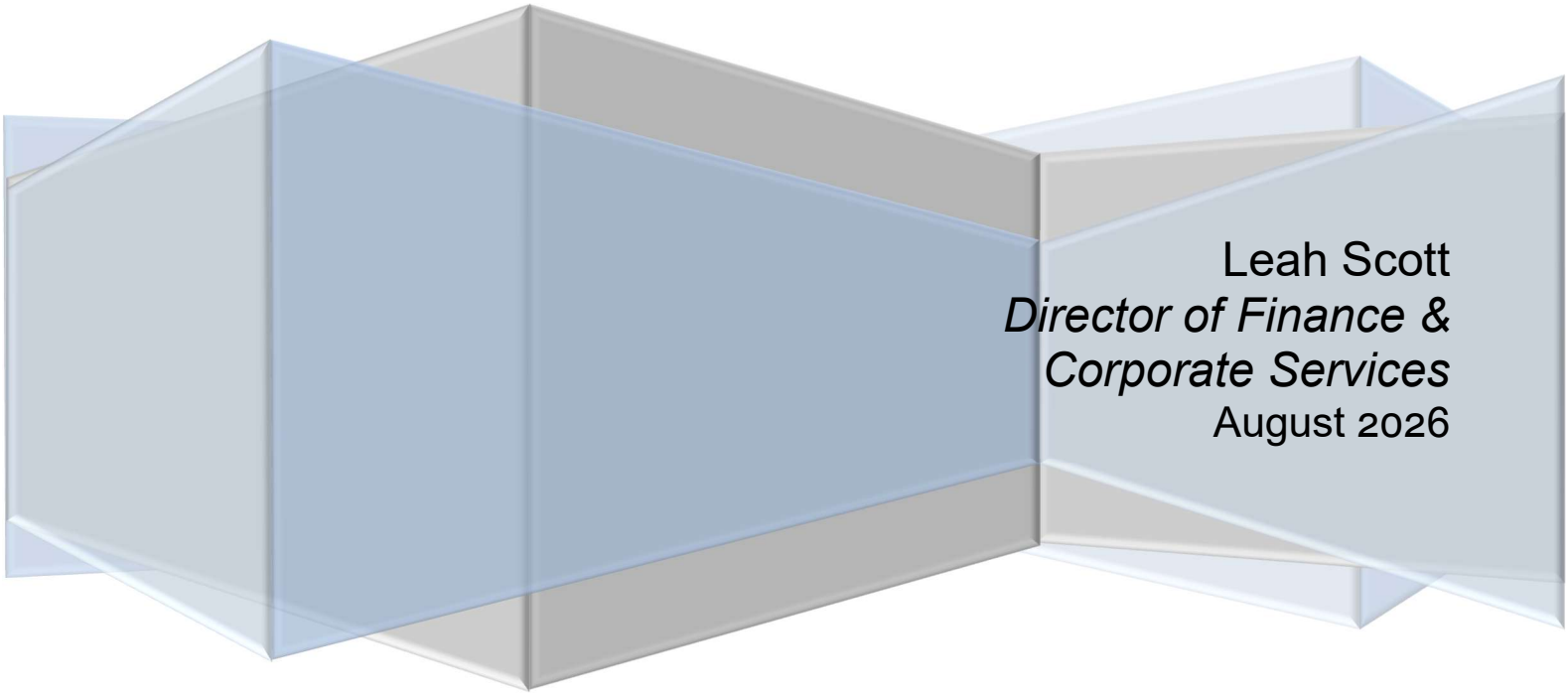
Thursday 20th August 2026 at 10.00am,
Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Signed by The Chair:

Colin Coffey

Date: 20 August 2026

Finance Report
Month 3 - June 2026



Leah Scott
Director of Finance & Corporate Services
August 2026

Introduction

This summary report outlines the Agency's statutory duties and provides an update on the financial position at month 3. However, due to the uncertainty around savings targets across the HSC, there is no confirmed allocation for PHA in 2026/27, and the Financial Plan 2026/27 has not yet been presented to PHA Board for approval.

Section A: Statutory Targets

- **Break-even**

The PHA is directed to achieve financial balance, with the statutory duty to break-even within a tolerance level of 0.25% of an underspend of the final agreed Revenue Resource Limit (RRL) or £20,000 of an underspend, whichever is the greater.

- **Financial Planning**

The Agency must annually plan service delivery in a way that meets its statutory responsibilities and ensures that expenditure is contained within the total RRL.

- **Prompt Payment**

The Department requires that PHA pay at least 95% of invoices (by volume) within 30 days, to their non-HSC trade payables in accordance with Government Accounting guidance.

Section B: Summary Position

The position at 30 June 2026 (Month 3) reflects a year-to-date (YTD) **underspend of £470k** and a forecast full year **deficit of £1.682m**. This reflects the difference between the 6% savings reduction (£5.046m) incorporated within the PHA's indicative allocation and the 4% savings programme (£3.364m) currently considered deliverable. Resolution of this position remains dependent on confirmation of the final DoH allocation and Ministerial decisions regarding the implementation of additional savings measures

Table 1: PHA Summary Revenue position – May 2026	Jun 26 Budget £'000	Jun 26 Actual £'000	Jun 26 Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast Expenditure £'000
Programme Expenditure by Trust	3,827	3,827	(0)	11,993	11,993	(0)	48,998
Programme Expenditure by PHA	2,447	2,473	(26)	8,371	8,277	94	57,414
Total Programme Expenditure	**6,275**	**6,300**	**(26)**	**20,364**	**20,270**	**94**	**106,412**
Management & Admin	**2,908**	**2,799**	**109**	**8,601**	**8,241**	**361**	**34,440**
Ringfenced by Trust	-	-	-	-	-	-	-
Ringfenced by PHA	79	55	24	152	138	14	764
Total Ringfenced	**79**	**55**	**24**	**152**	**138**	**14**	**764**
Other Revenue Income	**-**	**-**	**-**	**-**	**(1)**	**1**	**-**
PHA Total	**9,262**	**9,154**	**108**	**29,117**	**28,647**	**470**	**141,616**

Total Funding Available 2026-27 (Appendix 1)	**139,934**
Forecast Surplus/(Deficit)	**(1,682)**

Appendix 1 sets out further detail on the PHA **indicative** funding allocation of £139.9m.

The DoH receives a budget allocation from the Minister each year. The Department is then responsible for the allocation of funds across HSC organisations while ensuring financial balance is achieved. During the year the supplementary monitoring process provides a formal system for reviewing emerging pressures and priorities against the most up to date financial position.

The financial position remains subject to significant uncertainty pending confirmation of the final DoH allocation, agreement of an Executive Budget and any Ministerial direction regarding implementation of the full 6% reduction. In the absence of approval to reduce the proposed savings the PHA is reviewing all available options to bridge the residual gap. Given the limited scope to achieve saving from programme budgets without impacting service delivery, any additional savings are likely to arise from management & administration budgets. However, these opportunities are limited and may introduce further operational, workforce and organisational risks for the Agency

The Agency will continue to engage closely with DoH and maintain robust financial monitoring throughout the year to manage financial risks and maximise opportunities to achieve financial balance.

Section C: Expenditure to month 3

Based on the indicative allocation of £139.9m, the PHA is forecasting a full year deficit of £1.682m, as outlined in Section B above. **Table 2** provides a breakdown of the forecast expenditure of £141.6m by budget area.

Table 2: Breakdown by Budget Area	Jun 26 Budget £'000	Jun 26 Actual Exp £'000	Jun 26 Variance £'000	YTD Budget £'000	YTD Actual Exp £'000	YTD Variance £'000	Forecast Expenditure £'000
Programme Expenditure							
HSC Trust (See Table 3)							
Public Health	2,811	2,811	-	8,445	8,445	-	33,809
Population Health & Wellbeing	1,017	1,017	(0)	3,548	3,548	0	15,189
Chief Executive & Board	-	-	0	-	-	-	-
Sub Total By Trust	3,827	3,827	0	11,993	11,993	0	48,998
PHA Internal							
Public Health	1,605	1,668	(63)	3,793	3,794	(1)	28,982
Population Health & Wellbeing	723	721	3	4,114	4,064	50	23,667
Population Data & Intelligence	90	81	9	377	374	2	4,252
Chief Executive & Board	29	4	25	88	44	44	514
Sub Total By PHA Internal	2,447	2,473	(26)	8,371	8,276	95	57,414
Sub Total Trust + PHA Internal	6,275	6,300	(26)	20,364	20,269	95	106,412
Management & Admin							
Public Health	1,261	1,260	0	3,787	3,664	123	14,769
Population Health & Wellbeing	750	655	96	2,229	2,021	208	8,594
Finance & Corporate Services	399	373	26	1,147	1,049	98	4,298
Population Data & Intelligence	245	282	(37)	737	750	(13)	3,484
Chief Executive & Board	151	167	(16)	441	510	(69)	2,239
SBNI	102	63	39	260	246	14	1,057
Sub Total - Management & Admin	2,908	2,799	109	8,601	8,241	361	34,440
Ringfenced							
Trust	-	-	-	-	-	-	-
PHA Direct	79	55	24	152	138	14	764
Sub Total	79	55	24	152	138	14	764
PHA TOTAL	**9,262**	**9,154**	**108**	**29,117**	**28,647**	**470**	**141,616**

In respect of the year to date position:

Trust Programme - A *balanced position* is shown with all allocations to Trusts from PHA being considered to be fully spent.

PHA Internal Programme – An *underspend of £95k* is shown on PHA Internal programme budgets (i.e. Non-Trust) for the year-to-date. This relates to small underspends in each directorate due to timing of payments v budget profiling.

Management & Administration - A *surplus of £361k* is shown on the Management & Administration budget at month 3, primarily reflecting underspends generated by the current level of vacancies across the Agency. This position is in line with planning assumptions and has been incorporated within the Financial Plan to help mitigate

identified programme pressures and support the Agency's overall financial position during 2026/27.

Ringfenced Funding – a small *underspend of £14k* is shown for the year to date. The full year budget currently comprises of NI Protocol funding (£67k), COVID (£289k, mainly for vaccinations) and Tackling Paramilitarism / Fresh Start (£408k). A full year breakeven position is expected. This position will be kept under close review during the year, and potential slippage highlighted at an early stage if it arises.

Trust Allocations: Table 3 below summarises the allocations to the respective Trusts in 2026/27 to date.

Table 3: Trust Allocations	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS £'000	Total Planned Expenditure £'000
Public Health							
Health Protection	2,579	2,617	1,802	2,231	1,888	-	**11,117**
Service Development & Screening	8,615	3,700	1,005	2,592	3,338	-	**19,251**
Living Well	1,075	580	694	560	505	-	**3,414**
	12,270	**6,897**	**3,500**	**5,383**	**5,732**	**-**	**33,782**
Population Health & Wellbeing							
Ageing Well	274	69	204	110	37	-	**693**
Early Years	1,584	1,320	931	1,837	1,607	-	**7,278**
MH&LD	4,300	711	228	530	247	12	**6,029**
Partnership & Engagement	32	32	32	32	32	32	**193**
	6,190	**2,132**	**1,395**	**2,508**	**1,922**	**44**	**14,192**
Other - Yet to be allocated	359	445	144	15	-	61	**1,024**
Total Core Funding	**18,819**	**9,474**	**5,040**	**7,906**	**7,654**	**105**	**48,998**
Ringfenced - Covid	-	-	-	-	-	-	**-**
Total Current RRLs	**18,819**	**9,474**	**5,040**	**7,906**	**7,654**	**105**	**48,998**

All funding allocated to Trusts by PHA is considered to be fully spent unless notified otherwise by the Trust. Any notified underspends are retracted by PHA, hence no variance occurs for PHA on Trust allocations.

Section D: Risks

The following significant assumptions, risks or uncertainties facing have been considered in assessing the agency's forecast position at 30th June 2026.

Risks to Year-End breakeven

	Risk	Status
1.	**Failure to Deliver the Required Savings in 2026/27** The most significant financial risk is the £1.682m gap between the 4% saving programme considered deliverable and the 6% reduction within the indicative opening allocation. In the absence of Ministerial approval regarding proposed reductions to programme expenditure the PHA is reviewing all available options to bridge the residual gap.	**On-going, and significant** *Further engagement with DOH is required to clarity regarding the final 2627 allocation & saving requirements.*
2.	**Demand-led budgets** There are a number of demand-led budgetary areas that are more difficult to forecast the funding requirements and therefore manage the budgets. These include Nicotine Replacement Therapy (NRT) and various vaccination budgets totalling in excess of £25m. Demand for these services can fluctuate significantly during the year, creating potential financial pressures. The position will be closely monitored by the Immunisation & Vaccination and Finance teams to ensure any emerging risks are identified early and managed appropriately to minimise the impact on the Agency's financial position.	**On-going** *Both vaccines and NRT Smoking Cessation will continue to be closely monitored throughout the year.*
3.	**Administration Slippage** Historic levels of vacancy related slippage have reduced during 2026/27 as the Agency transitions to more substantive staffing structures. The Financial Plan includes an estimate of approximately £0.9m in-year slippage to help fund known pressures. The position will be closely monitored throughout the year, with any material changes reported promptly to AMT and the Board.	**On-going** Month 3 reports M&A slippage of £367k
4.	**Population Research & Intelligence Directorate** The approved funded structure under the Reshape & Refresh process includes £400k of M&A funding for this Directorate, based on the approved business case at the time. However, there was an acceptance that a larger funding envelope would be required in the long-term to appropriately staff this Directorate. PHA will need to identify further funding in order to adequately resource this team following the appointment of the Director of PRI	**On-going**

Risks to Longer-term Financial Stability

	Risk	Status
1.	**HSC-wide funding gap**: DoH have indicated an HSC funding gap in the region of £1 billion for 2026/27 and has provided early indications that HSC organisations may be required to deliver a total of 12% savings over a 3 years period commencing in 26/27. Delivery of cuts on this scale will have serious implications for the PHA's ability to achieve its corporate objectives, maintain investment in prevention and early intervention, and fully discharge its statutory duties. The PHA is continuing to engage with DoH on the outcome of this process and the impact for future years' allocations.	**On-going** *Further engagement will be required with DoH to ensure a viable recurrent budget is retained for future years*

Section E: Prompt Payment

Prompt Payment performance for June shows that PHA is above the 95% prompt payment target on volume but is below the target on value, due to two large invoices failing to meet the 30-day target. The year to date position shows that the PHA is achieving its target on volume but is slightly below on value. Prompt payment targets will continue to be monitored closely over the 2026/27 financial year.

Table 4: Prompt Payment Performance	**June 2026** **Value**	**June 2026** **Volume**	**Cumulative position as at June 2026** **Value**	**Cumulative position as at June 2026** **Volume**
Total bills paid (relating to Prompt Payment target)	£4,139,846	288	£13,899,930	949
Total bills paid on time (within 30 days or under other agreed terms)	£3,674,842	276	£13,119,886	913
Percentage of bills paid on time	**88.8%**	**95.8%**	**94.4%**	**96.2%**

The 10-day prompt payment performance remains above the current DoH target for 2026/27 of 70%, at 82.6% on volume for the year to date.

Section F: Capital position

The PHA has a capital allocation (CRL) of £13.458m at 30 June 2026. This mainly relates to projects managed through the Research & Development (R&D) team. An additional £5.5m is allocated to Trusts in-year and is not reflected in the table below.

The overall summary position, at the end of June 2026, is reflected in **Table 5** below.

Table 5: PHA Summary capital position – 30 June 2026

Capital Summary	Total CRL	Year to date spend	Full year forecast	Forecast Surplus/ (Deficit)
	£'000	£'000	£'000	£'000
HSC R&D:				
R&D - Health ALBs	261	-	261	-
R&D - held for Trusts	4,592	-	4,592	-
R&D - Other Bodies	3,859	496	3,859	-
R&D - Capital Receipts	(564)	-	(564)	-
Subtotal HSC R&D	**8,148**	**496**	**8,148**	**-**
Other:				
Congenital Heart Disease Network	627	-	627	-
iReach Project	1,589	-	1,589	-
R&D - NICOLA	691	-	691	-
Monitors for Directors	-	-	-	-
Planning Laptops	-	-	-	-
Device Refresh	-	-	-	-
R&D VPAG	1,281	-	1,281	-
R&D VPAG Trusts	626	-	626	-
R&D VPAG Other Bodies	496	-	496	-
Subtotal Other	**5,311**	**-**	**5,311**	**-**
Total PHA Capital position	**13,458**	**496**	**13,458**	**-**

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

The relatively low level of expenditure to date is in line with expectations, and a breakeven position is expected for year-end. Any departure from this position will be notified to AMT and Board as early as possible.

Recommendation

The PHA Board are asked to note the PHA financial update as at June 2026.

Appendix 1 – Breakdown of Funding Allocation 2026/27

Letter	Description	Total Allocation
DoH Allocation Letters:		
PHA 1	Indicative PHA Opening Allocation	**£138,278,747**
Assumed allocations to come from DoH (currently included in budget):		
	Fresh Start	£408,000
	Clinical Excellence Award	£60,931
	Joint Partnership Lead - J McGinty	£40,000
	Accommodation funding for LHS from SPPG	£250,000
	Sessional Vaccinators	£289,000
	SBNI CCE	£110,000
Assumed Funding from NIMDTA		£498,126
Total Funding for 2026-27		**£139,934,804**

item 10

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Annual Progress Report 2025-26 to the Equality Commission on implementation of Section 75 and the Duties under the Disability Discrimination Order
Reference	PHA/06/08/26
Prepared by	BSO Equality Unit
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is for the Board to note the contents of the PHA's Annual Progress Report and approve submission to the Equality Commission.

2 Key Issues

This Report follows a set template and is laid out as follows:

Chapter 1 – Summary Quantitative Report

Chapter 2 – Section 75 Progress Report

Chapter 3 – 2025-26 Progress Report on delivery on PHA Equality and Disability Action Plans 2023-28

Chapter 4 – PHA Equality and Disability Action Plans 2023-28 (updated August 2026)

Chapter 5 – Screening Report

Chapter 6 – Mitigation Report

This Report was approved by the Agency Management Team at its meeting on 17 August 2026.

As in previous years, all Directorates were asked to provide information to the Equality Unit – this process has been automated in the last three years, through the use of MS

Forms, to simplify the process for PHA staff. The Equality Unit then prepared the report for PHA on the basis of the information received.

Update on PHA Equality Forum

Plans for the PHA Equality Forum have developed and expanded over the past year. Following the establishment of the PHA Equality Forum and its first meeting in March 2026, discussions with PPI colleagues resulted in the decision to expand the remit of an Equality only Forum and establish a PHA Equality, Experience and Involvement (EE&I) Associates Forum. An information session at 'First Tuesday' was held on 31 March 2026 to advise staff of the new EE&I Forum and to seek interest. A further two in-depth Information Sessions were held in mid-May for those who expressed an interest and a Training and Onboarding session was held at the end of May. Over 20 staff (band 6 and above) have committed to this Forum. The first meeting of the EE&I Forum took place in June 2026 and the next meeting is scheduled for September 2026. Meeting will take place on a quarterly basis.

This EE&I Forum will support the PHA to meet statutory and policy responsibilities for Equality and Disability Duties and also human rights), Experience & Involvement duties and will embed Equality, Disability, Experience and Involvement (EE&I) across all Directorates. It will bring a stronger alignment with statutory duties and better reporting on activity taking place within PHA. It will allow improved staff capability, confidence and consistency and there will be a greater sharing of good practice, learning and staff engagement. It is expected that, as a result, there will be an increase in equality screenings and DPIAs and Involvement organisational monitoring returns.

The EE&I Forum will be jointly chaired between PHA Partnership & Engagement and Equality (Corporate Services) colleagues and will be accountable to AMT. Reporting to AMT will be via the Director of Finance & Corporate Services and Assistant Director, Partnership & Engagement.

3 Next Steps

Following approval the Report will be submitted to the Equality Commission.

Public Authority Statutory Equality, Good Relations and Disability Duties - Annual Progress Report 2025-26

Contact:

• Section 75 of the NI Act 1998 and Equality Scheme	Name: Leah Scott Telephone: 03005550114 Email: Leah.Scott@hscni.net
• Section 49A of the Disability Discrimination Act 1995 and Disability Action Plan	As above

(ECNI Q28):
Documents published relating to our Equality Scheme, including our most recent Five-Year-Review of Equality Scheme, can be found at:
http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality
Our Equality Scheme is due to be reviewed again by 30th June 2026.

Signature:

This report has been prepared adapting a template circulated by the Equality Commission. It presents our progress in fulfilling our statutory equality, good relations and disability duties. This report reflects progress made between April 2025 and March 2026.

Contents

Chapter 1: Summary Quantitative Report

(ECNI Q15,16,19)
Screening, EQIAs and Consultation

1. Number of policies screened (as recorded in screening reports). (see also Chapter 6)	**Screened in**	**Screened out with mitigation**	**Screened out without mitigation**	**Screening decision reviewed following concerns raised by consultees**
8	0	2	6	No concerns raised by consultees on screenings published in 2025-26
2. Number of policies subjected to Equality Impact Assessment.	1			
3. Indicate the stage of progress of each EQIA.	Physical Activity Referral Scheme (PARS): A draft EQIA for the current PARS service was prepared but not brought forward as the updated criteria and payment model was being piloted. Subsequent PHA restructuring delayed EQIA adoption. The PARS model and delivery organisations have been involved in a review process within 25/26 and new EQIA will be produced within 26/27 informed by the PARS service review recommendations and related adaptations.			

4. Number of policy consultations conducted	1
5. Number of policy consultations conducted with screening presented. (See also Chapter 2, Table 2)	1

(ECNI Q24)
Training

6. Staff training undertaken during 2025-26. (See also Chapter 2, Q6)

Course	**No of Staff Trained**	**No of Board Members Trained**
Equality Screening Training	4	0
Total	**4**	**0**

eLearning: 'Making a Difference' (mandatory equality awareness training)

Part 1 – All Staff	343
Part 2 – Line Managers	62

(ECNI Q27)
Complaints

7. **Number of complaints in relation to the Equality Scheme received during 2025-26**

1

Please provide detail of any complaints/grievances:

PHA's guidance/communications practice that assumes ETSU sufficiency and provides no indoor night LFN/infrasound protection, surveillance, or clinical signposting. Policy includes formal and informal practices.
Equality Scheme — alleged failures to comply: (1) screen/EQIA this practice; (2) publish screening decisions and consult; (3) monitor/review in light of new evidence affecting Section 75 groups.

(ECNI Q7)
Equality Action Plan (see also Chapter 3)

8. **Within the 2025-26 reporting period, please indicate the number of:**

Actions completed:	4	Actions ongoing:	3	Actions to commence:	1

(ECNI Part B Q1)
Disability Action Plan (see also Chapter 3)

9. **Within the 2025-26 reporting period, please indicate the number of:**

Actions completed:	4	Actions ongoing:	4	Actions to commence:	2

Chapter 2: Section 75 Progress Report

(ECNI Q1,3,3a,3b,23)

1. **In 2025-26, please provide examples of key policy/service delivery developments made by the public authority in this reporting period to better promote equality of opportunity and good relations; and the outcomes and improvements achieved. Please relate these to the implementation of your statutory equality and good relations duties and Equality Scheme where appropriate.**

Table 1 below outlines examples of progress to better promote equality of opportunity and good relations.

Changes resulting directly from equality screenings are reported in Chapter 6, the Mitigation Report. Those due to the implementation of Equality and Disability Action Plans are outlined in Chapter 3.

In many other cases, it is not possible to ascribe developments to one single factor of Equality Scheme implementation. New initiatives are not necessarily an outcome of any equality screenings or Equality Impacts Assessments. As mainstreaming progresses and the promotion of equality becomes part of the organisational culture and way of working, the more difficult it becomes to ascribe activities and outcomes to the application of a specific element of Equality Scheme implementation. From this point of view, staff training and engagement and consultation are arguably the most important factors.

Table 1:

	Outline new developments or changes in policies or practices and the difference they have made for specific equality groupings.
Persons of different religious belief	
Persons of different political opinion	
Persons of different racial groups	**Population Health and Wellbeing Directorate** The PHA **Keep Warm Pack Scheme** is an annual, regional winter preparedness intervention developed to provide immediate, short term support, to help those most vulnerable or at risk of fuel poverty to stay warmer at home during cold weather. Packs include items such as, a fleece, thermal underwear, socks and a blanket. The scheme is commissioned and co-ordinated by the PHA in collaboration with a range of local government, HSCT, community and voluntary partners. In 2025/2026 we introduced a new focus on targeting and distribution to people from Equality groups including and Inclusion Health Groups: People who experience homelessness, People from vulnerable migrant communities, Gypsy, Roma and Irish Traveller communities (ethnicity and racial backgrounds), People in contact with the justice system. The PHA worked with a range of stakeholder organisations to ensure effective targeting and distribution to these groups. Winter 2025/2026 partners with reach and capacity to support distribution to vulnerable minority ethnic groups, included: STEP; Inter Ethnic

	Forum; Chinese Welfare Association (CWA); BHSCT; SEHSCT; SHSCT/NINES; WHSCT; Toybox; Starling Collective; Start 360; HAPANI; Homeplus; Flourish NI. This intervention helps the most vulnerable, including people from vulnerable migrant communities, such as, Gypsy, Roma and Irish Traveller communities (ethnicity and racial backgrounds) at risk of fuel poverty to stay warmer at home during cold weather, often providing crisis winter support. This work also assists trusted partners across NI to provide additional crisis support in the form of client contact, engagement and the offer of other support pathways. In 2025/2026 a total of 6645 packs were distributed through the Keep Warm Pack Scheme. The new intervention targeting Equality Groups delivered a total of 1495 packs, which were distributed to people from Inclusion Health Groups. This new targeted scheme resulted in 22.5% of the total packs being targeted at these Equality Groups. We intend to continue to evolve existing targeted approach to become part of the core Keep Warm Pack Scheme contract, including shaping the EQIA associated with likely future re-procurement in 2027/2028. We plan to use the learning from this equality groups targeted approach in our other work within the Health Inequalities Team. **Public Health Services Directorate** **Infectious Diseases in Pregnancy Screening** has developed multilingual information videos on Hep B in pregnancy to support these women to understand the condition, attend their appointments and complete their infant

	vaccination schedule. This will provide greater accessibility for people whose first language is not English.
Persons of different age	**Population Health and Wellbeing Directorate** An **Age Friendly Awareness Training Programme** has been developed and implemented to strengthen organisational practice across statutory, community, voluntary and business sectors. The programme introduced a blended delivery model—combining in-person workshops with a pre-recorded online webinar—to improve accessibility, sustainability and reach. It has embedded experiential learning approaches, including ageing and visual-impairment simulation tools and lived-experience insights, to build greater empathy, challenge ageism, and support organisations to identify practical actions that improve the age-friendliness of their services. This represents a shift towards a more structured, consistent and scalable approach to age-friendly capacity building and workforce development. This development will make a positive and practical difference for older people by improving how services, organisations and communities understand, design and deliver support for later life. By equipping professionals across statutory, community, voluntary and business sectors with a stronger understanding of ageing, the programme helps to create more inclusive, respectful and accessible environments for older people. Specifically, older people will benefit from: • More age-friendly services and environments, as staff apply learning to reduce physical, communication and attitudinal barriers.

	• Improved experiences when accessing services, with greater awareness of age-related changes such as mobility, hearing, eyesight and cognitive needs. • Reduced ageism and stigma, resulting in older people feeling more respected, understood and valued. • Better responsiveness to need, as organisations identify and implement practical changes informed by lived-experience insights. • Greater confidence and independence, supported by services that are easier to navigate and more inclusive by design. Overall, the change supports fairer access, improved wellbeing and stronger inclusion for older people, enabling them to remain active, connected and engaged in their communities.
Persons with different marital status	
Persons of different sexual orientation	
Men and women generally	**Public Health Services Directorate** Newly updated Trans community Screening information leaflets: Clear, inclusive, and current information that reflects best practice, evolving terminology, and available services. It ensures individuals can easily access accurate guidance on healthcare pathways, support networks, and their rights, reducing confusion and

	improving engagement with services. Regularly refreshed content also demonstrates organisational commitment to equality, inclusion, and person-centred care—helping to build trust with a community that may have previously experienced barriers or stigma.
Persons with and without a disability	**Population Health and Wellbeing Directorate** **Co design of 10,000 MORE Voices project with service user groups within Cedar Foundation**; The purpose of this project is to explore how assistive technologies support people living with a disability. This also supports the voices of people with a disability to influence the strategic review of assistive technologies led by DoH - this includes sharing what went well, what can be improved and how people feel about their experience. This project was developed in 2025/2026; The project launched in February 2026 with dedicated story generation up to June 2026. The codesign of the project has informed the final survey and engagement plan for people with a disability - assuring the project will reach out across the people of NI so their voices are heard. This project has been commissioned through Chief AHP officer with a commitment to ensuring the experience shared will shape the new model for assistive technology across NI. We co-developed an accessible evidence -based resource on **pressure ulcer prevention** in collaboration with Tissue Viability Nurses, learning disability advocates connected via TILLI (Arc UK) and a wider regional pressure ulcer prevention group. The resource is suitable for adults with a learning disability

	and their carers and for staff supporting adults with a learning disability. The resource contains information about pressure ulcers, their causes and top tips to stop pressure ulcers. The resource also contains a QR link to a previously published video developed with a service user in partnership with QUB, Belfast Trust and the Northern Trust. In some cases more than one specific equality group may benefit. Outcomes relate to • Improved health outcomes for adults with a learning disability and their carers by providing information which enable them to care for their skin and prevent pressure ulcers • Enhanced clinical confidence of Registered Nurses caring for adults with learning disability. The inclusion of a **new sub-directorate within PHA called Mental Health, Substance use and Learning Disability**: There is a new Public Health Planning Team sub-group being established, specifically looking at the health and wellbeing needs of people with learning disabilities and this group will develop an action plan to addressed these issues. Priority issues will be identified and progressed. Key responsibilities of this group include: • Work in a connected, cross directorate, multi-disciplinary way across the PHA, harnessing skills, experience, knowledge and resources from across

	the organisation in the areas of Learning Disability, in order to effectively achieve corporate and ministerial priorities and outcomes • Ensure programmes and services commissioned by the PHA have a focus on equity and addressing health inequalities • Take an evidence based and data driven approach to inform work of this Learning Disability Sub Group. **Public Health Services Directorate** The **Newborn Hearing Screening Programme** created a stakeholder steering group to develop BSL/ISL accessible videos with planned further outputs to improve accessibility and Engagement. **Very High Risk Breast Screening** has developed a new video with BSL/ISL overlay to help women navigate the Antrim Area Hospital site and navigate between the MRI and Mammogram units. This work will achieve greater accessibility for our Deaf Community. Further work on promoting equality for people with a disability in the workplace is reported on in detail in Chapter 3 (the Equality and Disability Action Plan – Progress Report 2025-26).
Persons with and without dependants	

Public Health Services Directorate

The **Community Grants and Mentoring Support Programme** provides a range of resources to support the building of capacity within local community organisations. The programme offers a small grant, peer mentoring support and education and learning on community development and health inequalities. The programme is delivered by Community Health and Development Network. In 2025/26 we introduced an additional weighting score as part of the community grants programme. This allowed for a small additional mark to be awarded to the grant applications which supported more under-represented groups in the population. This provided an opportunity to improve health equity across the programme and include the voices of groups seldom heard.

The improvements in the distribution of small grants across the region will increase the awarding of funding and mentoring support to under-presented groups, improving the health equity of this programme. The programme supported a total of 21 community organisations and provided £100,000 of funding to support local action to address health inequalities and build community capacity.

We are undertaking Wide Spread Work across the **Screening Equity Project** to see how we can better reach more marginalised groups: We are looking to re-allocate our awareness raising budget and support community organisations to promote screening through their local networks. This work is carried out in tandem with Health Improvement to encourage the greatest level of integration with existing networks. We are looking into support both rural and urban areas with a mix across demographic groups aiming to target those cohorts we see the lowest returns from for Screening (including along the dimensions of age, religious belief, disability, ethnicity or racial groups, and sexual orientation).

Further Developments

The PHA has established an **internal Working Group** to embed an inclusive culture in respect of equality and disability duties across Directorates, Services and Teams in the PHA in order to improve compliance with

statutory duties and responsibilities and facilitate better work synergies. The group will contribute to driving the equality agenda, for all nine Section 75 groups, across the PHA, in particular the mainstreaming of equality in all its work. It likewise aims to provide a forum to reflect on and share knowledge and learning across the organisation. By doing so, the forum will not only play a key role in supporting the organisation to meet its duties but it will also provide support to Directors, Assistant Directors and Heads of Services in fulfilling their role in promoting equality, good relations and human rights for all nine Section 75 groups.

Over the past year, development has continued on the **SharePoint Equality Portal**. New content includes a range of screening guidance documents for example guidance for screening the procurement of a service. Screening evidence has been added, such as up-to-date data on regional interpreting service statistics and signposting to the Children and Young People's Strategic Partnership interactive map-based data on Children and Young People in NI. In addition, staff can now access clear information on how to book foreign language and sign language interpreting services.

(ECNI Q4,5,6)

2. During the 2025-26 reporting period

(a) were the Section 75 statutory duties integrated within…?

	Yes/No	Details
Job descriptions	Yes	For all new posts, the Job Description includes the following: "Assist the organisation in fulfilling its statutory duties under Section 75 of the Northern Ireland Act 1998 to promote equality of opportunity and good relations and under the Disability Discrimination (Northern Ireland) Order 2006. Staff are also required to support the organisation in complying with its obligations under Human Rights Legislation."
Performance objectives for staff	Yes	All PHA staff have a mandatory performance objective to complete the 'Equality, Good Relations and Human Rights: Making a Difference' training module which outlines the Section 75 statutory duties.

(b) were objectives and targets relating to Section 75 integrated into…?

	Yes/No	Details
Corporate/strategic plans	Yes	The PHA Corporate Plan 2025-30 includes four strategic themes. Against each theme, priorities and indicators are identified. Two themes relate directly to Section 75 groups (children and young people; older people). Some of the priorities against the other two themes likewise refer to specific Section 75 groups. Examples include the following:

		Starting Well - Laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years: • deliver universal and targeted support, including Healthy Child Healthy Future, Family Nurse Partnership, and Northern Ireland New Entrants service (NINES) Living Well: • support those living with long-term conditions to live well Ageing Well - Supporting people to age healthily throughout their live: • increase levels of physical activity and promote opportunities to stay active Protecting Health: • lead the development and commissioning of vaccine programmes to ensure they are accessible to all, addressing the associated barriers and inequalities and ensure there is a key focus on seldom heard groups
Annual business plans	Yes	Against the Corporate Plan priorities, a number of actions and objectives included in the Business Plan 2025-26 related to specific Section 75 groupings. For example: **Action:** Launch a constipation campaign, to include establishing an expert reference working group with the aim to co-produce a suite of resources / guidance to support people

		with learning disabilities, their families / carers and clinical staff to prevent, recognise and treat constipation across the lifespan **Anticipated Impact / Desired outcome for client population:** Improve knowledge and provision to reduce ill health and poor outcomes associated with constipation in people with learning disabilities across the lifespan

(ECNI Q11,12,17)

3. **Please provide any details and examples of good practice in consultation during the 2025-26 reporting period, on matters relevant (e.g. the development of a policy that has been screened in) to the need to promote equality of opportunity and/or the desirability of promoting good relations:**

Table 2

Policy publicly consulted on	**What equality document did you issue alongside the policy consultation document?**	**Which Section 75 groups did you consult with?**	**What consultation methods did you use?** **AND** **Which of these drew the greatest number of responses from consultees?**	**Please tell us about anything you feel worked particularly well / not so well in this consultation.**
PHA Partnership & Engagement Strategy	☒ Screening template ☐ EQIA report ☐ none	As part of the Engagement plan for the strategy consultation the Partnership and Engagement team reached out to all contracted partners in	Questionnaire (online or paper); Free written comments (email or paper submissions);	Building upon established networks within PHA Health Inequalities team. For future consultations we will include a record of who responds to the online

		the Health Improvement programme for Health Inequalities including Rural networks, Barnardo's, CAUSE, centre for independent living and extern. A specific session was also hosted for members of RNIB	Online events; In person events One-to-one meetings Presentations to defined groups linked to C&V In person events drew the greatest number of responses from consultees	consultation and include in the consultation report.

(ECNI Q21, 26)

4. In analysing monitoring information gathered, was any action taken to change/review any policies?

Table 3

Service or Policy	What equality monitoring information did you collect and analyse?	What action did you take as a result of this analysis to address any inequalities observed?	Which Section 75 equality groups benefited from these changes specifically?
HSC R&D Division Attendees of HSC R&D Division's 'Building Research Partnerships' (Public Involvement in Research training), and review panel members for HSC R&D Division's Enabling Research Award scheme completed the Equality Monitoring form.	equality monitoring data on all 9 equality categories	The analysis did not identify any inequalities.	Not applicable

PHA Health Improvement ask each contract provider to gather S75 data across each quarter and to provide a summary of data collated within their quarter 4 report.

Section 75 – Equality Monitoring Form

- Service providers must use the PHA S75 Equality Monitoring Form with their clients/service.
- This information is to be collated and returned online through the Citizens Space Website by 31st May 2026
- We also ask that contract providers confirm in each quarter that this information is being collected and to let us know if they identify any issues with data collection.
- Citizen Space returns are then analysed.

(ECNI Q22)

5. **Please provide any details or examples of where the monitoring of policies, during the 2025-26 reporting period, has shown changes to differential/adverse impacts previously assessed:**

Table 4

Policy previously screened or EQIAed	What were the inequalities identified in the screening or EQIA?	Did the equality monitoring data you collected show that these inequalities had changed in 2025-26?	Please tell us more about these changes and why you think this has happened.
Capacity Building, Community Grants and Mentoring Programme	Inequalities in uptake of services for under-represented groups including people from ethnic minority backgrounds.	yes	We saw an increase in representation from ethnic minority groups in the revised programme.

(ECNI Q25)

6. **Please provide any examples of relevant training shown to have worked well, in that participants have achieved the necessary skills and knowledge to achieve the stated objectives:**

The PHA avails of the joint Section 75 training programme that is coordinated and delivered by the BSO Equality Unit for staff across all 11 partner organisations. The following statistics thus relate to the evaluations undertaken by all participants for the training.

Screening Training Evaluations

The figures in bold below represent the percentage of participants who selected 'Very Well' or 'Well'. Participants were asked: "Overall how well do you think the course met its aims". Of those who completed these questions:

- To develop an understanding of the statutory requirements for screening: **100%**
- To develop an understanding of the benefits of screening: **100%**
- To develop an understanding of the screening process: **94%**
- To develop skills in practically carrying out screening: **94%**

(ECNI Q29)

7. Are there areas of the Equality Scheme arrangements (screening/consultation/training) your organisation anticipates will be focused upon in the next reporting period?

During 2026-27 we will focus on

- Five Year Review of Equality Scheme (to be completed by end June 2026)
- Equality screenings – we currently anticipate to screen the following policies/decisions:
    - PHA Savings Plan 26/27
    - Public Health Planning Team Strategic Plans
    - Annual Business Plan 26/27
    - Age Friendly Framework
    - New service specification for stop smoking services in community pharmacy & New training framework.
    - If the Department of Health publish the new HSC R&D Strategy for NI within this time-frame, HSC R&D Division will develop an implementation plan and carry out an equality screening.

Appendix – Further Explanatory Notes

1 Consultation and Engagement

(ECNI Q10)
targeting – we used a targeted approach to consultation in addition to wider consultation activities.

(ECNI Q13)
awareness raising for consultees on Equality Scheme commitments – in the context of our quarterly equality screening reports, we raised awareness of our commitments in relation to screenings.

(ECNI Q14)
consultation list – we reviewed our consultation list every quarter in relation to bounce backs.

2 Audit of Information Systems

(ECNI Q20)
We completed an audit of information systems at an early stage of our Equality Scheme implementation, in line with our Scheme commitments.

Chapter 3: PHA Equality and Disability Action Plans - Progress Report 2025-26

Equality and Disability Action Plans 2023-28
Report on progress made during 2025-26

This document summarises progress made during 2025-26 against the actions we identified in our Equality and Disability Action Plans. The plans are available on our website: http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

Any request for this document in another format or language will be considered.

Disability Action Plan 2023-28

DAP01: Antenatal Infection Screening Programme, by 31 March 2026

What we will do: Infectious Diseases in Pregnancy Screening (IDPS) programme

Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against.

Work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.

What we are trying to achieve and who for: Promoting positive attitudes and Encouraging participation in public life

To ensure equality of care for all pregnant women screened positive for HIV.

To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.

Performance Indicators and Targets: QA structures for the IDPS programme agreed and implemented. (will be resource dependent)

Progress 2025-26: All Trusts have now had at least one meeting of their QA co-ordinating groups.

How we met the performance indicator: The last Trust had their first meeting in December 2025.

Action Status: Action complete - this is an annual action

DAP02: BSO Equality Unit, by 31 March 2028

What we will do: Disability Awareness Days - Raise awareness of the lived experience of people with specific disabilities and conditions.

What we are trying to achieve and who for: Promoting positive attitudes:

Increased staff awareness of a range of disabilities and conditions.

Performance Indicators and Targets: 2 awareness days profiled every year

Progress 2025-26: Our first Awareness Day covered Autism and ADHD. It was held on 3 December 2025, facilitated by Specialisterne. The second Awareness Day, held on 24 March 2026, focused on Chest, Heart and Stroke Conditions. Northern Ireland Chest, Heart and Stroke staff provided presentations on the day. Materials have been made available for staff and board members unable to attend on the day.

How we met the performance indicator: 2 days delivered

Action Status: Action complete - this is an annual action

DAP03: BSO Equality Unit, by 31 March 2028

What we will do: Disability Placement Scheme - Create and promote meaningful placement opportunities for people with disabilities.

What we are trying to achieve and who for: Promoting positive attitudes and Encouraging participation in public life:

People with a disability gain meaningful work experience.

People with a disability are successful in applying for paid employment after they have completed a placement.

Performance Indicators and Targets: At least 3 placements in the PHA offered every year.

Feedback through annual evaluation of scheme indicates that placement meets expectations.

At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.

Progress 2025-26: During this year, the Framework for Disability Placements was finalised and signed off in the BSO, who led on this joint initiative for BSO and partner organisations. Further consideration was given to safeguarding issues and it was agreed that having in place Adult Safeguarding Arrangements will be a prerequisite for hosting placements. This has pushed back timelines for commencing placements into 2026-27, until participating organisations have a policy, champion and reporting arrangements in place and staff have been trained at the appropriate level.

Action Status: No progress made

Future changes to action: PHA will be supported by the BSO Human Resources team, who have taken the lead on this work

DAP04: BSO Equality Unit, by 31 March 2028

What we will do: Tapestry Network - Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its priorities.

What we are trying to achieve and who for: Encouraging participation in public life:

Staff with a disability feel more confident that their voice is heard in decision-making.

Staff with a disability feel better supported.

Performance Indicators and Targets: Tapestry staff survey

Increase in Tapestry membership or in participation at meetings

Progress 2025-26: Tapestry, the staff disability network, met in July 2025. Subsequently, the chair resigned due to competing work commitments and a number of active members have now moved on to new employers. In the absence of a chair, secretary and treasurer, face-to-face meetings were paused. Tapestry has continued as a network via email and staff queries, advice and support requests continue to be responded to.

Action Status: Action complete - this is an annual action

Future changes to action: Reworded Action: Advise staff of the existence and contact details of the Tapestry staff network.

DAP06a: Digital Communications, by 31 March 2026

What we will do: PHA Websites - Ensure that content is reflective of society, including imagery, case studies and advice reflects diversity of race, ability and sexual orientation.

What we are trying to achieve and who for: Having due regard to the need to promote equality of opportunity; encouraging participation in public life:

To help ensure that people from a range of backgrounds feel represented.

Progress 2025-26: A discovery phase project was undertaken to assess PHA websites in relation to accessibility, inclusivity, and usability. This included an audit of the corporate website and microsites, supported by research to identify gaps in signed video provision, content representation, and overall usability (including subtitles and navigation). This was conducted October 2025 – February 2026.

- Audit completed and priority areas identified
- Interim accessibility and content improvements implemented on the corporate website
- Contact information reviewed and updated
- Enhancements made to better reflect diversity and inclusion
- Strategic plan agreed for development of an integrated PHA digital hub

Action Status: More work needs to be done

Future changes to action:

- Implement interim changes to the existing PHA corporate website (introduce HTML format for content going forward, improve sitemap structure, navigation)
- Develop and implement integrated PHA hub - migrate microsites to support accessibility
- Expand accessible content formats
- Ongoing monitoring and compliance with accessibility standards

DAP06b: Digital Communications, by 31 March 2026

What we will do: PHA Websites - Improve accessibility/usability (incl. use of subtitles)

What we are trying to achieve and who for: Having due regard to the need to promote equality of opportunity; encouraging participation in public life:

To help ensure that people with a disability receive information that is appropriately delivered to increase accessibility.

Progress 2025-26: A discovery phase project was undertaken to assess PHA websites in relation to accessibility, inclusivity, and usability. This included an audit of the corporate website and microsites, supported by research to identify gaps in signed video provision, content representation, and overall usability (including subtitles and navigation). – conducted October 2025 – February 2026

- Audit completed and priority areas identified
- Interim accessibility and content improvements implemented on the corporate website
- Contact information reviewed and updated
- Enhancements made to better reflect diversity and inclusion
- Strategic plan agreed for development of an integrated PHA digital hub

Action Status: More work needs to be done

Future changes to action:

- Implement interim changes to the existing PHA corporate website (introduce HTML format for content going forward, improve sitemap structure, navigation)
- Develop and implement integrated PHA hub - migrate microsites to support accessibility
- Expand accessible content formats
- Ongoing monitoring and compliance with accessibility standards

DAP06c: Digital Communications, by 31 March 2028

What we will do: PHA Websites - Undertake an audit of PHA websites, make key information on the website available in signed video format, and ensure relevant contact details are available and up to date in relation to requesting signed format versions.

What we are trying to achieve and who for: Having due regard to the need to promote equality of opportunity; encouraging participation in public life:

To help ensure that people with a disability receive information that is relevant to them and appropriately delivered to increase accessibility.

Progress 2025-26: A discovery phase project was undertaken to assess PHA websites in relation to accessibility, inclusivity, and usability. This included an audit of the corporate website and microsites, supported by research to identify gaps in signed video provision, content representation, and overall usability (including subtitles and navigation). – conducted October 2025 – February 2026

- Audit completed and priority areas identified
- Interim accessibility and content improvements implemented on the corporate website
- Contact information reviewed and updated
- Enhancements made to better reflect diversity and inclusion
- Strategic plan agreed for development of an integrated PHA digital hub

Action Status: More work needs to be done

Future changes to action:

- Implement interim changes to the existing PHA corporate website (introduce HTML format for content going forward, improve sitemap structure, navigation)
- Develop and implement integrated PHA hub - migrate microsites to support accessibility
- Expand accessible content formats
- Ongoing monitoring and compliance with accessibility standards

DAP08: Personal and Public Involvement, by 31 March 2028

What we will do: Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability.

Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC

What we are trying to achieve and who for: Encouraging and facilitating participation in public life:

Help to inform HSC staff how they could support and encourage active involvement of service users and carers with a disability.

Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC

Performance Indicators and Targets: Production of a Guide targeted at informing staff about ways in which to support involvement of service users and carers with a disability.

Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities

Progress 2025-26: Hosted by Participation & Engagement team the Regional PPI forum participated in a workshop in Sept 2025 to discuss priority areas relating to Health Inequalities, with additional discussion on Inclusion Health categories; This will inform a regional guide to support involvement of service users and carers with a disability. This action is part of the Partnership & Engagement strategy and will be reflected in the Participation & Engagement priorities for 26/27

How we met the performance indicator: working towards completion March 2028 through integration into Participation & Engagement strategy and reflected through related reporting mechanisms

Action Status: More work needs to be done

DAP09: Personal and Public Involvement, by 31 March 2028

What we will do: Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide

What we are trying to achieve and who for: Encouraging and facilitating participation in public life:

Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.

Performance Indicators and Targets: Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances.

Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities.

Progress 2025-26: Renumeration of Service Users and Carers is part of the Strategic Approach to Public Engagement as led by the Department of Health. This work was on hold during 25/26 with no progress to report, however it is anticipated this will be visited in 26/27. PHA will support renumeration to remains a key element of the review.

How we met the performance indicator: this target date will be influenced by the policy direction set out by the Department of Health

Action Status: No progress made

Future changes to action: Responsible team should be amended to Partnership and Engagement to reflect the integration of PPI with PCE

DAP10: Partnership and Engagement (Personal and Public Involvement Lead), by 31 March 2026

What we will do: Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland

What we are trying to achieve and who for: Encouraging participation in public life:

Improve opportunity for people of NI to provide feedback on experiences across HSCNI

Performance Indicators and Targets: All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability

Progress 2025-26: New promotion materials developed in 2025/2026 have been developed in Easy Read format and accessible formats for screen readers. This commitment is reflected in the Participation & Engagement Strategy. Under 10,000 MORE Voices the Participation & Engagement team are leading a study entitled "My Experience of assistive technology to support my disability"; This project was codesigned with service user groups within Cedar Foundation, translated into Easy Read and implementation supported by a Engagement plan which included links with C&V partners.

How we met the performance indicator: Target met in 25/26 with ongoing commitment for all work in 26/27

Action Status: Action complete - this is an annual action

(5) Additional Measures

- We always include Disability on our list of things to talk about at our quarterly Equality Forum with our partner organisations.
- We report on progress against our Disability Action Plan to our Board and Agency Management Team (the people at the top of our organisation) every year.

(6) Encourage Others

- We did not undertake any activities to encourage others.

(7) Monitoring

- We did not undertake any monitoring activities in addition to what is listed above.

(8) Revisions

- We have made some minor revisions to our Disability Action Plan 2023-28. These are reflected in the updated PHA Equality and Disability Action Plans 2023-28 (see Chap 4).

Disability Action Plan - Conclusions

- We completed 4 actions (DAP01, 02, 04, 10).
- We have more work to do on 4 actions (DAP06a,b,c, and 08)
- We didn’t do any work on 2 actions (DAP03,09).
- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people with a disability. We will tell the Equality Commission about any changes.

Equality Action Plan 2023-28

EAP01: Diabetic Eye Screening, by 31 March 2026

What we will do: Support the implementation of an online booking system for diabetic eye screening**.**

What we are trying to achieve and who for: Disability, Dependants, Age

Allowing participants to select a date for screening more suitable to them via a link within their invitation letter

Giving more flexibility to individuals with caring responsibilities, young people and those of working age

Reducing the number of clinic DNAs

Performance Indicators and Targets: The impact of the system will be reviewed by the Belfast HSC Trust along with input from PHA Screening.

Progress 2025-26: Supporting information poster and QR code was produced. Online is now widely available to participants. PHA will work with Belfast HSC Trust to review the impact upon DNA rates and anecdotal evidence from trust screening staff regarding feedback from users

How we met the performance indicator: System rollout was a longer process than anticipated, formal assessment of the impact has not yet been completed.

Action Status: More work needs to be done

EAP02a: Allied Health Professions, by 31 March 2026

What we will do: Through partnership working with key stakeholders, both statutory and non-statutory to help to determine and plan for the predicted healthcare needs of children and young people with Special Educational Needs (SEN):

Develop a standardised regional pathway and process across the health and social care system for the identification of children with Special Educational Needs, advice and recommendations on the provision required to meet these needs and the intended outcome of this provision in meeting these needs.

What we are trying to achieve and who for: Disability, Age

Children and young people (CYP) with SEN will benefit from a standardised health statutory assessment process towards timely access to AHP support/recommendations within the educational setting

Performance Indicators and Targets: Health services will more consistently meet KPI in respect of the submission of health reports for SEN statutory assessment process.

Progress 2025-26: A standardised regional pathway has been agreed, developed, built into Encompass and shared for operationalisation across 5 of the professional groups currently involved in this process. Details are held on a regional digital platform as a guide for professions. As more professional groups are invovled their pathways will be included in this resource.

How we met the performance indicator: There is no current formal reporting mechanism against this KPI. This KPI is dependant upon otehre factors e.g. availability of Trust workforce across a range of professional groups.

Action Status: Action complete

EAP03: Cancer Screening, by 31 March 2026

What we will do: Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people:

Develop a wider action plan to address inequalities across all screening programmes

What we are trying to achieve and who for: Ethnicity, Disability, Sexual Orientation, Age, Gender, Dependency, Marital Status

Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening.

To engage with those in the above S75 groups and deprived areas across NI to raise awareness of cancer signs and symptoms.

Progress 2025-26: Through a contract with the Women's Resoure and Development Agency, 124 peer led educational sessions to promote cancer screening were delivered to 1,392 people in the target groups. An additional 90 sessions were delivered to 972 people in groups with additional needs.

A wider action plan to address inequalities across all screening programmes has been developed.

How we met the performance indicator: 38.7% of participants in the sessions considered themselves to have a disability/illness.

13.9% of participants described their ethnicity as something other than white.

Action Status: Action complete - this is an annual action

EAP04a: Antenatal Infection Screening Programme, by 31 March 2026

What we will do: Infectious Diseases in Pregnancy Screening (IDPS)

Ensure that all women from section 75 categories have access to Infectious Diseases in Pregnancy Screening (IDPS) early in pregnancy and that there is equality of access into clinical care for those screening positive for infections:

Provide information leaflets about the IDPS programme in an accessible format in different languages.

What we are trying to achieve and who for: Persons from ethnic minority groups, asylum seekers and migrants

Ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening.

Performance Indicators and Targets: Quarterly statistics collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments:

performance against each standard reached the acceptable level and hopefully achieve achievable level (top level)

Progress 2025-26: All IDPS leaflets have been translated into the top 10 most common languages.

How we met the performance indicator: Target met.- the IDPS leaflets are availble in translated form and our uptake rate shows that we achieved the highest level of performance.

Action Status: Action complete

EAP04c: Antenatal Infection Screening Programme, by 31 March 2026

What we will do: Infectious Diseases in Pregnancy Screening (IDPS)

Ensure that all women from section 75 categories have access to Infectious Diseases in Pregnancy Screening (IDPS) early in pregnancy and that there is equality of access into clinical care for those screening positive for infections:

Monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.

What we are trying to achieve and who for: Persons from ethnic minority groups, asylum seekers and migrants.

Ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening.

Ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.

Performance Indicators and Targets: Quarterly statistics collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments:

performance against each standard should reach the acceptable level and hopefully achieve the achievable level (top level)

Health equity audit to be completed around women screened positive for hepatitis B- this will highlight inequalities of access amongst women attending specialist services.

Progress 2025-26: Hepatitis B audit completed and although the numbers were small and there was no statistical significant difference between teh section 75 groups the audit did show that women from this group, particularly non - English speaking women from ethnic minority background, were more likely to not attend their appointments with hepatology.

How we met the performance indicator: Target met-annual data for 2024/2025 and for the first two quarters of 2025/2026 showed that we are achieving the highest level of performance for uptake and the

acceptable level of performance for the attendance at specialist appointments.

The Health equity audit was completed.

Action Status: Action complete - this is an annual action

EAP07: PHA Health Improvement and Operations, by 31 March 2026

What we will do: Equality Monitoring

Commitment to collect additional equality data and outline planned analysis to be carried out on specific data that will be collected.

What we are trying to achieve and who for: All S75 Groups

Gather additional information relating to S75 groups and explore how this can be used to inform wider decisions

Performance Indicators and Targets: Audit what information is currently gathered and develop plan to identify opportunities to collect additional data

Identify data that allows further analysis to be carried out

Progress 2025-26: As part of Health Improvement contract management processes Section 75 monitoring data is requested/ reported on a yearly basis from HSC Trusts and C&V contracts. The current request will be issued by end April 2026 with a closing date of mid-June. Contract managers will encourage providers to return the information. S75 data collected in previous years has been used to inform service planning/equality screenings, including for example for Under 18 postvention services which will be tendered for in 26/27. Likewise, the review report on the Physical Activity Referral Scheme utilised equality data and highlighted, for instance, that completion rates were similar by gender; older participants completed at higher rates than those aged 40–49: those aged 60–69 were 28% more likely to complete, and those aged 70–79 were 49% more likely.

Physical Activity Referral Scheme (PARS): The PARS model and delivery organisations have been involved in a review process within 25/26 and new EQIA will be produced within 26/27 informed by the PARS service review recommendations and related adaptations. Section 75 information and Monitoring Data will be utilised to inform PARS revised service.

How we met the performance indicator: 24/25 data was received. 25/26 data will not be received until mid-June, therefore target not yet met.

Action Status: More work needs to be done

Future changes to action: Consideration will need to be given to how this is coordinated/Led in PHA given the changes following Reshape and Refresh in the PHA

EAP08: PHA Governance, by 31 March 2026

What we will do: Establish a PHA Equality Working Group

What we are trying to achieve and who for: All S75 Groups

Ensure Equality is considered at a strategic level within PHA

Aim to change culture of organisation to ensure equality issues are being considered and addressed

Performance Indicators and Targets: Group established and meeting regularly

Terms Of Reference agreed and action plan in place

Progress 2025-26: After Terms of Reference and a paper were prepared and presented to the PHA Agency Management Team (AMT) (Chief Executive and Directors) seeking nominations, it became evident that PPI colleagues were working to set up a similar group in relation to Experience and Involvement. It was then agreed that there would be significant benefits to drawing these together and establishing a PHA Equality, Experience and Involvement (EE&I) Associates Working Group. The Working Group held its first meeting in March 2026.

Work is underway to seek nominations from individuals across the organisation with an interest in this working group. Information sessions will be held in May 2026 and at the end of May 2026 a training and onboarding session is planned (28 May 2026). The revised Working Group will hold its first meeting on 5th June 2026.

How we met the performance indicator: Group has been established and met in March 2026. Future meetings have been scheduled.

Action Status: Action complete

EAP09: Personal and Public Involvement, by 31 March 2026

What we will do: Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.

What we are trying to achieve and who for: All S75 Groups

Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC

Performance Indicators and Targets: Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA.

Increase in understanding of the rationale for embedding best practice in equality matters.

Progress 2025-26: This action was paused due to planned commitment to developing a Regional framework for training in 2026/2027. Discussion for Section 75 Groups is included in all training delivered by the Participation & Engagement team in PHA and across the wider system, however this action needs underpinned with regional agreement on content and delivery of the Equality specific training.

How we met the performance indicator: Target not met in full - will be progressed as part of the development of Regional framework for Involvement training

Action Status: No progress made

Future changes to action: Propose a new target date of March 2027 to align with the planned publication of the Regional training framework

Equality Action Plan - Conclusions

- We completed 4 actions (EAP02a,03,04a,08).
- We have more work to do on 3 actions (EAP01,04c,07).
- We didn’t do any work on 1 action (DAP09).
- All of the actions in our action plan are at regional and at local level.
- Our action plan is a live document. If we make any big changes to our plan we will involve people in the Section 75 categories. We will tell the Equality Commission about any changes.

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August 2026

Public Health Agency (PHA) Equality and Disability Action Plans 2023-28

Updated August 2026

1. Equality Action Plan 2023-28: What we will do to promote equality and good relations

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Service Development and Screening Support the implementation of an online booking system for diabetic eye screening. *	**Disability, Dependants, Age** The online booking system allows participants to select a date for screening more suitable to them via a link within their invitation letter. The objective of this system is to give more flexibility to individuals with caring responsibilities, young people and those of working age. It is also hoped that this in turn will reduce the number of clinic DNAs.	Usage of the system will need to be restricted until the programme has recovered sufficiently and has capacity to offer a variety of screening clinic slots online. The other impact will be the implementation of a low risk pathway in 2023/24, the effects of this new pathway will not be realised until 2025/26 as eligible patients will be moved in a phased approach over 2 years. The impact of the system will be reviewed by the Belfast HSC Trust along with input from PHA Screening.	The implementation and management of the booking system is the responsibility of the Belfast HSC Trust, however the PHA will support the implementation and the impact of the system will be kept under review by the NIDESP Operational Group (with PHA and Belfast HSC Trust membership) by Mar 2027.

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Cancer Screening Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people • Develop a wider action plan to address inequalities across all screening programmes	**Ethnicity, Disability, Sexual Orientation, Age, Gender, Dependents, Marital Status** Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening. To engage with those in the above S75 groups and deprived areas across NI to raise awareness of cancer signs and symptoms.	Agree model to target low uptake areas to reduce inequalities and implement by March 2027. Develop and commence implementation of action plan to reduce inequalities in screening participation by March 2027.	PHA by Mar 2027
Infectious diseases in pregnancy screening (IDPS): - Ensure that all women from section 75 categories have access to IDPS early in pregnancy and that there is	**Persons from ethnic minority groups, asylum seekers and migrants.** We are trying to ensure that people from the above groups	1.Quarterly statistics will be collected from each Trust to show performance against National standards and these will provide	PHA Regional antenatal infection screening programme co-ordinator

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
equality of access into clinical care for those screening positive for infections. • We will monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.	know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening. We are trying to ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.	evidence of IDPS uptake and attendance at specialist appointments. The target would be that performance against each standard would reach the acceptable level and hopefully achieve the achievable level (top level) 2. Audit in progress around women screened positive for hepatitis B- this will highlight inequalities of access amongst women attending specialist services.	By Mar 2027
Equality Monitoring Commitment to collect additional equality data and outline planned analysis to be carried out on specific data that will be collected.	**All S75 Groups** Gather additional information relating to S75 groups and explore how this can be used to inform wider decisions	Audit what information is currently gathered and develop plan to identify opportunities to collect additional data	PHA Health Improvement and Operations

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
		Identify data that allows further analysis to be carried out	by Mar 2027 and annually until End Mar 2028
Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.	**All S75 Groups** Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC	Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA. Increase in understanding of the rationale for embedding best practice in equality matters.	PHA Partnership and Engagement by Mar 2027

*Due to an ongoing post Covid recovery programme and the implementation of an extended screening interval in 2023/24, the availability of the online booking has had to be restricted to smaller groups, initially it is being used with those who have previously DNA'd. A review will then be carried out looking at functionality, and uptake amongst those targeted. Following this it is expected that availability will be extended to other groups within our eligible population, e.g. those newly diagnosed with diabetes, younger age groups etc.

2. Disability Action Plan 2023-28: What we will do to promote positive attitudes towards people with a disability and encourage the participation of people with a disability in public life

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Service Development and Screening **Infectious diseases in pregnancy screening (IDPS) programme** Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against. • The PHA will work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.	**Promoting positive attitudes and Encouraging participation in public life** To ensure equality of care for all pregnant women screened positive for HIV. To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.	QA structures for the IDPS programme agreed and implemented. (will be resource dependent)	PHA Consultant responsible for the IDPS programme and PHA Regional antenatal infection screening programme co-ordinator, by Mar 2027.

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Awareness Days Raise awareness of the lived experience of people with specific disabilities and conditions.	**Promoting positive attitudes:** Increased staff awareness of a range of disabilities and conditions.	2 awareness days profiled every year.	Agency Management Team (AMT) with support from BSO Equality Unit. by Mar 2028
Placement Scheme Create and promote meaningful placement opportunities for people with disabilities.	**Promoting positive attitudes and Encouraging participation in public life:** People with a disability gain meaningful work experience. People with a disability are successful in applying for paid employment after they have completed a placement.	At least 3 placements in the PHA offered every year. Feedback through annual evaluation of scheme indicates that placement meets expectations. At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.	Agency Management Team (AMT) with support from BSO Human Resources. by Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Tapestry Network Advise staff of the existence and contact details of the Tapestry staff network	**Encouraging participation in public life:** Staff with a disability feel more confident that their voice is heard in decision-making. Staff with a disability feel better supported.	Tapestry staff survey Increase in Tapestry membership or in participation at meetings	Agency Management Team (AMT) with support from BSO Equality Unit by Mar 2028
Strategic Planning Teams Create and promote opportunities for people with disabilities to participate in PHA's strategic planning process to ensure the needs of people with disabilities are appropriately reflected when setting commissioning priorities: • Review current participation opportunities • Develop and implement engagement plan	**Encouraging participation in public life:** People with a disability are meaningfully involved in setting commissioning priorities initially in the following areas (to be regularly reviewed): • Mental Health • Older People • Alcohol and Drugs		PHA Planning and Operational Services AD by Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
PHA Websites • Implement interim changes to the existing PHA corporate website (introduce HTML format for content going forward, improve sitemap structure, navigation) • Develop and implement integrated PHA hub - migrate microsites to support accessibility • Expand accessible content formats • Ongoing monitoring and compliance with accessibility standards	**Promoting positive attitudes and Encouraging participation in public life:** Ensure that content is accessible to people who are deaf	Audit to identify key information to be made available and where contact details are provided completed	PHA Digital Communications by Mar 2027
Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability.	**Encouraging and facilitating participation in public life.** Help to inform HSC staff how they could support and	Production of a Guide targeted at informing staff about ways in which to support involvement of	PHA Partnership and Engagement by Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC	encourage active involvement of service users and carers with a disability. Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC	service users and carers with a disability. Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities	
Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide	**Encouraging and facilitating participation in public life**. Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.	Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances. Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities.	PHA Partnership and Engagement by Mar 2028.

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland	Improve opportunity for people of NI to provide feedback on experiences across HSCNI	All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability	PHA Partnership and Engagement Team by Mar 2028

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August 2026

Equality and Human Rights Screening Report

April 2025 – March 2026

These screenings can be viewed on the BSO website under:

https://bso.hscni.net/directorates/people-and-place/equality-and-human-rights/equality-screening/

Policy / Procedure	Policy Aims	Date	Screening Decision
Corporate Plan 2025-2030	The PHA Corporate Plan 2025-2030 sets out the strategic direction for the next five years. It details our vision, ambitions and evidence-based strategic priorities for the period 2025-2030.	Mar-25	Screened out without mitigation
Fixed Term Workers Policy & Procedure	This policy sets out principles for the appropriate use of fixed-term contracts, ensuring compliance with legislation and preventing less favourable treatment of fixed-term employees. It clarifies when such contracts are suitable and provides a fair procedure that balances employee interests with service needs. Fixed-term contracts should only be used in defined, time-limited circumstances. Employees on these contracts must receive equal treatment to comparable permanent staff, including access to training, promotion, transfer, appraisal, and the ability to apply for permanent vacancies via the HSC Recruit website, unless an objective reason justifies otherwise.	Dec-24	Screened out without mitigation
Internal Talent Mobility Process	Facilitating the internal movement of staff to fill short term gaps whilst bringing the benefit of promoting opportunities for staff development and cross Directorate collaboration, this model has brought significant benefit to the Public Health Agency (PHA) since introduction particularly whilst the organisations remains in a period of significant organisational change.	Feb-25	Screened out without mitigation

People Strategy 2026-2030	The Public Health Agency (the Agency) values its staff and the contribution they make to Health & Social Care every day. We recognise our people as our greatest asset and are proud of what has been achieved to date. This People Strategy aims to create a culture where everyone feels valued, respected and supported, unlocking the full potential of our workforce through growth, encouraging innovation, and giving staff a voice in shaping the future of the Agency. Our strategy addresses current challenges and anticipates future needs, supporting an agile and resilient workplace. Through collaboration and continuous learning, we will empower our staff to deliver excellence and make a lasting difference to health and wellbeing in Northern Ireland. Our ambition is to create a compassionate and inclusive workplace that builds on the dedication and commitment of our staff, empowering our people through openness and collaboration to improve health and wellbeing across Northern Ireland.	Feb-26	Screened out without mitigation
Secondment Guidance for Line Managers and Employees	This Secondment Guidance is aimed at supporting Managers and staff to understand the arrangements for considering a secondment opportunity. The PHA recognises that secondments can provide staff with valuable development opportunities and can bring mutual benefit to the organisation through learning new skills or enhancing existing skills, enabling PHA to develop and retain experienced, skilled and valued employees.	Dec-24	Screened out without mitigation

Skills Development Framework	The Framework has been designed to provide a practical framework and reference point to empower PHA staff in their continuous professional development. It is about ensuring teams have the right skills and capabilities to effectively discharge their duties as well as ensuring a culture of life long learning.	Feb-25	Screened out without mitigation
Standards for Cervical Screening Sample Taking Programmes	These education standards have been developed for nursing and midwifery education providers in Northern Ireland who provide cervical screening sample taking education programmes. They replace the Public Health Agency 2016 version of the education standards. These standards provide details of the theoretical content and practical assessment, required within the education programme to prepare students to deliver a competent person-centred cervical screening service in clinical practice. These standards will provide consistency, standardisation and quality assurance in the delivery of the education programme and the update programme.	Jun-24	Screened out with mitigation
Terms of Reference for the Safer Mobility Model NI Service User and Carer Reference Group	The Service User and Carer Group exists to ensure that the voices, experiences, and perspectives of service users and carers are central to the planning, delivery, and evaluation of the Safer Mobility Model. It provides a forum for meaningful engagement, collaboration, and co-production between service users, carers, and staff. Its aims to do the following; • To represent the views and experiences of service users and carers in supporting decision-making processes within the model. • To advise on service improvements, • To promote equality, diversity, and inclusion in all aspects of service design and delivery. • To identify barriers to participation and	Jan-26	Screened out with mitigation

	suggest practical solutions. • To support continuous improvement through feedback and shared learning.		

No concerns were raised by consultees on any of the screenings published in 2025-26.

Chapter 6: Mitigation Report

Equality and Human Rights Mitigation Report

April 2025 – March 2026

Standards for Cervical Screening Sample Taking Programmes

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Gender. The guidance makes explicit reference to the target gender and inludes anyone in the NI population with a cervix- women, transgender males.	Review and update guidance as required.
Age. The guidance makes explicit reference to the target age - anyone with a cervix aged 25 – 64 years.	Review and update guidance as required.
The guidance makes reference to the need for nurse and midwife educators to include course content relating to the engagement and care of individuals with additional needs for example women/individuals with a physical or learning disability, who have experienced female genital mutilation and those from ethnic groups	Review and update guidance as required.

Terms of Reference for the Safer Mobility Model NI Service User and Carer Reference Group

In developing the policy or decision what did you do or change to address the equality issues you identified?	*What do you intend to do in future to address the equality issues you identified?*
Accessibility: • Meetings will be held in venues that are fully accessible for people with physical disabilities. • Alternative formats (easy-read, large print, Braille) and assistive technologies will be provided on request. • Online participation options will be available for those unable to attend in person. • A written summary will be provided after each meeting. • Staff support on request after each meeting. • All meetings dates and times provided in advance. • Touch base sessions for Service Users and Carers who miss a meeting. • Post hard copies of the slides and meeting papers on request. • Calendar meeting invites and reminders. **Language and Communication:** • Plain language will be used in all documents and communications. • Interpreting and translation services will be offered for minority ethnic participants and those with language needs. **Flexible Engagement** • Meetings will be scheduled at varied times and offer hybrid options to	**Monitor Participation and Representation:** • Collect and review demographic data (Section 75 categories) of group members and participants. • Identify gaps in representation and take targeted action to recruit underrepresented groups. **Enhance Accessibility:** • Regularly review venues, digital platforms, and materials for accessibility. • Expand use of assistive technologies and alternative formats as needed. **Improve Language and Cultural Inclusion** • Maintain a register of interpreting and translation services. • Engage with minority ethnic and cultural organisations to inform inclusive practices. **Support Carers and People with Dependants** • Continue offering flexible meeting times and hybrid options. • Explore funding for childcare and travel reimbursement to remove participation barriers. **Strengthen Training and Awareness** • Provide ongoing equality and diversity training for staff supporting the group.

accommodate carers and those with dependants. • Expenses for travel and childcare will be reimbursed where possible. **Representation and Inclusion** • Recruitment will actively seek diverse representation across Section 75 categories, including age, gender, disability, ethnicity, and sexual orientation. • Terms of Reference will include a clear commitment to equality, diversity, and respect. **Training and Support** • Induction and ongoing support will be provided for service users and carers to build confidence and understanding of their role. • Staff supporting the group will receive equality and inclusion training. **Monitoring and Review** • Participation will be monitored by Section 75 categories to identify gaps. • Feedback from members will be regularly reviewed to inform improvements.	• Offer induction and confidence-building sessions for service users and carers. **Embed Intersectionality** • Review feedback and complaints for issues affecting people with multiple identities. • Adapt engagement methods to address compounded barriers (e.g., disabled minority ethnic participants). **Continuous Feedback and Review** • Establish a feedback mechanism for members to raise equality concerns. • Review Terms of Reference annually to ensure it reflects best practice and emerging needs.

item 11

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Performance Management Report
Reference	PHA/07/08/26
Prepared by	Julie Mawhinney
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2026/27.

2 Key Issues

The attached paper provides a summary of progress made against 43 Actions included in the 2026–27 Annual Business Plan as at the end of Q1 - up to 30th June 2026.

In total, **132 KPIs are detailed** across five key priority areas. Progress against each KPI is reported by the designated Lead Officer and is assessed using a BRAG status

Of the 132 KPIs, **10 are rated blue**, **79 are rated green**, **37 are rated amber** and **6 are rated red**. Further details are provided on those actions currently rated amber or red.

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

An addendum has been provided to review progress of Amber and Red actions carried over from the 2025/26 Annual Business Plan.

The Performance Management Report was considered by the Planning, Performance and Resources Committee at its meeting on 20 August 2026.

3 Next Steps

The next quarterly Performance Management Report update will be brought to the Board in November 2026.

PERFORMANCE MANAGEMENT REPORT

Q1 Monitoring of KPIs Identified in

The Annual Business Plan 2026 – 2027

Introduction

The Public Health Agency (PHA) Annual Business Plan sets out the key actions for 2026/27 that will support Ministerial and Departmental priorities, while demonstrating progress against the objectives outlined in the Corporate Plan.

This report provides an update on the progress of 43 Actions and associated KPI(s) included in the 2026–27 Annual Business Plan. Progress against each action is reported by the designated Lead Officers and is assessed using a BRAG status, defined as follows:

BRAG Status:

🔵	Action completed.
🟢	Action on track for completion by target date.
🟡	Significant risk of action being slightly delayed after target date.
🔴	Risk of action being significantly delayed/unable to be completed.

At the end of June 2026, across 43 Actions, there are 132 KPIs. 10 are currently rated Blue, 79 are currently rated Green, 37 are currently rated Amber, and 6 are currently rated red.

An addendum has been provided to review progress of amber and red actions carried over from the 2025/26 Annual Business Plan Monitoring report.

HSC Public Health Agency

Action	CP Priority	2026-27 Annual Business Plan Action Summary	KPI BRAG Position (Q1)
		PROTECTING HEALTH	
1	6	Develop targeted action plans to reverse declining uptake across childhood, adult and seasonal vaccination programmes.	
2	6,12,32	Implement vaccine policy, including Varicella catch-up (ages 3y4m–6y) and expanded RSV vaccination for over-80s.	
3	5,23	Implement targeted models to reduce inequalities in screening and vaccination uptake	
4	5,32	Implementation of the extended age range of the bowel screening programme	
5	5,23	Targeted lung cancer screening programme	
6	5,23, O4	Digital solution for screening programmes	
7	5	Cervical screening programme and QA	
8		Pandemic Preparedness	
9	2,3,4,8	Work with stakeholders to implement the BBV strategy and deliver a holistic BBV care model	
		STARTING WELL	
10	17	Work with policy and professional leads to expand routine enquiry and address root causes of domestic abuse	
11		Improve safety, quality and consistency of maternity care to reduce perinatal mortality and morbidity.	
12	3,5,12,14	Encompass: Universal Health Promotion and Childhood Vaccination programmes	
13	15	Population health and therapeutic needs assessment of children with SEND	
14	11,13	Update and implement the 2025–2028 Strategic Breastfeeding Action Plan	
15	18,24, 27, 28,9	Deliver PHA actions in the DoH Healthy Futures Framework to prevent obesity-related harm	
16	9,10 11, 12,13	Expand Family Nurse Partnership delivery to mothers up to age 24 with social complexity	
17		Review YES delivery model; develop a universal youth substance-use prevention service	
18		Step 2 Youth Treatment and Problematic Parental Substance Use procurement	
		LIVING WELL	
19	20	Deliver PHA-led actions within the Mental Health Strategy	
20	20,21,22, 34	Deliver PL2 and Substance Use Plan actions in partnership with stakeholders.	
21	15,24	Develop action plan to embed Learning Disability needs in PHA commissioning	
22	2,5, 6	Review and redesign of the Inclusion Health Services at the HSC Trusts to optimise the integration and coordination of the services	
23	28	Implement and test the Health Inequalities Framework across a place, condition, and planning team	
24	28	Develop and roll out Health Inequalities training across PHA and partner sectors	
25	18,22,25	Review and revise Stop Smoking service models in pharmacies and implement updated Trust service specifications.	
26	18,19,20	Work with SPPG, Councils and Trusts to commission services using the enhanced PARS specification	
27		Roll out the 'This is Our Health' public engagement programme with DoH and HSC partners.	

AGEING WELL			
28	**29,35,38**	Design and implement a regional WHO Age Friendly Communities model using the AGE-CYCLE plan	
29	**30,31,33**	Implement a new Safer Mobility Model across community settings in NI.	
30	**37**	Implement the ACP Policy for Adults through coordinated action across communication, operations, training and evaluation.	
31	**31**	Support neighbourhood-level action to reduce frailty through early identification, prevention and intervention for over-65s	
OUR ORGANISATION AND PEOPLE			
32	**O2, O3**	Implement the Partnership & Engagement Strategy and embed experience and involvement across PHA practice	
33	**36, O3**	Finalise and implement a framework to support PHA Quality and Safety processes	
34	**20, 21, 22, 34, O2**	Provide professional advice to SPPG and Trusts to support commissioning of high-quality, efficient services and reduce health inequalities.	
35	**O1**	Implementation and delivery of the People Strategy	
36	**O3**	Enhance procurement processes to strengthen accountability and implement the 2026/27 Procurement Plan	
37	**O3**	Embed Public Health Planning Team structures and deliver 3-year strategic plans and induction programme.	
38	**O3**	Implement the new integrated EQUIP Finance, Procurement and HR system	
39	**O2, O4**	Develop and launch a new PHA corporate website with enhanced functionality	
40	**O2**	Development and implementation of a PHA Stakeholder Engagement Action Plan	
41	**O3**	PHA will deliver within tolerances set by department for 26/27 budget	
42	**O5**	Implementation following launch of the new DoH HSC Research and Development (R&D) Strategy 2026-2030	
43	**O5**	Lead Northern Ireland's role in the UK Clinical Research Delivery programme and the VPAG Investment Programme.	

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At the end of June 2026, 43 KPIs have been identified with an Amber or Red BRAG status. Further details of these KPIs and mitigating actions are detailed below.

A copy of the full 2026/27 Annual Business Plan can be found here: PHA_Annual_Business_Plan_2026-27_FINA

PROTECTING HEALTH					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
1. Develop programme specific action plans to halt the decline where there is a fall in uptake (to include childhood, adult and seasonal programmes)					Joanne McClean Rachel Spiers / Cara Anderson
Uptake rates to hold or improve for the following: • MMR at 2 years and 5 years • Shingrix (shingles) • Health & Social Care workers flu vaccine	Mar 2027	Flu vaccine uptake in Trust-employed HSCW – flu vaccine improved for 25/26 compared to 24/25 (from 21.4% to 30.5%). 26/27 campaign will commence October 2026. Shingrix – official uptake not yet published, a total of 34,945 vaccines have been administered to date. MMR vaccine at 2 and 5 years – data not yet available for end June 2026. However, at the end of March 2026, MMR1 measured at 5 years remained stable at 92.4% and MMR2 at 5 years declined by 0.3% to 83.6%.			
Establish low uptake oversight board	May 2026	Board established			
Development of action plans	Nov 2026	Draft action plans for pregnancy and flu have been developed and shared			

PROTECTING HEALTH								
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
		with the low uptake oversight board. The childhood and adult action plans are currently being drafted.						
Reduction in total number of cases in meningococcal disease and measles	Mar 2027	There were no confirmed measles cases reported between April and June 2026. Measles infection update | HSC Public Health Agency						
2. Implement vaccine policy including;								Joanne McClean, Cara Anderson / Rachel Spiers
MMRV selective catch up	Nov 2026	Planning is underway for commencement in November 2026. The child health system changes have been requested and a number of professional engagement activities are planned. Public information is currently being developed.						
Implementation of the RSV vaccine to those aged over 80 years	May 2026	The programme was fully implemented in April 2026.						
3. Implement targeted model to reduce inequalities in screening participation and vaccination uptake Commence implementation of action plan to reduce inequalities in screening participation								Joanne McClean, Bronagh Clarke
Agree model to target low uptake areas and implement	Mar 2027	Agreement has been reached to progress with a community champions model to address inequities in screening uptake in the targeted DEA						

PROTECTING HEALTH					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		areas with lowest uptake across the adult screening programmes. Discussions will now progress with potential providers to agree the service model and contract enhancements.			
4. Commence implementation of the extended age range of the bowel screening programme					Christine McKee
Increased detection of early stage bowel cancer	Mar 2027	Preparatory work completed by programme, awaiting funding allocation from Department of Health.			
5. Scope the system requirements for the implementation of a targeted lung cancer screening programme					Joanne McClean, Tracy Owen / Cara Anderson
Development of project plan	Jun 2026	Direction was received from DoH in July 2026 to request PHA to establish and take forward a project to develop an outline business case. Process to recruit project support now commencing.			

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PROTECTING HEALTH						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
6. Design a digital solution for screening programmes							Joanne McClean, Tracy Owen / Gary Loughran
Completion and evaluation of build for breast cervical screening.	Apr/May 2026	Work is ongoing with the EPIC team to scope the needs across the screening programmes in order to inform a business case.					
Future screening platform	May/Jun 2026	Initial requirement scoping meetings have taken place with DESP, Bowel, AAA Programmes, Funding and resourcing to be sourced via encompass Business Case addendum. This has paused progress until funding approval for necessary resources is in place.					
Further screening programmes	Mar 2027	Funding and resourcing to be sourced via encompass Business Case addendum. This has paused progress until funding approval for necessary resources is in place.					
7. Implement recommendations relating to cervical screening programme and QA							Joanne McClean Tracy Owen
Implementation of all PHA actions set out in the plan	Mar 2027	Implementation of the joint action plan is ongoing					

PROTECTING HEALTH						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
Implementation of recommendations from improvement project.	Dec 2026	Significant progress has been made with appointment of a Professional and Clinical Advisor for laboratories for the NI CSP and the establishment of a new regional MDM and processes for the audit of invasive cervical cancer.					
8. The PHA will strengthen its preparedness for protracted response to a public health incident, including pandemic, through:							Joanne McClean Leah Scott
Update all BIAs to be reviewed in line with new PHA Structures	Mar 2027	Existing BIA's in place with programme of work now underway					
EPRR Policy in place	Jun 2026	Complete. Policy published on PHA intranet.					
Business Continuity Awareness e-learning for staff	Jun 2026	Complete					
Staff mobilisation plan	Mar 2027	Project implementation document agreed and work now underway to scope agency staff resourcing in line with wider project plan.					
EPRR training programme aligned to the National Minimal Occupational Standards for EPRR established	Mar 2027	26-27 EPRR training programme ongoing.					

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PROTECTING HEALTH					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
9. Working with stakeholders in the implementation of a BBV (Hepatitis B and C and HIV) strategy to provide a holistic BBV care model					
Adopted WHO Bloodborne virus elimination targets	Mar 2027	The DOH have advised the draft of the new BBV strategy will be with PHA by end of August 2026 for review and input. The current and new strategy incorporate the WHO Bloodborne virus elimination target.			Joanne McClean ~~Iheadi Onwukwe~~ Peter Naughton
Ability to report that all prisoners have access to BBV testing in prison by March 2027 (Possibly SE Trust funding dependent).		Ongoing engagement with prison healthcare, virology, hepatology and PHA surveillance on coding, testing and reporting. Capacity within prison healthcare continues to be a concern			
BBV positive prisoners reporting on release from prison that they have treatment/know how to access treatment/ continuing on treatment pathway.		This measure is not currently quantifiable and will not be reported against during the current period.			
Community and voluntary sector engaging in BBV programmes for learning and engagement with the at-risk population		BBV awareness package near completion, will share with sector when ready.			

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STARTING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
10. Work with Policy and professional leads to address the root causes of domestic abuse through further expansion of the model of routine enquiry							Emily Roberts, A. Mc Cloughlin
Model of Routine Enquiry	Mar 2027	PHA and DOH will lead the work, in partnership with other statutory and non-statutory agencies.					
Mandate secured and partners engaged (DoH & trusts). Agree service areas	Jun 2026	Mandate secured. DOH engaged. Key personnel identified. Trusts not yet engaged.				Delay in progress due to staff absence, should be complete end of Q2	
Steering and working group established.	Sept 2026	Steering group established. One preparatory steering group meeting held. TOR drafted. Application to Domestic and Sexual Abuse Strategy fund for project manager.					
Training and development of guidance.	Mar 2027	Training provider engaged for working group					
11. Improve the safety, quality and consistency of maternity care across the region							Emily Roberts
Development of a Regional Maternity and New Born Partnership	Apr 2026	ToR and membership of steering & advisory group agreed					
Regional Maternity Improvement Action Plan	Jun 2026	Development of action plan underway expected completion of draft by September. Draft will then be shared with stakeholders for any further comments or changes before final action plan is agreed				Work on action plan delayed potentially to Q3 due to delays in ToR agreed by stakeholders. SPPG & PHA are now meeting regularly to progress action plan.	

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STARTING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
Compliance with core elements of Saving Babies' Lives v3	Mar 2027	In Northern Ireland, a regional action plan comprising of 10 strategic actions was developed to support implementation. To date, 3 actions have been completed, while 7 remain ongoing. While we have made notable progress in implementing Saving Babies' Lives Care Bundle across NI, it is clear that further advancement is contingent upon two critical enablers: The commissioning of essential services including funding, and The development of robust, quality-assured data systems. At present, the lack of accessible, standardised data continues to impact all six elements of the bundle. This limitation hinders the ability to monitor and evaluate outcomes effectively, which is essential for sustained improvement.		Following submission of the plan there has been significant system wide savings requests. Unlikely to be able to progress. SBL Implementation Group has been placed in shadow form until funding has been confirmed. Business Cases have been prepared for all aspects of funding through Women and Children's Planning Team, these are on a priority list in case funding becomes available.	
Implementation of safe sodium valproate pathways	Mar 2027	Valproate pathways continue to be implemented with ongoing improvement		A business case for recurring funding is being progressed.	

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STARTING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		In addition, pop up warnings on GP clinical systems appear whenever Valproate and Topiramate scripts are requested. Work with SPPG includes the development of a Valproate register on encompass which is at an early stage. Valproate Care Pathway issued June 2025.					
Increase in the proportion of women receiving continuity of midwifery carer	Mar 2027	SHSCT has commenced a 3rd COMC team. BHSCT have commenced a 2nd COMC team. Percentage of women receiving COMC care when comparing March 2025 and March 2026 remains the same. In Q1 WHSCT have not launched any COMC teams and NHSCT & SEHSCT teams impacted by staff sickness and are not currently offering the full model. NHSCT have proposed an alternative model of COMC care. This is currently being considered and modelling for each trust undertaken to assess any impacts or feasibility. From Q1 3/5 trusts are expressing difficulty progressing.				Meetings have now been re-established to regain momentum however progress is dependent on trusts ability to release staff from core services to CoMC without destabilising services	

STARTING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		SPPG have also raised concerns about progressing without funding and risking destabilising services. There is a risk that this measure will not be achieved by March 2027.			
12. Work with Encompass to ensure the new system replicates Child Health functions and enhances scheduling, recall, failsafe, data and reporting					Joanne McClean G. Weir / Deirdre Ward
PHA contribute to the replacement project structure	Mar 2027	Progress has been made in the last quarter. PHA has participated in ensuring build has been completed in a number of areas including workflows and build. PHA have been involved in set-up of end user acceptance and parallel testing. PHA has have helped coordinate training sessions in preparation for go live. PHA have negotiated and managed communication and progress between trusts and Encompass. Encompass unable to provide a suitable solution for Preschool Vaccinations & Immunisations for Aug go live. PH Nursing workflow is dependent on Preschool V&I.		The project is the responsibility of the Encompass project team. Continue with completion of build and testing. Focus Design Groups to provide assurance to Steering Group via submission of area Project Plans. Senior leadership within PHA, Encompass and trusts will agree a way forward and establish new timelines for go live. Consideration to be given to a phased approach to go live. PHA will lead on a project to consider solutions for pre-school vaccinations. PHA's Senior Project Manager will work with stakeholders to ensure readiness assurance prior to Go Live and new Go Live Date	

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STARTING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		Lack of readiness assurance from stakeholders. Delay in go live 10th Aug			
Evidence of PHA engagement and issues escalated		A number of PHA colleagues are Chairs of Focus Design Groups and have led the way in agreeing the workflow and build of encompass. Other PHA colleagues participate as members of groups within the Governance Structure. PHA have provided professional advice in the areas of New-born Bloodspot screening and Vaccinations All issues which need to be escalated have been through the agreed governance structure; 8 x Focus Design Groups to Working Group to Steering Group. Each of these meetings are monthly. Decision to delay Go Live was taken at June's Steering Group meeting.			

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STARTING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
13. Regional assessment of the population health and therapeutic needs of children with SEND attending NI special schools							Emily Roberts G. Teague / E. McGregor / L. Ringland
Assessment completed (findings presented to AMT and DoH)	Jun 2026	Therapeutic needs assessment underway. Data being re-reviewed, update presented to JEHOG and support for engagement requested.				Staffing issues has caused a delay. Secured support from Living Well AHP colleague 1 day per week to help deliver project. Seeking to gain support from Population Research & Intelligence	
DoH implementation plan, project board established, task and finish groups created	Sept 2026	Implementation plan received for nursing needs assessment. Working Group established across DoH, PHA and education. Work being taken forward on timelines through joint working group					
Completion of actions agreed by the Project Board and progress report submitted to DoH	Dec 2026	As above – work progressing through joint working group					
Further delivery of implementation plan actions. Review of recommendations achieved to date. Forward plan established to guide long-term, sustainable work in line with DoH implementation plan.	Mar 2027	Work to follow on from above					

HSC Public Health Agency

STARTING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
14. Strategic Breastfeeding Action Plan (2025 - 2028)							Emily Roberts Catherine Magennis
Development and launch of agreed medium-term strategic action plan	Apr 2026	Breastfeeding Action Plan 2026-2029 has been developed and approved.					
Development of North-South Breastfeeding Forum	Jul 2026	The North-South Breastfeeding Network has been established and first meeting pending on July 8th 2026.					
Expansion of the Breastfeeding Welcome Here Scheme (BWHS) to include all council areas and PHA buildings	Dec 2026	BWH scheme continues to expand across council areas with a recent celebration event in North Down and Ards Council. PHA buildings yet to progress					
New public awareness raising breastfeeding opportunities	Mar 2027	Work to follow on from Breastfeeding Action Plan					
Percentage of mothers breastfeeding on discharge and at 6 months		Work to follow on from Breastfeeding Action Plan					
15. Deliver the PHA's actions within the new DoH Healthy Futures Strategic Framework to prevent harm caused by Obesity							Maurice Meehan/ Hannah McCourt / Gerard Walls / L. Taylor
Current early years obesity prevention programme evaluated	Mar 2027	Health Improvement and Health Intelligence beginning the process after successful DPIA.					
Self-directed weight management interventions including digital approaches scoped	Mar 2027	Scoping process initiated in Q1, a short briefing paper on tier 2 & tier 1 weight management interventions has been drawn up in Q1.					

HSC Public Health Agency

STARTING WELL									
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
		Contact made in Q1 with UK Public Health colleagues seeking to discuss tier 2 and tier 1 weight management interventions arounds the regions.						
Number of Council Whole System Adopter sites progressed	Mar 2027	3 Council areas (Ards and North Down BC, Belfast City Council, Derry City Strabane DC) currently progressed through to Phase 4 of the 6 phased approach. Contact made with Causeway Coast and Glens BC and Antrim and Newtownabbey BC in Q1 to revisit and discuss initiating the process within their localities.						
16. Expand the delivery of the Family Nurse Partnership Programme to mothers up to age 24 experiencing social complexity								
Engagement session completed with the 5 HSCTS	May 2026	Engagement has taken place with HSCT via FNP Advisory Boards and supervisors in 3 trusts.					NHSCT & SHSCT dates to be discussed at next Heads of Service Meetings in August	Catherine Magennis / Deirdre Ward
Scope capacity within existing FNP Teams	Aug 2026	Capacity within teams fluctuates considerably each month. All teams are currently working at or near full capacity for staff in post allowing for vacancies and maternity leave and sick leave.						
Business case developed	Jun 2026	The business case has been developed proposing to appoint 2x 0.6 WTE Family Nurses in 2 trusts.						

HSC Public Health Agency

STARTING WELL								
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
Implementation Plan developed	Sept 2026	Implementation plan currently under development						
Revised FNP resources developed	Dec 2026	Revision of resources has not started yet due to time constraints and service pressures created by the transition of the FNP data system to encompass.					Should be developed by March 2027	
Pilot commenced	Mar 2027	On track for March						
17. Review the delivery model for Youth Engagement Services for Substance Use								
Agreement on a youth prevention service model	Mar 2027	The PHA Health Improvement Managers have begun to review the evidence and current service provision as we seek to develop an all island prevention policy brief and a PHA position. Estimated date for completion: November 2026. Wider system engagement will commence from December-March 2027.					A commitment from the N/S Alcohol Policy Group to work with the DoH and PHA to develop a prevention policy brief within our timeframe outlined. An agency committed timeline of actions has been agreed.	Emily Roberts, Fiona Teague, / Stephanie Hanlon
Joint procurement process with PHA and the Education Authority	Mar 2027	Engagement with DE and EA will commence in Q2 once the PHA have determined their position on the prevention model.					Through the SUS Programme Board, DE have given assurances to remain committed to engagement and seek opportunities for joint funding processes of the Prevention model.	

STARTING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
18. Substance Use Step 2 Youth Treatment service and the Problematic Parental Substance Use					
Procurement process completed and services operational	Mar 2027	PHA have experienced significant delays in the issue of both the Youth Treatment & PPSU tenders due to outstanding issue of Terms & Conditions which is with DLS. The tender pack has been completed & we await completion of the DLS actions before advertisement.		This has been raised at PHA procurement board and once resolved the PHA can work towards tender advertisement. The PHA Substance Use Team continue to update the Substance Use Procurement timetable	Emily Roberts, Fiona Teague / Stephanie Hanlon

HSC Public Health Agency

LIVING WELL								
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
19. Facilitate delivery of actions within the Mental Health Strategy								
Plan for a rolling programme of communications and public awareness raising activity	Mar 2027	Comms forum established with external partners and first meeting held on 19th of May. ECHO learning network session held 18th June focussing on campaigns and public awareness raising. MH Literacy task and finish group established and two meetings held.						Emily Roberts Denise O'Hagan / Sinéad Malone, Mary Emerson
Refreshed steering group and partnership structure	Jun 2026	Terms of reference has been refreshed and membership review is ongoing.					Will be finalised at next steering group meeting in September.	
Mechanisms in place to enable shared learning and reflective practice among cross-sectoral partner stakeholders	Dec 2026	ECHO learning network relaunched and curriculum agreed – first session held in May. Theme agreed and plans underway for a regional conference on 15th October						
Action plan developed to include agreement on Mental Health Crisis Pathway	Dec 2026	Action plan for implementation of Actions 12 'Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health' and 27 'Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons						

LIVING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		in mental health or suicidal crisis' are on track. Crisis Pathway development is ongoing and co-led with SPPG Crisis strategic implementation group (SIG) continues to meet quarterly and has representation from a wide range of stakeholders. A Crisis Mental Health Liaison (MHL) and Crisis Response Home Treatment (CRHT) Care Network has been established and meets quarterly. There are two workstreams from this care network to work toward regional consistency for operational procedures.					
20. Facilitate delivery of the Protect Life 2 Action Plan and Substance Use Commissioning and Implementation Plan							
Expansion of Postvention services, for Children and Young People	Jul 2026	Delayed due to T&C's amendments being delayed by DLS.				Currently roll forward service has been extended.	Fiona Teague,
At risk groups targeted through grants programme	Mar 2027	Advertisement of Small Grants programme slightly delayed due to staffing capacity.				Grants programme will be advertised in early July. Other self-harm / suicide prevention services commissioned under PL2 remain available.	Kathy Owens / Shauna Houston,
Substance use services procurement	Mar 2027	Significant delays due to outstanding paperwork from DLS. Pre-tender documentation for tranche 2 and 3 services in preparation.				The procurement timetable on the PHA website continues to be updated to inform the sector. PHA Procurement Board kept informed.	Stephanie Hanlon

LIVING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		Procurement of the low threshold service has been paused.			
21. Ensure needs of people with Learning Disabilities are addressed in PHA's commissioning of public health services across the lifespan					Siobhan Rogan Denise O'Hagan
Establish a new Learning Disability sub-group to represent all life stages.	Apr 2026	Learning Disability Sub-Group of the MHLDSU PHPT has been established, with membership from across the Public Health Planning Teams. The group has met, and is in the initial stages of planning the work of the Sub-Group.			
Action Plan development	Mar 2027	The development of this Action Plan is a key deliverable for the Learning Disability sub-group. The group will develop the Action Plan and progress will be monitored at each meeting.			
22. Review and redesign of the Inclusion Health Services at the HSC Trusts to optimise the integration and coordination of the services					Joanne McClean Rachel Coyle, Alison Little
Reduce alcohol and substance use-related hospital admissions	Mar 2027				

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LIVING WELL									
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
Reduction in A&E attendances among people experiencing homelessness and/or people who inject drugs (PWID)		Engagement ongoing with BHSCT to support the provision of premises for BIHS Engagement ongoing with PHA, EXTERN and Belfast Council to secure premises when current lease ends in Sept 2026 GP LES for Homelessness renewed for a further 3years with updated service specification. Further engagement planned with GP in Grosvenor to refine data reporting requirements to evidence health outcomes Meeting arranged with BHSCT Inclusion Health service to discuss current PHA investment in NINES service 17th August.						~~Iheadi Onwukwe~~
Increased uptake of primary care services / GP Registration								
Increased uptake of Social prescribing / number of persons reached by Navigators								
Reduction in drug-related overdoses								
Reduced "Did Not Attend" (DNA) rates								
Increased screening uptake (cervical, bowel, blood-borne viruses)								
Number/percentage of homeless persons moved from temporary to settled accommodation								
Reduction in rough sleeping episodes								
Increased trust in health services (measured via service-user surveys)								
23. Implementation and testing of the Health Inequalities Framework: A geographical location, A health-condition, A Public Health Planning Team								Joanne McClean, Andrew Steenson
Identification of 3 areas for focus	Mar 2027							

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LIVING WELL									
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
Development and delivery of capacity building support		Work is continuing in south Belfast, equity in screening, and following last LW PHPT, a conversation has begun to look at smoking cessation and lung cancer. Also, opportunities for other PHPT's as conscious we would like all working on implementing the framework						
Develop 1 insight report for each of the 3 areas for focus								
Mapping exercises of partnerships and assets within each of the 3 areas of focus								
24. Development and rollout of Health Inequalities training to staff in PHA and other relevant community, voluntary and statutory organisations								
Develop 1 eLearning module on Health Inequalities	Mar 2027	Working in partnership with Screening colleagues, a Project Plan has been developed including a proposed model to work with existing community providers (Healthy Living Centres & Rural Support Networks) to deliver local awareness raising in areas where screening uptake levels are significantly lower than the NI average (data-led), and where health outcomes for life expectancy and disease prevalence are some of the poorest across the region. This proposal represents a 'test' approach to support learning and						Joanne McClean, Andrew Steenson
Engage with partner organisations								
Host eLearning module internally								
eLearning Health Inequalities Training externally								

LIVING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		inform future scaling and procurement of targeted, place-based prevention services tackling health inequalities. Paper to AMT on 6th July 2026- approval granted to proceed with contract enhancement.			
25. (i) Implement a review and revision of the service provision model of all Pharmacy based Stop Smoking Services across NI, considering refreshed NICE guidance and evidence base in re-commissioning of services. **25. (ii) Implement updated specification for Trust based Stop Smoking services commissioned via PHA, to ensure regionally consistent and comparable, measurable services are in place to meet population needs in each Trust.**					
NI Pharmacy based Stop Smoking Services	Mar 2027	The MOIC Community Pharmacy Evaluation is in its final draft stage (June 2026). Recommendations from the evaluation will inform the development of the new service specification. A Band 7 officer has been successfully recruited and will lead this workstream.			Joanne McClean Colette Rogers

LIVING WELL					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
Trust based Stop Smoking Services	Mar 2027	The specification is in its final draft. An implementation plan has been prepared.			
26. JOINT ACTION WITH STARTING WELL No. 15 Physical Activity Referral Scheme (PARS)					
Review the PARS scheme; development of new service specification to include a proposed regional Model for Prehabilitation	Mar 2027	The enhanced service specification has not been completed however following the PARS level 3 review completed in April 2026, this includes the need for a review of service specification.		To enable progress of this objective a workstream will need to be established with identified leadership within PHA and engagement with all key stakeholders	Joanne McClean, Siobhan Donald, Lorna Nevin David Calvin
27. This is Our Health - roll out of the public engagement programme at scale in partnership with DoH and the wider HSC partners					
Programme delivery partnership in place including DoH/PCC/ SCTs/ CPNI and C+V sector	Jun 2026	Programme partnership structures in place and meeting regularly including at Programme Board level chaired by Perm Sec, Project Steering group			Stephen Wilson

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LIVING WELL								
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
		chaired by PHA CEO and Project planning group chaired by HoCEO						Martin Quinn
Engagement programme	Jun 2026	Engagement programme designed and delivered through multiple stakeholders. Programme has been extended out to end of August by agreement with Programme Board						
Awareness of 'Deal' between NI public and HSC system measured by Omnibus survey	Sept 2026	The construct of the 'Deal' is currently under development however the timescale for introduction and measurement has been extended in agreement with the Programme Board.					Programme Board has revised the timescale for the deal to commence in Sept 26 and a provisional date for Omnibus survey will be agreed circa end of Sept.	

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AGEING WELL								
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
28. Design and implement a new regional WHO Age Friendly Communities/Cities Model for NI using an 'AGE-CYCLE' Plan								
Regional Age Friendly Action Plan for NI.	Sept 2026	A multi-agency Age Friendly Workshop was held on the 18th June to discuss the development of a new regional Age Friendly action plan and priority areas. An AMT paper will be developed to provide information on the proposed way forward.						Emily Roberts Diane McIntyre Jeff Scroggie
Age Friendly Outcomes Framework developed and implemented	Mar 2027	Currently in draft form with a view to begin to implement in Q3 monitoring.						
Regional communication plan designed and implemented	Dec 2026	The Ageing Well Communication Plan has been developed and is being implemented by Comms.						
Business case developed and commissioning agreed	Apr 2026	5-year Business case developed and agreed by AMT						
29. Implement a new Safer Mobility Model across Community Settings in NI								
Regional safer mobility steering group established	Sept 2026	Regional Safer Mobility Steering Group and Task and Finish groups established with service user representation. Meetings take place bi-monthly / monthly.						Emily Roberts Diane McIntyre Jeff Scroggie
Working with key stakeholders to identify gaps in services	Dec 2026	Complete – huge gaps in service provision / delivery exist. This is largely due to inconsistent investment across HSC Trusts. This will challenge the adoption of a single SM model for NI.						

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AGEING WELL						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		Meeting with SPPG arranged to explore gaps in commissioning and service provision					
Populate the PHA dashboard	Sept 2026	Capacity issues have been flagged by PHA Data Science re the development of a regional falls monitoring dashboard.				Opportunities to utilise project SAPPHIRE (Neighbourhood Model / frailty) as an alternative is being explored. The development of a regional dashboard has been added to a new Health Intelligence workplan for consideration.	
Update the Population Health Dashboard	Sept 2026	On track					
30. Implementation of the For Now and For the Future Advance Care Planning (ACP) Policy for Adults							Sandra Aitcheson Sally Convery Caroline Lecky
Governance and Accountability structures established – Clinical leads identified and programme team in place.	Jun 2026	Awaiting resource to progress				Dependant on DOH.	
Integration of ReSPECT documentation to Encompass	Sept 2026	Progressing, however may be delayed as this is also dependant on the programme being stood up.				Dependant on DOH.	
Public messaging resource to support implementation and sustainability of ACP policy including ReSPECT plan will be agreed and available on a phased approach	Dec 2026	Awaiting resource to progress				Dependant on DOH	
HSC Staff Training	Mar 2027	All 3 levels of training are available for staff to access.				Discussions are being progressed to embed it into undergraduate and post graduate training. There is currently a risk of promoting training if the policy implementation continues to be delayed	

HSC Public Health Agency

AGEING WELL									
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**				**Mitigating Actions**	**Lead Director**
System Wide Implementation of ReSPECT Plan and phasing out of DNACPR		Awaiting resource to progress with standing up full structure to support system implementation.					Dependant on DOH.	
31. Work at neighbourhood level to reduce frailty by supporting early identification, prevention and intervention for people 65+								Emily Roberts Sandra Aitchison
Produce baseline Frailty prevalence data for NI	Jun 2026	Work on going as transition from Big Discussion to Neighbourhood continues. Some baseline data will be financially dependent.					Lead is currently on unplanned leave. Progress will pick up on their return.	
Agreed ToR and process for the Regional Neighbourhood Nursing Oversight Group	Jun 2026	There is a meeting of the Regional Neighbourhood Nursing Oversight Group on 7 July. This action is dependent on DOH and partners.					Michelle Laverty will attend the 7 July meeting in the leads absence and can provide an update after that meeting takes place.	
Agreed model for the identification and recording of frailty across the 65+ population in primary care using the Electronic Frailty Index 2	Sept 2026	Work on going as transition from Big Discussion to Neighbourhood continues. Some baseline data will be financially dependent.					Lead is currently on unplanned leave. Progress will pick up on their return.	
Working with the DoH and NIPEC A Regional Neighbourhood Nursing Framework will be developed that demonstrates the contribution of all primary and community nursing services within a neighbourhood model.	Mar 2027	There is a meeting of the Regional Neighbourhood Nursing Oversight Group on 7 July. This action is dependent on DOH and partners.						
Develop evidence-based pathways to reduce the impact of frailty	Mar 2027	There is a meeting of the Regional Neighbourhood Nursing Oversight Group on 7 July. This action is dependent on DOH and partners.						

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
32. Implement the Partnership & Engagement Strategy and evolve key priorities					Martin Quinn
Partnership and Engagement Strategy finalised & published alongside and Implementation Action Plan	Jun 2026	P&E strategy launched on 28th May 2026 alongside action plan. Publish on Engage Website.			
Experience & Involvement evident in structures, processes and approaches of the PHA including SU/C membership of / contribution to PHPTs, Joint Commissioning Groups etc	Jan 2027	Consistent approach to PHPT agreed within team including objectives; Discussion with planning team on delivery of training for PHPT		Q1 – PCE & PPI in PHPT terms of Ref. Request to meet PHPT leads agreed. No clarity yet though for Joint Commissioning groups	
Care Opinion, 10 Thousand More Voices and involvement monitoring	Mar 2027	Included in the Regional Priority workplan for Experience and Involvement programmes			
Annual joint PCE & PPI report	Mar 2027	Report will be informed by the framework detailed in the P&E strategy and corresponding action plan.			
33. Finalise and implement a framework to support Quality and Safety corporate processes for PHA.					Denise Boulter / Grainne Cushley
Year 1 evaluation report	Mar 2027	Safety & Quality Framework has been developed and approved by JAG. The document will be continually updated as new procedures relating to patient safety			
Support the implementation of the new Patient Safety Incidents (PSI) Framework					

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		are published e.g. PSI framework, being human framework. A governance model to support integration with JPPT and PHPTs is under development with workshop planned for July 26. The full implementation of Quality & Safety Framework has been delayed due to a number of factors including capacity restraints. Review & prioritisation of workplans within team.			
34. Continue to provide professional advice to SPPG and Trusts to support commissioning of high quality, effective and efficient services including inequality specific services and identification of greater opportunities to reduce health Inequalities					
Starting Well	Sept 2026	Leads to be identified for this action. To be approved by Interim Director & AD Starting Well; Representatives from the Starting Well Team contribute to two Joint Planning Teams: Women and Children's Joint Planning Team (WACPT) and Children's Social Care Joint Planning Team.			All Directors

OUR ORGANISATION						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		WACPT provides a key mechanism to identify and articulate emerging needs across the population of women and children, aligned with corporate priorities. Emerging needs are identified through internal governance structures and are brought to WACPT for consideration within the service commissioning process. This ensures that commissioned services are informed by robust public health intelligence and are responsive to population need. In contrast, the Children's Social Care Joint Planning Team is at an earlier stage of development. The group is currently establishing its remit, membership, available data, and identifying priority areas to inform its work programme for the year ahead.					
Living Well	Sept 2026	Continued to support SPPG and JPPTs to influence commissioning in line with Living Well priorities. Scoped homelessness service investment to identify gaps and support improved Hepatitis C					

OUR ORGANISATION						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		outcomes for Inclusion Health groups. Contributed to Cancer, Gynaecology GIRFT, Stroke, Thrombectomy and Obesity programmes to support commissioning, service improvement and equitable access. Supported development of a Healthcare in Prison action plan with SPPG to improve healthcare access and continuity of care.					
Ageing Well	Sept 2026	Sandra Aitcheson is PHA co-chair of the JPPT. The JPPT will continue to provide a strategic forum for joint planning between PHA & SPPG, maintaining focus on improving outcomes and reducing health inequalities. Progress has continued on the agreed priority areas of frailty and dementia, with ongoing engagement across the AW PHPT and PHA Frailty Network via Sandra. The group has also maintained links with the emerging Neighbourhood Model to ensure alignment with neighbourhood-based planning and commissioning priorities.					

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		Work of the JPPT will align closely with the emerging Neighbourhood Model, which will inform future priorities & delivery. Neighbourhood Teams are currently in the early stages of development however, the Co-Chairs are engaged through SPPG Neighbourhood Implementation Group to support alignment as the model evolves, this group has had an introductory meeting.			
35. Implementation and delivery of the People Strategy					
Implementation of Key Priorities within each year of the strategy document	Mar 2027	People Strategy is delivered operationally through ODEF. ODEF has been re-established; JNF has been re-established; HROD Committee is due to have first meeting in August The Action plan is now in progress with a monitoring process established by the BSO HR Team to ensure all is on track. At end of June 48% of Year 1 actions were in progress; 8% were established / complete. Those not started are being planned or are dependent on those currently in progress.			Leah Scott

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
36. Enhance procurement processes to ensure strong accountability and implement the procurement plan 2026/27					
Agreed procurement plan	May 2026	2026/27 Procurement Plan developed and agreed at the June Procurement Board. New procurement tracker and dashboard developed and shared with Procurement Board. All current commissioning processes being reviewed and updated in partnership with PHPTs.		The planning and performance division are actively engaging with PHPTs to review both Trust and non-Trust contracts to support implementation of the procurement plan. Awareness raising sessions focused on commissioning, procurement, and outcomes-based accountability are scheduled for Oct and Nov in support of the PHPT induction programme.	DFCS and All Directors
All procurement activities scheduled for 26/27 implemented	Mar 2027				
37. Embed Public Health Planning Teams structure					
Agreed plan in place for each PHPT setting out the specific priorities that PHA will focus on delivering over the coming 3-year period	Mar 2027	PID for development of 3-year plans developed and working through approvals. Workshop organised for 3rd July to initiate process			DFCS & PHPT Chairs
Induction process developed and rolled out	Nov 2026	Induction programme topics agreed and indicative programme developed. Final plans being made and launch agreed for 3rd July			

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
38. Implementation of EQUIP					
Implementation of (EQUIP) with a wide range of self-service options aimed at modernisation and improved user experience	Mar 2027	System implementation project underway, with Go Live date of 1 November 2026. Team are fully engaged in testing and training process		Significant complexity and time pressure have resulted in an amber rating. However, Finance Team are working closely with HSC and external colleagues to ensure PHA is well-positioned to transition to the new system with as little disruption as possible. • PHA have appointed an equip finance programme manager (Jul 26) to participate in the regional readiness group. • Regional Equip Programme Board • Regional BSF linked to the Regional Programme Board. • Go live readiness assessments at 30-day intervals commencing June 2026	DFCS
39. Development and in-year launch of a new PHA Corporate Website					
Meeting of scheduled development/roll out mile stones	Monthly	Project team established and meeting regularly to develop and deliver the project plan.			Stephen Wilson
In-year go live of new website	Mar 2027	New 'look' website under development. Original plan for development of a new Integrated hub model has however been amended			Margaret McCrory

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OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		to reflect the absence of capital budget in year. This plan remains in place and will be delivered pending approval of budget from DCHCNI.			
40. Stakeholder Engagement Action Plan					Stephen Wilson
Launch of action plan	Jun 2026	Stakeholder engagement action plan developed in draft but still to be discussed and agreed at PHPTs and PHA Board.		Stakeholder engagement is ongoing by project leads. Timeline for development and sign off of new plan will be brought to AMT in late August 26.	
Number and diversity of stakeholders engaged (pre and post survey measurement)	Mar 2027	Delay in finalising action plan may have knock on impact on post survey measurement		Stakeholder engagement is ongoing by project leads. Timeline for development and sign off of new plan will be brought to AMT in late August 26.	
41. PHA will deliver within tolerances set by department for 26/27 budget					Leah Scott
Develop and approve a financial plan for 2026/7	Jun 2026	Financial Plan has been drafted, but further clarity still required around the savings target to be achieved by		Engagement with DoH Finance colleagues is on-going, however further clarity over the savings target has not yet been received, and the challenging	

OUR ORGANISATION					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
		PHA. Absence of confirmed final 2026/27 allocation. No written Ministerial direction regarding implementation of the full 6% savings requirement with limited ability to achieve further savings without impacting commissioned services and programme delivery.		nature of the 6% target has resulted in the amber rating.	
Deliver financial breakeven within tolerances	Mar 2027	Due to uncertainty around the funding gap across the HSC and the level of savings required, PHA has not received formal confirmation of its allocation for 2026/27. However, an indicative allocation has been issued and PHA Finance will continue to work with budget holders and AMT to deliver a breakeven position against this funding envelope, and respond quickly should the position change.		PHA Finance will continue to work with budget holders and AMT to deliver a strong financial control environment within the Agency. Continued close engagement with DoH Finance will enable the Agency to respond quickly and effectively to any changes to the funding position.	
42. Implementation following launch of the new DoH HSC Research and Development (R&D) Strategy 2026-2030					Joanne McClean Rhonda Campbell
Development and launch of Implementation Plan	Mar 2027	A Departmental decision has been made, to delay development/launch of the Implementation Plan, so that the new CSA/Director of HSC R&D can take the lead on this and allow			

OUR ORGANISATION						
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**			**Mitigating Actions**	**Lead Director**
		further engagement with the wider research ecosystem regarding *pillars* of the new Strategy. The CSA/Director recruitment is open, closing on 31.07.26.					
43. Lead on NI's role in UK Clinical Research Delivery and the VPAG (Voluntary Scheme for Branded Medicines Pricing, Access, and Growth) Investment Programme							
Agreed and UKCRD KPIs	Mar 2027	VPAG funding is in progress and the budgets/finances/reporting continue to be routinely monitored.					Joanne McClean Rhonda Campbell
Associated HSC Trust/site level metrics		All HSC Trusts working to deliver nationally agreed metrics as set out by the UKCRD with a focus on the 90 day* trial set-up metrics (with a specific focus on commercial CTIMPS). *HSC R&D Approval to study opening [60 day target], time from opening to first patient recruited [30 day target]).					
Implementation of the one for NI Commercial Research Delivery Centre		Northern Ireland (NI) Commercial Research Delivery Centre (CRDC) Operational Group continue to meet quarterly.					
Agreed VPAG Investment Programme Impact Metrics		Department of Health & Social Care (DHSC) midpoint review of the VPAG Investment Programme is currently underway (June 2026)					

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Addendum

The following Actions have been carried over from the 2025/26 PHA Annual Business Plan Performance Management Report. An update is provided below on how each action will be managed.

PROTECTING HEALTH						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
1	**Develop a public facing, universal indicator dashboard covering communicable diseases and related special health matters.**					
	Review and further development	Mar 2026 position	This work has been paused due to competing work priorities. Ongoing work required on HPZ data proof of concept (GZE) and integration of measles and pertussis based on current public facing reports.		Work to resume subject to staffing capacity	
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.			**BRAG**	This work remains paused- we hope to pick it up again soon but no change to the item as outlined below. The dashboard has been developed but not yet populated with indicators from all elements of surveillance. Competing urgent demands, and team members changing roles, have limited progress. Additional resource is required to complete development and maintain this system into the future and this will be requested.	Joanne McClean Declan Bradley

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PROTECTING HEALTH					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
4	**Complete option appraisal and commence the development of a business plan that addresses the digital needs of all screening programmes.**				
Business Plan	Mar 2026 Position	The experience of CHS and encompass has varied the approach to developing screening programmes in encompass. Given the external developments by NIDIS and NHSE it is important to be fully assured end-to-end screening can work effectively in encompass. Resources have been secured by encompass to develop a Proof of Concept system for screening programmes. There will be a cost to PHA for this work, however, it is deemed essential to ensure the decision to forego NIDIS/NHSE developments and move to encompass is sound. The Business Plan is on track to be in place by the end of October and will reflect the changing circumstance of the Proof of Concept build. Should this prove successful then a plan to get to go live will follow.		Encompass Proof of Concept developed and demonstrated at a workshop which included members of the Screening Digital Modernisation Board. Final decision on encompass will be made at a Screening Digital Modernisation Board meeting on May 1st 2027 at which point timescales etc. for go-live will become clearer.	Joanne McClean Gary Loughran

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PROTECTING HEALTH					
Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.			**BRAG**	The recommendation to endorse screening programmes transition to encompass was made at the May 1st meeting by the Screening Digital Modernisation Board. Resourcing for the Programme will be provided via encompass' addendum Business Case. Until this is completed and approved the activity of the Screening Modernisation Programme will be on hold. Resource requirements have been highlighted to DoH.	

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STARTING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
7	**Universal Child Health Promotion Programme Healthy Child Healthy Future (HCHF) - strengthen reach and impact to enhance early intervention and developmental support from universal services and AHPs to meet the specific and developmental needs of children.**					
	Establishment of NI Implementation Group	Mar 2026 position	The Programme Implementation Board has not been stood up to date as a policy lead needs to be agreed		PHA have requested that the additional /amended reviews within the refreshed HCHF are built in the Encompass system in preparation for the implementation of the refreshed programme. A letter has been forwarded from PHA to DoH to further enquire if a decision has been made about the policy lead for HCHF in order for work to begin.	Emily Roberts Deirdre Ward
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		No further progress as DoH have not confirmed a policy lead or funding	**BRAG**	Not included in SW 26-27 plan until further progress / update. AD will follow up with DoH Chief Midwifery Officer	

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STARTING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
8	**Drive and support the transfer of the NI Child Health system onto Encompass including supporting the build for the system with EPIC developers**					
	Full availability of CHS functionality on Encompass and go live.	Mar 2026 position	Detailed review of project undertaken and detailed scoping document developed and shared with senior Encompass team. Core build complete end Feb 26. Agreement at Steering group on 19th March to go live 10th Aug 26. The first Go Live Readiness Assessment (GLRA150) successfully took place 31st March. Risks / issues highlighted and discussed. Hope to see progress by GLRA120 on 27th April.		Mitigations in place re risks / issues. Improvements after GLRA ongoing. Seeking further advice from Epic in relation to Childhood vaccination schedule. Action continued in 26-27	Emily Roberts / Joanne McClean Deirdre Ward-/ Gillian Weir
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		Progress has been made in the last quarter. PHA has participated in ensuring build has been completed in a number of areas including workflows and build. PHA have been involved in set-up of end user acceptance and parallel testing. PHA has have helped coordinate training sessions in preparation for go live. PHA have negotiated and	**BRAG**	The project is the responsibility of the Encompass project team. Continue with completion of build and testing. Focus Design Groups to provide assurance to Steering Group via submission of area Project Plans. Senior leadership within PHA, Encompass and trusts will agree a way forward and establish new timelines for go live. Consideration to be given to a phased approach to go live	

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STARTING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			managed communication and progress between trusts and Encompass		PHA will lead on a project to consider solutions for pre-school vaccinations PHA's Senior Project Manager will work with stakeholders to ensure readiness assurance prior to Go Live and new Go Live Date In Q4 2025/26 we reported that BRAG was amber as monitoring was based on Encompass progress. In 2026/27 we are reporting on PHA's progress on their responsible actions for the transfer and we are on track.	
9	Completion of needs assessment for children with complex health care needs attending special schools: Therapeutic needs assessment	Mar 2026 position	Working with relevant stakeholders, PHA leads have developed a scoping tool to capture relevant data in support of an assessment of therapeutic needs with an initial focus on CYP in Special Schools and Special Provision Schools. The tool is in initial stages of testing. Scope commenced on therapeutic needs commencing with CYP identified with nursing needs in special schools. Scoping tool has been implemented with the first phases of data being returned for analysis. This work has been paused due to vacancies in the team. outstanding report from AHPs		This work has been paused due to vacancies in the team. outstanding report from AHPs, this will be progressed in 2026-27 upon team return. To be continued / updated upon staff return Q3 2026-27 pending capacity and assistance from Health Intelligence and data analysis.	

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STARTING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		Therapeutic needs assessment underway. Data being re-reviewed, update presented to JEHOG and support for engagement requested.	BRAG	Staffing issues has caused a delay. Secured support from Living Well AHP colleague 1 day per week to help deliver project. Seeking to gain support from Population Research & Intelligence. 2026/27 target is June anticipating report completion in October	

HSC Public Health Agency

LIVING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Review and update the Regional PL2 Action Plan and local Protect Life Implementation Groups (PLIGs) Action Plans to reflect updated PL2 Strategy priorities					
10	New PLIG Action Plans	Dec 2025	The PHA have worked in partnership with local Protect Life Implementation Groups (PLIGs) to revise their Action Plans for 2026-2029. Final drafts are currently being screened, utilising a regionally agreed tool, prior to sign-off. Regional Terms of Reference for local PLIGs have been co-produced with PLIG reps. A guidance document to inform PLIG membership is also in development.		Anticipated that screenings will be complete and action plans approved by local PLIGs forthcoming meetings.	Joanne McClean Emily Roberts / Fiona Teague
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		All action plans have now been completed, screened and approved by local Protect Life Implementation Groups. This action should be managed through routine reporting going forward.	**BRAG**		

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LIVING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
11	**Implement a review and revision of the service provision model of all Pharmacy based Stop Smoking Services across NI, considering refreshed NICE guidance and evidence base in re-commissioning of services. Implement a review of all Trust based Stop Smoking services commissioned via PHA, to ensure regionally consistent and comparable, measurable services are in place to meet population needs in each Trust.**					Joanne McClean Colette Rogers
	Revised Pharmacy based Stop Smoking services rollout to begin across NI in partnership with SPPG	Mar 2026 position	Medicines Optimisation Innovation Centre (MOIC). The stop smoking service evaluation surveys have closed 31.03.26 to new responses and work will begin on analysing these and the interviews. This review and evaluation findings report due in June 2026 will inform the refreshed specification.		Rollout timelines were not achieved as planned. This work has been incorporated into the 2026/27 Business Plan to support delivery	
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		Action carried into 26/27 ABP and is being reported on quarterly	**BRAG**	The MOIC Community Pharmacy Evaluation is in its final draft stage (June 2026). Recommendations from the evaluation will inform the development of the new service specification. A Band 7 officer has been successfully recruited and will lead this workstream.	

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LIVING WELL						
	Action and KPI(s)	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Launch a constipation campaign, to include establishing an expert reference working group with the aim to co-produce a suite of resources / guidance to support people with learning disabilities, their families / carers and clinical staff to prevent, recognise and treat constipation across the lifespan.					
14	Expert reference working group established.	Mar 2026 position	Scoping has been completed and consideration is now being given to progressing a Phase 1 of this campaign. Membership of the Expert Reference Group is currently under consideration. Upon confirmation, formal representation will be appointed to enable the group to commence work on Phase 1.			
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		The working group has been established to progress this work, with Terms of Reference agreed and planning initiated. A reference group will also be set up to engage and involve people with learning disabilities, their families and carers in the development of these resources. This work will be reported to the LD subgroup of the MHLDSU PHPT	**BRAG**		

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AGEING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
17	**Update and test MDT decision making pathway for care home residents to reduce unnecessary admission to hospital.**					
	Test new decision-making pathway in SHSCT to refine approach	Mar 2026 position	The learning from this work was used to host an information session for all care homes in SHSCT in December 2025 re management of an unwell resident and the options/ services available. There is also a similar deep dive being conducted in a second home n SHSCT to assess if there are themes or threads across homes in Trust locality. Monitoring of impact ongoing		MDT decision making and support for deteriorating patient work being taken forward via Big Discussion In year we have reviewed NIAS data and used that to target information to homes on alternatives to ED/NIAS for residents We are continuing to develop models for ensuring advance care plans are completed for residents.	Emily Roberts, Alison Ferris
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.			**BRAG**	Action taken forward by Big Discussion	
	Present findings and recommendations to relevant commissioning teams and PTEB	Mar 2026 position	Dependent on above		MDT decision making and support for deteriorating patient work being taken forward via Big Discussion	

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AGEING WELL						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
					In year we have reviewed NIAS data and used that to target information to homes on alternatives to ED/NIAS for residents We are continuing to develop models for ensuring advance care plans are completed for residents.	
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.			**BRAG**	Action taken forward by Big Discussion. We are continuing to develop models for ensuring advance care plans are completed for residents in ABP 26/27 e.g. Take forward Implementation of the For Now and For the Future Advance Care Planning (ACP) Policy for Adults in Northern Ireland	

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OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
20	**New Operational Framework for Public Health Planning Teams and performance management framework, aligned to the new PHA operational model, to be developed and approved by PHA board.**					Leah Scott Stephen Murray
	PHPT Framework agreed	Mar 2026 position	Draft PHPT Governance and Accountability Framework document has been developed and reviewed by the Senior Leadership Forum. Finalisation of the framework has been delayed as there are on-going discussions to clarify accountability and reporting arrangements for PHA staff that have Chairing responsibilities for both PHPT's and JPPT's		Finalised Framework document will be submitted for approval to Board in May 2026	
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		PHPT Governance and Accountability Framework was approved by AMT on 29th June 2026. The paper is also tabled for discussion at the next PPR Committee meeting	**BRAG**		
	Performance Framework approved	Mar 2026 position	A draft performance framework has been developed and will be reviewed by PHPT Chairs and Senior Leadership Forum. Finalisation of the Performance Framework is linked to the finalisation of the PHPT Operational framework noted above.		Draft Performance management framework will be finalised and submitted for approval to AMT / PHA Board.	

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OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		Following approval of the PHPT Governance and Accountability Framework, work is underway to finalise the Performance Framework for review for Senior Leadership Forum and AMT in September 2026	BRAG		
21	**PHA Procurement Plan to be reviewed and updated and Procurement Plan priorities 2025/6 to be progressed in line with agreed timelines**					All Directors (as per Leads for individual tenders)
	Procurement Plan 2025/6 delivered in line with agreed timelines.	Mar 2026 position	Tenders planned for issue to the market in 2025/26 are progressing. However there has been a slight delay in getting tenders out to the market due to a regional review of T&Cs having to be undertaken by DLS to ensure they align with the new Legislation and Public Procurement Policy.		DLS has provided updated T&C's for review by PHA/PaLs. Comments have been provided to DLS and a final version of T&Cs will be issued by DLS as soon as possible. Publication timelines for Postvention, PPSU and YT will be confirmed once the final set of revised T&C's have been approved.	
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		New procurement strategy has been developed and Procurement Plan for 2026/27 agreed and work progressing on this plan. The review of T&Cs remains an outstanding issue but we are actively engaging with DLS and a final T&Cs is expected to be agreed in August 2026. Reporting and monitoring will continue through the Procurement Plan for 2026/27 through the	BRAG		

HSC Public Health Agency

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
			Procurement Board on a quarterly basis.			
24	**Finalise a framework to support Quality and Safety corporate processes for PHA**					
	Framework will be finalised for AMT and Board	Mar 2026 position	A joint PHA/SPPG Quality and Safety framework is under development.		The Framework will be submitted to PHA Board Q1 26/27	Emily Roberts Denise Boulter / Grainne Cushley
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine reporting or addressed through the 26/27 annual business plan.		**Framework finalised (living document) and been through JAM**	**BRAG**		
25	**Conclude Agency Reshape and Refresh change management programme**					
	Reshape and refresh outcome measures delivered in line with Project plan timescales.	Mar 2026 position	A Reshape Refresh Closure Report was presented to the PHA Board in November 2025. This report will be shared with the Department and will be discussed at the Accountability Review meeting. An evaluation exercise based on the programme is being taken forward during Q4.		Evaluation exercise to be taken forward into 26/27	Aidan Dawson (CEO) Grainne Cushley
	Update at 30 June 2026 Please indicate how this action will be managed on an ongoing basis i.e. routine		Staff survey addressing Reshape and Refresh Benefits Realisation is planned for Q3 in year. Pending	**BRAG**		

OUR ORGANISATION						
	KPI and Milestones	**Date**	**Progress** (100 Words max)	**Q1-Q4**	**Mitigating Actions**	**Lead Director**
	reporting or addressed through the 26/27 annual business plan.		analysis, final outcomes paper will be presented to AMT and Board in Q3/Q4			

item 12

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Complaints, Compliments and Claims Quarterly Report
Reference	PHA/08/08/26
Prepared by	Alastair Ross / Ashley Stoney
Lead Director	Aidan Dawson

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

1 Purpose

The purpose of this paper is for the Board to note the latest report on complaints, compliments and claims against the PHA.

2 Background Information

This report has been prepared in accordance with the Northern Ireland Public Services Ombudsman's Model Complaints Handling Procedure, which requires Health and Social Care organisations, including the PHA, to report complaints performance information to senior management on at least a quarterly basis.

The report also includes information relating to claims management within the Agency, in response to a recommendation arising from the 2023 Internal Audit of Complaints and Claims Management within the PHA.

The format of this report has been revised to reflect the introduction of the new Stage 1 and Stage 2 complaints handling procedures.

3 Key Issues

During the first quarters of 2026/27, the PHA received one formal complaint, one compliment and no claims have been closed.

4 Next Steps

The next Report will be brought to the Board in October 2026.

2026/2027
Complaints, Compliments and Claims
Quarterly Report

Internal Qtr 1 Report

Position as at 30 June 2026

Report Prepared by PHA Complaints Office

CONTEXT

On 1 January 2026, the Northern Ireland Public Services Ombudsman's Model Complaints Handling Procedure (MCHP) came into effect for the Health and Social Care sector. The MCHP establishes the framework and standards that Health and Social Care organisations, including the PHA, must follow when managing complaints.

As part of its requirements, the MCHP mandates the regular reporting of complaints performance information to support organisational learning, accountability and transparency. This report has been prepared in accordance with those requirements. The report also includes information relating to claims management within the Agency, in response to a recommendation arising from the 2023 Internal Audit of Complaints and Claims Management within the PHA.

SECTION 1 - COMPLAINTS

1.1 Definitions

Complaint

- A complaint is an expression of dissatisfaction by one or more members of the public about an organisation's action or lack of action, or about the standard of service provided by or on behalf of an organisation.

Stage One Complaints

- Stage One is an early resolution process designed to address and resolve complaints quickly and close to the point at which the service was delivered. Complaints should normally be responded to within five working days, with provision for an extension of up to five additional working days where necessary.

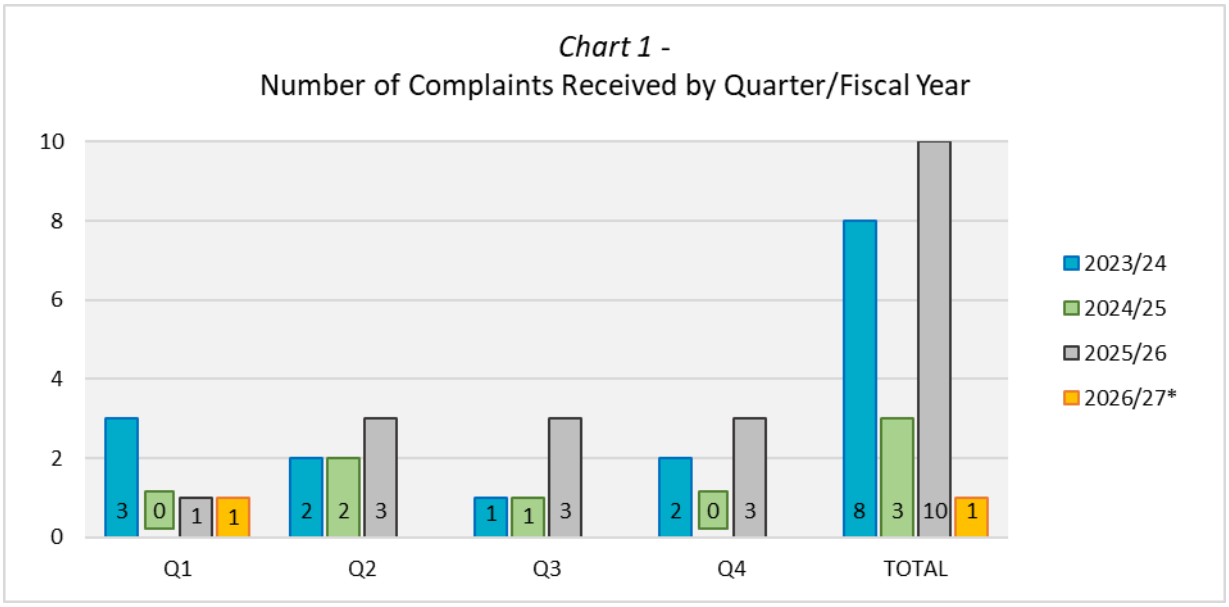
Stage Two Complaints

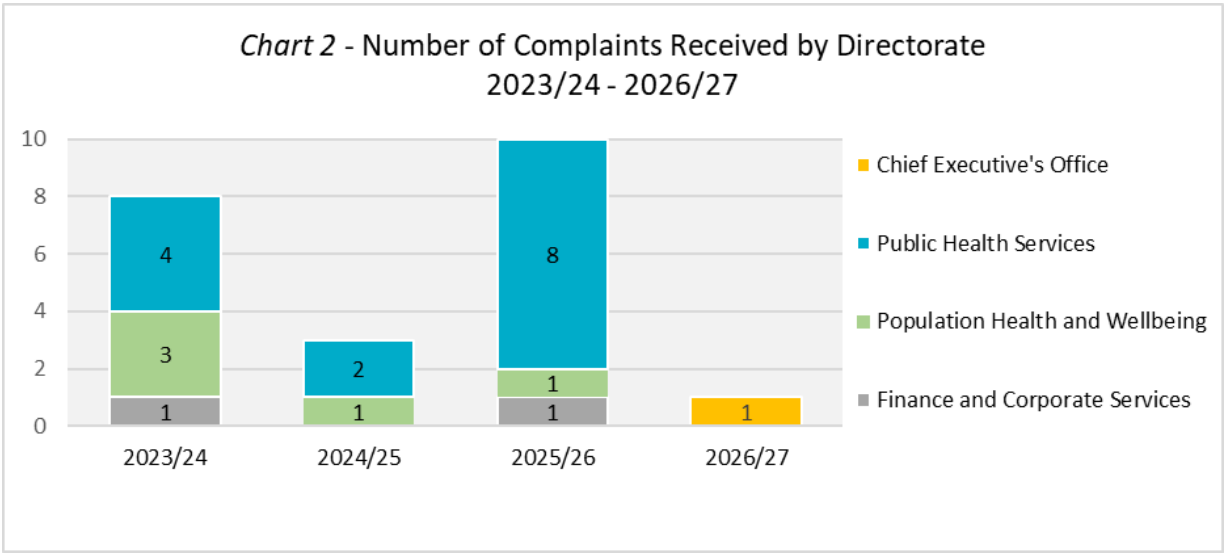
- Stage Two is a formal process for complaints that have not been resolved at Stage One or where the complainant remains dissatisfied with the response provided. Complaints should normally be responded to within 20 working days of their acceptance at Stage Two. Where this is not possible, complainants must be provided with updates at least every 20 working days until a final response is issued.

1.2 2026/27 Overview

Between 1 April 2026 and 30 June 2026, one complaint was reported to the PHA Complaints Office.

Further detail in relation to the receipt of complaints by quarter, fiscal year and PHA Directorate is set out across Charts 1 and 2.





HSC Public Health Agency

1.3 2026/27 Closed Complaints

No complaints were closed within the Agency during quarter one of 2026/27.

Tables 1 - 6 provide information on complaints closed since the start of Quarter 4 2025/26, when the Agency's complaints reporting arrangements were revised to align with the Northern Ireland Public Services Ombudsman's MCHP.

Table 1 Number of Complaints Closed by Stage

	Number of Complaints Closed	Number of Complaints Closed at Stage One	Number of Complaints Closed at Stage Two
Q4 2025/26	3	3	-
Q1 2026/27	0	-	-

Table 2 Stage One Outcomes

	Number of Complaints Closed	Number 'resolved'	Outcome 'upheld'	Outcome 'partially upheld'	Outcome 'not upheld'
Q4 2025/26	3	3	1	0	2
Q1 2026/27	-	-	-	-	-

Table 3 Stage Two Outcomes

	Number of Complaints Closed	Number 'resolved'	Outcome 'upheld'	Outcome 'partially upheld'	Outcome 'not upheld'
Q4 2025/26	-	-	-	-	-
Q1 2026/27	-	-	-	-	-

Table 4 Stage One Complaint Tenures

	Number and % of Stage One Complaints closed within 5 working days	Average time taken to issue response (working days)	Shortest time taken to issue response (working days)	Longest time taken to issue response (working days)
Q4 2025/26	3 (67%)	3	1	6
Q1 2026/27	-	-	-	-

-

Table 5 Stage Two Complaint Tenures

	Number and % of Stage Two Complaints closed within 20 working days	Average time taken to issue response (working days)	Shortest time taken to issue response (working days)	Longest time taken to issue response (working days)
Q4 2025/26	-	-	-	-
Q1 2026/27	-	-	-	-

Table 6 Synopsis of Closed Complaints 2026/27

PHA Ref	Responsible Directorate	Synopsis of Complaint and Response
No complaints were closed during quarter one of 2026/27		

1.4 2026/27 Open Complaints

As at 30 June 2026, the PHA has one open complaint.

1.5 Northern Ireland Public Services Ombudsman

Upon the completion of the PHA complaints process, each complainant is signposted to the Ombudsman should they be dissatisfied with the outcome they have received.

As at 30 June 2026, the PHA is aware of no open PHA complaint investigations with the Ombudsman.

SECTION 2 - COMPLIMENTS

2.1 Definition

Compliment

- A compliment is an expression of appreciation felt by service users, carers, relatives, members of the public and/or external professional bodies for the work undertaken by the PHA.

During the period, 1 April 2026 - 30 June 2026, the PHA Complaints Office was notified of one compliment.

Table 7 Compliments Received 2026/27

PHA Ref	Directorate in Receipt of Compliment	Sender of Compliment	Compliment
01/2627	Population Health and Wellbeing	Chief Allied Health Professional Officer	*'I wanted to write to congratulate you and the team on the launch of the Care Home Nutrition and Hydration Guidelines… It was an excellent event, and the extent of multi-disciplinary, multi-agency partnership working was very evident. These guidelines are a significant contribution to improving and extending people's lives, and that is what matters most.'*

SECTION 3 - CLAIMS MANAGEMENT

3.1 Potential Liabilities

Claims within the PHA are aligned to four types of potential liability:

- Clinical/Medical Negligence,
- Employer's and Occupier's Liability,
- Injury Benefit and
- Employment Law.

The level of provision made in respect of potential liabilities for claims is based on professional legal advice from the Directorate of Legal Services. Information in respect of provisions are set out in the PHA Annual Report.

3.2 Closed Claims (Settled and Withdrawn)

No claims in relation to the PHA have been closed during the 1 April 2026 to 30 June 2026 period.

3.3 Open Claims

The Agency has no open claims as at 30 June 2026.

PHA Complaints Office
complaints.pha@hscni.net

END

item 14

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Gifts and Hospitality Policy
Reference	PHA/09/08/26
Prepared by	Helen O'Hare / Karen Braithwaite
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to bring the updated PHA Gifts and Hospitality Policy to the PHA Board for approval.

2 Key Issues

The attached PHA Gifts and Hospitality Policy has been updated to align with HSC(F) 19-2025 – Guidance on the Acceptance and Provision of Gifts and Hospitality.

The main changes to this policy include the requirement for approval by a Director and the raising of a purchase order for all external hire of venue and hospitality. The £50 threshold for gifts, the general rule of no hospitality for internal-only meetings, the use of external venues to be used as a last resort and the requirement to record all offers of gifts and hospitality in the Gifts and Hospital Register, remain in this revised policy.

The updated Gifts and Hospitality Policy was approved by the Agency Management Team at its meeting on 11 May 2026 and by the Governance and Audit Committee at its meeting on 11 June 2026.

3 Next Steps

Following approval, the Policy will be published on the PHA Intranet.

GIFTS AND HOSPITALITY

POLICY

Version	**3.0**
Date version 3 approved by PHA board	
Review completed	
Reviewed policy approved by AMT	**11/05/26**
Reviewed policy approved by GAC	**11/06/26**
Scheduled review date	**30/06/29**

CONTENTS

1.0 INTRODUCTION

The purpose of the Gifts and Hospitality Policy is to ensure that the Public Health Agency (PHA) meets its obligations under all relevant legislative requirements and associated guidance, in particular the Bribery Act 2010.

All decisions by PHA staff on the acceptance or provision of gifts and hospitality must be able to withstand both internal and external scrutiny. The Gifts and Hospitality policy is intended to provide advice to all PHA staff who may, in the course of their day-to-day work or as a result of their employment, receive offers of gifts, hospitality or considerations of any kind from contractors, agents, organisations, firms or individuals. The policy also provides advice on the provision of gifts and hospitality to others on behalf of the PHA.

This policy has been reviewed against HSC(F) 19-2025 – Guidance on the Acceptance and Provision of Gifts and Hospitality, Managing Public Money Northern Ireland, and relevant legislative requirements, including the Bribery Act 2010. It should be read in conjunction with: PHA's Standing Orders, Standing Financial Instructions and the PHA Code of Conduct (September 2016).

This Gifts and Hospitality policy is part of the PHA's overall Governance Framework. **All offers of gifts, hospitality or invitations either accepted or rejected must be recorded in the Gifts and Hospitality Register as set out in this policy**.

A gift is defined as something voluntarily donated, with no preconditions and without the expectation of any return. This includes all transactions which are economically indistinguishable from gifts, such as trade loyalty or discount cards, awards/prizes, donations or long-term loans. Grants and grants-in-aid are not considered gifts and are governed by separate arrangements.

Hospitality includes any type of refreshments or entertainment provided out of public funds to anyone, be they a public servant or official, representative of a public or private body or organisation, or a private individual.

Hospitality, gifts or financial support associated with awards ceremonies, conferences, seminars or similar events are subject to approval, value-for-money assessment, procurement compliance and recording requirements outlined in the policy.

Where this policy refers to Director approval, this means approval by an Executive Director, with referral to the Director of Finance and Corporate Services where interpretation, value-for-money, taxation or propriety concerns arise.

2.0 GIFTS

2.1 Acceptance of Gifts

The conduct of PHA staff must not even foster the suspicion of a conflict of interest. Therefore, staff should not do anything that may give the impression to colleagues, members of the public, or people with whom they deal in an official capacity, that they have been, or may have been, influenced by a gift or consideration to show bias either for or against any person or organisation while carrying out their official duties.

Furthermore, under the Prevention of Corruption Act 1916, any money, gift or consideration received by a member of staff from a person or organisation holding, or seeking to obtain, a government contract will be deemed by the Courts to have been received corruptly unless you can prove to the contrary.

The general principle therefore is that all gifts offered to staff should be refused. However, modest seasonal or promotional gifts (such as calendars, diaries, pens or similar items) with a **value of less than £50** may be accepted without the need for these to be reported or approved in advance by line management, provided they bear Company names and/or logos. This type of gift is easily distinguishable from more expensive or substantial items, which cannot on any account be accepted.

It is recognised that there are exceptional cases where refusal of a gift would clearly offend the donor, cause embarrassment or appear discourteous, such as gifts received from an overseas government or governmental organisation. In these cases, full details of the circumstances should be notified to the Director of Finance and Corporate Services for consideration in line with this policy.

All gifts offered with a value of £50 or more, regardless of whether they are accepted, declined or returned should, in all cases, be reported and recorded in the PHA Gifts and Hospitality Register in accordance with this policy. Please see Section 4.

2.2 Provision of Gifts by PHA

ALBs have a delegated limit of £250 for gifts to an individual. Department of Finance (DoF) approval is required for any gift made with a value of £250. In respect of collective gifts to any range of individuals or entities where the value of the gift(s) to any one individual exceeds £250 or when the value of the collective gift(s) exceeds £5,000, prior approval must be sought from DoF. In these cases, a submission should be sent to Finance Policy and Accountability Unit, D3, Castle Buildings (or email to fpau@health-ni.gov.uk) who will seek approval from DoF Supply.

The regulations governing expenditure on gifts are contained in Annex 4.12 of Managing Public Money Northern Ireland (MPMNI) Managing Public Money Northern Ireland Managing Public Money NI.

3.0 HOSPITALITY

3.1 Acceptance of Hospitality

The handling of offers of hospitality is recognised as being much more difficult to regulate but it is an area in which staff must exercise careful judgment.

In deciding whether hospitality can be accepted, it is important to consider not just the offer itself, but also the appearance of the offer to others and the circumstances surrounding it. For example, an isolated acceptance of, for example, meals, tickets to sporting, cultural or social events may be acceptable if attendance is justifiable in the interests of the PHA, Government or Departments. However, acceptance of frequent, regular, annual or seasonal invitations, particularly from the same source, may breach the required standards of conduct.

In deciding whether hospitality can be accepted, you should bear in mind the following principles:

a) Acceptance should be considered in the context of business need and/or effectiveness;

b) Acceptance must not place any obligation on the recipient;

c) Hospitality that is frequent, lavish or prolonged should not generally be accepted;

d) Any hospitality should be unconnected with any decision affecting the organisation or individual offering it;

e) Hospitality that is accepted should always be justifiable; and

f) The benefits of acceptance should outweigh the risk of possible misrepresentation of the hospitality.

In all instances where other than conventional hospitality is offered, approval should be sought in line with the organisational policy and delegated limits. If doubts persist the matter should be referred to the Director of Finance and Corporate Services.

Some invitations, particularly to senior staff, are extended in a representational capacity. Whilst such invitations may generally be accepted within reasonable limits, care should be taken to ensure that the this does not result in PHA over-representation at the function concerned.

On occasions it may be appropriate for a partner to accompany you as a senior officer where the event so justifies.

Numbers of ALB officials should be kept to the minimum necessary and should not normally exceed the number of visitors. The same guests should not be offered hospitality on an automatically recurrent or regular basis, or solely as a return gesture.

3.2 PROVISION OF HOSPITALITY

On every occasion hospitality extended should be in the direct interest of the Public Health Agency and proportionate to that interest. It is essential that staff exercise careful budgetary control over such expenditure.

3.2.1 Provision of Hospitality – Internal to PHA:

As a general rule, hospitality **should not be** provided for internal-only meetings and events. Exceptions where internal hospitality *may* be considered (subject to prior Director approval via the form in Appendix 1) are strictly limited to:

- **External Majority:** The primary purpose is to host external partners, and the majority of attendees are not PHA staff.
- **Public-Facing Events:** Events integral to public engagement where hospitality is offered to the public and external stakeholders.

3.2.2 Provision of Hospitality and Use of External Venues:

All venue selection must follow a strict hierarchy to ensure value for money and appropriate use of public funds.

Guiding Principles Use of Venue:

- **Priority 1:** In-House Facilities:
  Meetings should ideally be held in-house or virtually. You **must** check if suitable internal PHA meeting rooms are available and suitable before looking externally.

- **Priority 2:** Other Public Sector Buildings:
  If PHA facilities are unsuitable or unavailable, you **must** explore the use of facilities in other HSC bodies, government departments or council buildings.

- **Priority 3:** External Commercial Venues
  Using an external commercial venue (like a hotel or conference centre) is a last resort, only permissible if Priorities 1 and 2 are demonstrably unsuitable or unavailable.

Justification: A robust justification is required on Appendix 1 for why publicly owned venues could not be used and that they demonstrate Value for Money.
Appropriate Venue: External venues must be functional and professional, not associated with entertainment or luxury.
Prior Approval is Mandatory: You **must** complete the form in Appendix 1 and receive signed approval from a Director **before** booking the venue or incurring cancellation fees.

You **must complete a Purchase Order** for all external hire of venue and hospitality in advance of booking.

Please contact eproc@hscni.net for purchase order guidance.

All expenditure on hospitality must comply with procurement control limits and procedures. Gifts/Hospitality costs must be clearly identified and coded to appropriate general ledger codes and must not be subsumed within other expenditure categories. Supporting documentation (approvals, guest lists, invoices and receipts) must be retained for audit and inspection purposes.

4.0 GIFTS AND HOSPITALITY REGISTER

In all instances where hospitality (other than conventional hospitality such as infrequent working lunches) is offered by external organisations, this should be declared and the approval of the Director sought using the form at Appendix 2 Gift/Hospitality Approval Form (Acceptance), which should be copied to the PHA IG Team IGTeam.PHA@hscni.net for recording in the Gifts and Hospitality Register (see Appendix 4).

If the recipient has, or will, reject the offer of hospitality they need to send details to their Line Manager for inclusion in the Gifts and Hospitality Register. Appendix 2 Gift/Hospitality Approval Form (Acceptance) should be used to record the offer of a gift, hospitality or invitation and Appendix 3 Template for Return of Offer of Gift/Hospitality should be used to return it to the provider.

All offers of gifts, hospitality or invitations either accepted or rejected must be recorded in the Gifts and Hospitality Register.

The PHA will maintain a Gifts and Hospitality Register which will be available for periodic review. This Register is held by the IG Team in the Finance and Corporate Services Directorate.

All completed forms should be forwarded to the IG Team Email:IGTeam.PHA@hscni.net for the purposes of maintaining the Register.

This Gifts and Hospitality Register will be presented to the Governance and Audit Committee for review annually (see Appendix 4 for Gifts and Hospitality Register template).

The Gifts and Hospitality Register may be subject to Freedom of Information requests and must therefore be complete, accurate and capable of withstanding public scrutiny.

5.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

5.1 Equality

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

5.2 Human Rights

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

This policy will be included in the PHA's Register of Screening documentation and maintained for inspection whilst it remains in force**.**

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

6.0 REVIEW OF POLICY

The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

This policy will be reviewed by the Director of Finance and Corporate Services on 30 June 2029 or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

APPENDIX 1

HSC Public Health Agency

GIFT/HOSPITALITY REQUEST FORM (Provision)

Application for Approval of Providing Gift/Hospitality	
Requestor:	
Directorate:	
Team:	
Cost Centre:	
Purpose:	
Reason why Gift/Hospitality is required:	
Potential Venue:	
If non-government venue – please confirm that non-government venues were considered and include reason why rejected:	
Total Expected Number of Attendees:	
Number of these Attendees that are PHA employees	
Number of these Attendees that are not Employed by PHA (set out what organisation they are from or reason that they are in attendance)	
Indicative Cost:	
Set out how this demonstrates Value for Money:	
Approved by Director: (insert signature)	
Date approved by Director:	
Outcome confirmed to requestor:(Y/N)	
Purchase Order Raised: (Y/N)	
Gift/Hospitality Register Ref:	

Please return completed form to the PHA IG Team IGTeam.PHA@hscni.net

HSC Public Health Agency

GIFT/HOSPITALITY APPROVAL FORM (Acceptance)

PART 1 – To be completed by recipient of gift/hospitality

Gift / Hospitality Authorisation Form	
Name of person to whom offer made:	
Date of event or gift offered:	
Name of originator of offer:	
Description of offer and reason:	
Estimated/actual value of offer:	
State whether the offer was declined:	
Is there a current/potential contract with the donor? If yes, provide details:	
Signature of recipient:	Signed: Date:

PART 2 – To be completed by the Director

Gift / Hospitality Authorisation Form (Outcome)	
Decision: (Approved/Not Approved)	
Reason why approval has/has not been granted:	
Is gift being returned? (If so, letter as per Appendix 3 should be used)	
Has the gift been used or disposed of? If so, give details:	
Has the gift been donated to a nominated charity?	
Has the Gifts and Hospitality register been updated?	
Signature of the Director:	Signed: Date:

Please return completed form to the PHA IG Team IGTeam.PHA@hscni.net

APPENDIX 3

HSC Public Health Agency

TEMPLATE FOR RETURN OF OFFER OF GIFT/HOSPITALITY

(The content of this template should be tailored to suit each circumstance)

Contact name

Contact details etc

Date

Dear

The Public Health Agency operates a Gift and Hospitality Policy to ensure high standards of propriety in the conduct of its business.

On account of public confidence, perception is as important as reality and because of this I am obliged to return your kind offer of……..

This is not meant in any way to offend or imply that your [gift/hospitality] was offered in anything but the utmost of good faith, but is designed to protect both individual members of staff and the Public Health Agency. I hope you will accept our response in that spirit and that we can look forward to continued effective working relationships.

Yours …….

GIFTS AND HOSPITALITY REGISTER

REGISTER OF GIFTS 1 APRIL 20XX – 31 MARCH 20XX

Date of Event or Gift Offered	Offered to:	Ultimate Recipient	Offered From	Description of Gift / Offer	Reason for Offer	Est. value / actual value of Gift / Offer

item 15

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Health and Safety, Fire Safety and Security Annual Report 2025/26
Reference	PHA/10/08/26
Prepared by	Karen Braithwaite
Lead Director	Leah Scott

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

1 Purpose

The purpose of this paper is to bring the annual Health and Safety, Fire Safety and Security Annual Report to the PHA Board for noting.

2 Key Issues

This Annual Report provides detail of the activity during the year 1 April 2025 – 31 March 2026 within the Public Health Agency (PHA) in the areas of Health and Safety, Fire Safety and Security. This report supports the PHA in demonstrating compliance with its statutory and legal responsibilities by providing assurances to the Chief Executive and Agency Management Team that appropriate systems and processes are in place and these are being effectively managed and reported on.

3 Next Steps

A number of actions will be taken forward in 2026/27 and these are outlined at the conclusion of the report.

HSC Public Health Agency

Health and Safety, Fire Safety and Security Annual Report

1 April 2025 – 31 March 2026

Contents

Introduction

This Annual Report provides detail of the activity during the year 1 April 2025 – 31 March 2026 within the Public Health Agency (PHA) in the areas of Health and Safety, Fire Safety and Security. This report supports the PHA in demonstrating compliance with its statutory and legal responsibilities by providing assurances to the Chief Executive and Agency Management Team that appropriate systems and processes are in place and these are being effectively managed and reported on.

The Management of Health and Safety at Work Regulations (NI) 2000 sets out what organisations must do to comply with the Health and Safety at Work (NI) Order 1978. This Order places duties on employers to ensure, as far as is reasonably practicable, the health and safety of their employees and similarly details responsibilities on employees to comply with the measures put in place for their health and safety.

All PHA staff are required to comply with the PHA Health and Safety, Fire Safety and Security policies. The vast majority of PHA staff are located within SPPG premises; PHA staff in these facilities are required to adopt SPPG policies and to participate in site specific training in relation to Fire Safety and Evacuation Procedures. PHA policies relating to Health and Safety, Fire Safety and Security reference the need for staff to comply with relevant SPPG policies where appropriate. The PHA policies and relevant SPPG policies are available on the PHA's Intranet site, Connect.

Governance Arrangements

Health and Safety Committee

The PHA Health and Safety Committee oversees health and safety, fire safety, and wider premises and workplace requirements across PHA-occupied offices, including Linum Chambers, Bedford Street, Belfast. It also regularly reviews incidents and near misses relating to PHA staff, occurring in any other premises occupied by PHA staff.

The SPPG has established Premises, Fire and Health and Safety Committees (known as the 'Premises Committees') for each of their facilities; PHA staff are represented on each Premises Committee. With the change in management arrangement for PHA and SPPG, PHA will become a joint chair of these premises in future. The Chief Executive

and members of the board have a collective and individual responsibility for health and safety and fire safety. They have a legal duty to make the workplace safe and eliminate or control risks to health, to ensure that safe systems of work are set and followed, to ensure employees are given information, instruction, training and supervision necessary for their health and safety and that staff are consulted on health and safety matters. The existence of Premises Committees helps achieve these aims.

Policies

There are a range of policies in place concerning health and safety matters. These include a Health and Safety Policy, Fire Safety Policy, Fire Alarm and Evacuation Policy for Linum Chambers in Belfast Security Management Policy and Incident and Near Miss Reporting Policy and Procedure.

These policies will be kept under review and updated and amended as necessary.

Legislative Changes

There were no significant changes to the Agency's legislative responsibilities to report during the year.

Risk Management

Health and Safety Risk Assessments

The PHA is required to comply with the Management of Health and Safety at Work Regulations (NI) 2000 and to mitigate health and safety risks arising from PHA activities. Health and safety risk assessments have been undertaken by PHA for Linum Chambers. SPPG are responsible for undertaking the risk assessments in their premises, where PHA staff are also accommodated. There were no substantive changes to office accommodation or staffing numbers during the year.

Display Screen Equipment assessments, or workstation assessments as they are more commonly referred to, are undertaken as and when required. Appropriate adjustments are made as necessary as a result of these assessments. The assessments are undertaken by the Head of Governance or Assistant Governance Manager who have been trained in their conduct.

Health and Safety Performance

Personal Emergency Evacuation

The Health and Safety at Work (NI) Order 1978, the Management of Health & Safety at Work Regulations (NI) 2000, the Disability Discrimination Act 1995 and The Fire Safety Regulations (Northern Ireland) 2010 place duties on the PHA to implement effective arrangements for access and emergency evacuation for employees and visitors. A Personal Emergency Evacuation Plan (PEEP) will be drawn up for any employee who requires assistance with any aspect of emergency evacuation. The plan will include assistance required from the point of raising the alarm to passing through the final exit of the building.

This is a regular item on the PHA Health and Safety Committee; representatives on this committee have been made aware, and are regularly reminded, of the guidance surrounding the creation of a PEEP and they will liaise with the Head of Governance should the need arise.

Unannounced Inspections

An Unannounced Inspection covering the areas of health and safety, fire safety and security were carried out in Linum Chambers on 30th July 2025. A report of findings was provided to the PHA Health and Safety Committee. The representatives on the Health and Safety Committee then fed back the results, which included any actions required, to staff in their relevant sections. In the inspection it was noted that general good housekeeping was being implemented and no major issues for concern were identified.

Similar inspections are also undertaken in SPPG premises by SPPG staff and any relevant findings are reported back to relevant PHA staff. Again, results of unannounced inspections are fed back to PHA staff via their representatives on the SPPG Premises Committees.

Fire Risk Assessments

The PHA is required to comply with all relevant fire legislation which includes The Fire and Rescue Service (NI Order 2006 Part 3) and the Fire Safety Regulations (NI) 2010. As the PHA does not own the premises it occupies, Fire Risk Assessments are therefore undertaken by the relevant landlord or host organisation, as the Responsible Person under the Fire Safety Regulations (Northern Ireland) 2010. The PHA

seeks assurance that suitable and sufficient Fire Risk Assessments are in place and ensures that appropriate local fire safety arrangements, training and evacuation procedures are implemented for PHA staff. During 2025/26 a Fire Inspection was carried out in Tower Hill, Armagh by the Southern HSC Trust. A report on findings is awaited.

Fire Evacuation Plans

All PHA premises are required to have an emergency fire evacuation plan in place. A Fire Evacuation Plan for Linum Chambers, Belfast is in place and this is available to staff on Connect (intranet site).

Similar plans are in place across HSCNI premises which provide PHA staff with the necessary information for emergency evacuation from its offices at 12/22 Linenhall Street, Belfast; Gransha Park House, Clooney Road, L'Derry, and Tower Hill, Armagh. (The SPPG offices at County Hall, Ballymena are owned by the Department of Finance (DOF) and they manage the provision of all facilities related matters). Information for PHA staff in Ballymena is also available on Connect.

Fire Incidents

There were no fire incidents during the period 1 April 2025 to 31 March 2026.

Unwanted Fire Signals

An Unwanted Fire Signal (UFS) is defined as a signal transmitted by an automatic fire alarm system reporting a fire where upon arrival of the fire service it is found that a fire has not occurred; in other words, a false alarm. It is incumbent upon the organisation to ensure that these are kept to a minimum and preferably eliminated.

During the year under review there were no unwanted fire signals.

Nominated Officer (Fire) and Deputy Nominated Officers (Fire) / Fire Wardens

The PHA takes seriously its duties in respect of Fire Safety. In the buildings managed by PHA, Nominated/Deputy Nominated Officers (Fire) /Fire Wardens have been appointed and receive appropriate training. Refresher training took place in April 2026. In addition to this,

a basis fire awareness training session was held in Linum Chambers on 24 June 2025.

PHA staff located in HSCNI premises who undertake Deputy Nominated Officer (Fire) and Fire Warden duties receive appropriate training, which is organised through local site arrangements.

Incidents and Near Misses

The PHA recognises the need to keep workplace injuries and serious adverse incidents to a minimum. This requires a proactive safety culture and one where we also record and report all incidents/near misses that occur, in order to learn from our mistakes, help prevent future accidents where possible and help keep the workplace safe and secure for all staff and visitors.

An important part of the management of incidents/near misses is the 'sign-off' stage. This affords the opportunity to consider whether or not the incident has been thoroughly investigated, and whether the remedial action identified is considered appropriate and sufficient. It also affords the opportunity for monitoring trends and disseminating any learning throughout the PHA.

An enhanced 'sign-off' process for Incidents/Near Misses has been adopted. On an as and when basis a meeting is convened to include the Assistant Director of Finance and Corporate Services, the Assistant Director of Planning and Performance and the Head of Governance. Each incident/near miss is reviewed to consider if the investigation undertaken is deemed appropriate and sufficient so that the incident can be "signed-off" and closed. This review also affords the opportunity to consider whether any trends are emerging and also if any local or regional learning can be derived from the incident. If so, appropriate sharing will be arranged.

During the year 2025/26 there were three incidents reported which involved PHA staff:

- One relating to a false alarm, when PSNI arrived at Linum Chambers to speak to a PHA member of staff. The matter had been a misunderstanding.
- One relating to a burn from a geyser in Linum Chambers
- One relating to a leak from a sink in the kitchen in Linum Chambers

RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR (NI) 1997)

No reporting of any incidents to the Health and Safety Executive NI under RIDDOR was required during 2025/26.

Training

Fire Safety Training

PHA staff are required to complete mandatory fire safety training through the HSCNI e-learning platform. Staff with additional fire safety responsibilities, such as Fire Wardens, receive more specialised training, which includes a combination of online and practical elements delivered through local site arrangements.

The mandatory Fire Safety Awareness Training is to be undertaken on an annual basis. During 2025/26 a total of 346 PHA staff (78%) were up-to-date with this training.

Health and Safety Training

The mandatory Health and Safety Awareness e-learning training is available to all staff via LearnHSCNI and is to be undertaken every two years. During 2025/26 a total of 372 PHA staff (84%) were up-to-date with this this training.

Similarly, mandatory Manual Handling Awareness training is available on LearnHSCNI and is to be undertaken every two years. During 2025/26 a total of 352 PHA staff (80%) were up-to-date with this training.

From 2026-27 onwards, Assistant Directors will be provided with a report on compliance with all mandatory training for the staff under their management. It is hope that this will result in increased uptake of mandatory training, including those noted above.

Security Report

Security Provision

In shared HSCNI offices, security (where provided) is through local site management and facilities arrangements. In Linum Chambers, security is provided by Bedford Street Developments Limited (BSDL), as Landlord for the Invest NI building. County Hall, Ballymena is under the management of the Department of Infrastructure, and they provide security for all public bodies located in that building. Linenhall Street, Belfast has security in place from 7-9am; from 9am-5pm there is reception cover in place and security resumes from 5pm to 7.30pm. Security in Gransha Park House, L/Derry (a Western HSC Trust owned facility) ceased on 31 March 2026. A fob access system was removed by the Trust and staff have now been given keys for their offices - office doors were replaced with new ones. In Tower Hill, Armagh (a Southern HSC Trust owned facility) there is no security – the main access door requires fob access and all staff have been provided with a fob. There is reception cover and porters are on site.

Security Incidents

There were no security incidents relating to theft, vandalism, intrusions, assaults or threats to report during the year. There were no issues reported in relation to asset or data security which might impact health and safety of staff or the public during 2025/6.

Conclusion and Way Ahead for 2026/27

Over the past year continued progress has been made in strengthening and embedding systems and processes to effectively manage health and safety, security and fire safety throughout the PHA.

During 2025/26 mandatory training for Health & Safety and Fire Safety have continued to be monitored to ensure compliance. As at 31 March 2026, compliance with Health and Safety training was 84%, while Fire Safety training compliance was 78%, with Manual Handling at 80% compliance. Further work is required to improve compliance levels, particularly in relation to fire safety training.

As noted above, from 2026-27 onwards, Assistant Directors will be provided with a quarterly report on compliance with all mandatory training for the staff under their management to allow them to follow up with staff for whom compliance in any of the mandatory programmes is yet to be achieved.

All policies will be kept under review and risk assessments will be reviewed to ensure they are up-to-date and relevant to each facility.

Key performance indicators for health and safety, security and fire safety will continue to be reviewed and monitored by the Health & Safety Committee during 2026/27.

A request to ensure that all Incident Near Misses occurring in SPPG buildings relating to PHA staff is reported to PHA has been raised with SPPG to ensure that there is full oversight by PHA.

In conclusion, management are satisfied that there is an adequate system of control in place to ensure that the Agency complies with Health and safety and Fire Safety responsibilities. Based on the information available at the time of the report there are no significant areas of concern at this time.

item 16

PHA Board Meeting

Title of Meeting	PHA Board Meeting
Date	27 August 2026
Title of paper	Infectious Diseases in Pregnancy Screening Programme (IDPS) Annual Report: April 2021 to March 2022
Reference	PHA/11/08/26
Prepared by	Dr Tracy Owen
Lead Director	Dr Joanne McClean

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

1 Purpose

The purpose of this paper is to bring the Annual Report for the Northern Ireland Infectious Diseases in Pregnancy Screening (IDPS) Programme for 2021/22 to the PHA Board for noting.

2 Key Issues

This Report provides an overview of performance in relation to the UK national standards. The IDPS programme in Northern Ireland offers screening for: Human immunodeficiency virus (HIV); hepatitis B; syphilis; and rubella susceptibility. Performance data in relation to the screening offer, uptake and actions taken on receipt of positive/rubella susceptible results from 1st April 2021 to 31st March 2022 are outlined.

During this period the programme has:

Exceeded achievable (highest) performance levels for the following national standards:

- Standards 1-3: Identifying population and coverage for HIV, hepatitis B and syphilis (99.98%).
- Standard 4: Test turnaround time (TTT) for all samples testing both positive and negative (100.00%).

- Standard 5**:** Timely assessment of women confirmed as screen positive for HIV and hepatitis B within 10 working days of result receipt (100.00%).

Achieved and acceptable level performance for the following national standards:

- Standard 6: Diagnosis/intervention - Timely assessment of women with either with a new diagnosis of Hepatitis B or already known with high infectivity markers, within 6 weeks of positive result receipt by hepatology (82.24%).

Did not achieve the acceptable performance level for the following National standards:

- Standard 5: Timely assessment of women confirmed as screen positive for syphilis (94.44%). Acceptable level 95%

- Standard 7: Intervention/treatment - Timely neonatal hepatitis B vaccination and immunoglobulin of babies born to women screened positive for hepatitis B during 2021/22 (96%). Acceptable level 97%.

This report provides evidence of a high level of programme performance against most of the UK national standards, whilst highlighting some areas for improvement. The NI IDPS Programme achieved higher performance levels than England for all standards, apart from standard 7 - the timely vaccinations of babies born to hepatitis B positive mothers. This was because of the small numbers involved and the fact that a small number (n<5) of babies were born deceased and therefore ineligible for the vaccine, but still included in the performance figure.

Areas for improvement include:

- the review, within ten days, of women screened positive for syphilis infection.
- the review by hepatology, within six weeks, of women screened positive for hepatitis B infection.
- the uptake of postnatal MMR vaccination, for women screened susceptible to rubella.

It should be recognised that sometimes patient related factors, that affect performance against standards, are unavoidable e.g. women leaving the country.

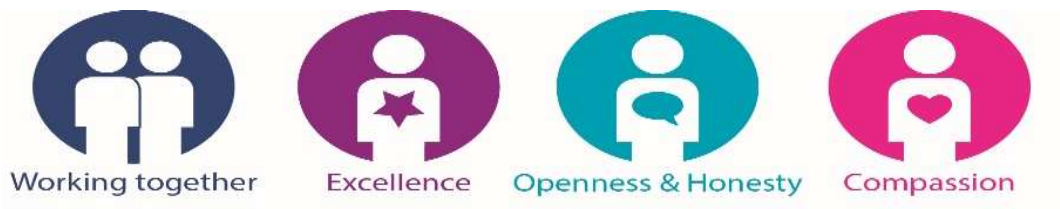
3 Next Steps

The PHA will continue to monitor the quarterly returns for women who do not meet the national standard for review and work with Trusts to take appropriate actions.

HSC Public Health Agency

Infectious Diseases in pregnancy screening programme (IDPS) annual report.

April 2021 to March 2022



Document Title	Northern Ireland Infectious Diseases in Pregnancy Screening Programme Performance Report April 2021-March 2022
Author	**Lorna Hawe** - Regional Antenatal Infection Screening Programme Co-ordinator, Public Health Agency (PHA)
Owners	Northern Ireland Infectious Diseases in Pregnancy Screening Programme
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Approved by	Senior Management Team PHA (SMT) on [DN: Insert date]

Contents

1.0 Executive summary

The Infectious Diseases in Pregnancy Screening (IDPS) Programme in Northern Ireland offers screening to all eligible pregnant women for human immunodeficiency virus (HIV), hepatitis B and syphilis infections and for susceptibility to rubella infection. The screening blood tests are routinely offered at the booking appointment, ideally by 10 weeks[1] gestation, or at the earliest opportunity thereafter when a woman presents to maternity services.

This annual report provides an overview of the performance of the Northern Ireland IDPS programme in relation to the seven national standards between 1st April 2021 to 31st March 2022 [2]. The Northern Ireland IDSP Programme met the achievable (highest) level of performance for four of these standards (standards 1-4); two (out of three) parts of standard 5 and one (out of two) parts of standard 7. It achieved the acceptable level in standard 6 and failed to achieve the acceptable level in one part of standard 5 and one part of standard 7.

It should be noted that small numbers affect the performance percentages dramatically and also that there are valid reasons for not achieving some of the standards such as babies being stillborn and not eligible for the hepatitis B vaccine.

In summary: -

- Coverage for the IDPS programme remains very high (99.98%), with only a small number of women declining screening.
- 100% of the screening samples were turned around within 8 working days.
- 100% of women who screened positive for HIV or hepatitis B were reviewed within the ten-day standard.
- 82.24% of women with hepatitis, who were newly diagnosed or known cases with high infectivity markers, were seen within six weeks of the result notification.
- All eligible babies born to women with hepatitis received their hepatitis B vaccine and hepatitis B immunoglobulin within 24 hours of birth.

Areas for improvement include:

- Review, within ten days, of women screened positive for syphilis infection.
- Review by hepatology, within six weeks, of women screened positive for hepatitis B infection.
- Uptake of postnatal MMR vaccination, for women identified as susceptible to rubella.

There were no cases of mother to child transmission of the infections screened for during 2021/2022 in Northern Ireland.

The programme is commissioned and quality assured by the Public Health Agency (PHA). Monitoring against nationally agreed standards for screening is an important element of quality assurance for the IDPS programme and allows those involved in its organisation and delivery to identify potential areas for improvement.

2.0 Background

The objective of IDPS is to enable the identification of HIV, hepatitis B and syphilis infection in early pregnancy, thus allowing early intervention. Pathways are in place for women with positive screening results to be referred to specialist services for review and treatment if necessary, thus improving the health of the mother and reducing the risk of mother to child transmission (MTCT) of HIV, hepatitis B and syphilis.
Pregnant women who are identified as susceptible to rubella, with no documented evidence of two previous measles, mumps, and rubella (MMR) vaccinations, are offered an MMR vaccination postnatally, prior to discharge from hospital, to help prevent rubella infection in future pregnancies. They are also offered a second MMR, if necessary, by the GP at least 4 weeks later, depending on their previous vaccination history, which their GP should have access to.

There are various failsafe systems in place to ensure all pregnant women are offered IDPS screening and that every woman screened has a result reported. The weekly failsafe report, sent to the antenatal screening coordinators (ANSC) in each trust, lists women who have missing blood results 14 days after her booking date. In addition, the daily mismatch report will pick up results which cannot cross the electronic interface between the Northern Ireland Blood Transfusion Service (NIBTS) laboratory IT system and the Northern Ireland Maternity IT System (NIMATS), due to a mismatch of details e.g. name changes.
More information on the IDPS Programme is available at:
https://www.nidirect.gov.uk/articles/antenatal-infectious-disease-screening

3.0 Performance against standards.

Performance of the Northern Ireland IDPS Programme between 1st April 2021 and 31st March 2022 against the national standards is summarised below. Due to small numbers of women screening positive for infection in some Trusts, the figures are only reported for the whole of Northern Ireland.

In 2021/2022 there were seven national standards against which the performance of the IDPS Programme was monitored. Each standard has two performance thresholds: an acceptable level and an achievable level.

The acceptable threshold is the lowest level of performance which screening services are expected to attain. All screening services should aim to exceed the acceptable threshold and agree service improvement plans to meet the achievable threshold. Screening services not meeting the acceptable threshold are expected to put in place recovery plans to deliver rapid and sustained improvement.

The achievable threshold represents the level at which the screening service is likely to be running optimally. All screening services should aspire to attain and maintain performance at or above this level.[3]

3.1 Standards 1-3: Coverage for HIV, hepatitis B, syphilis and rubella

These standards measure the number of eligible, pregnant women offered and accepting screening for HIV, hepatitis B and syphilis who have a confirmed result within the reporting period.

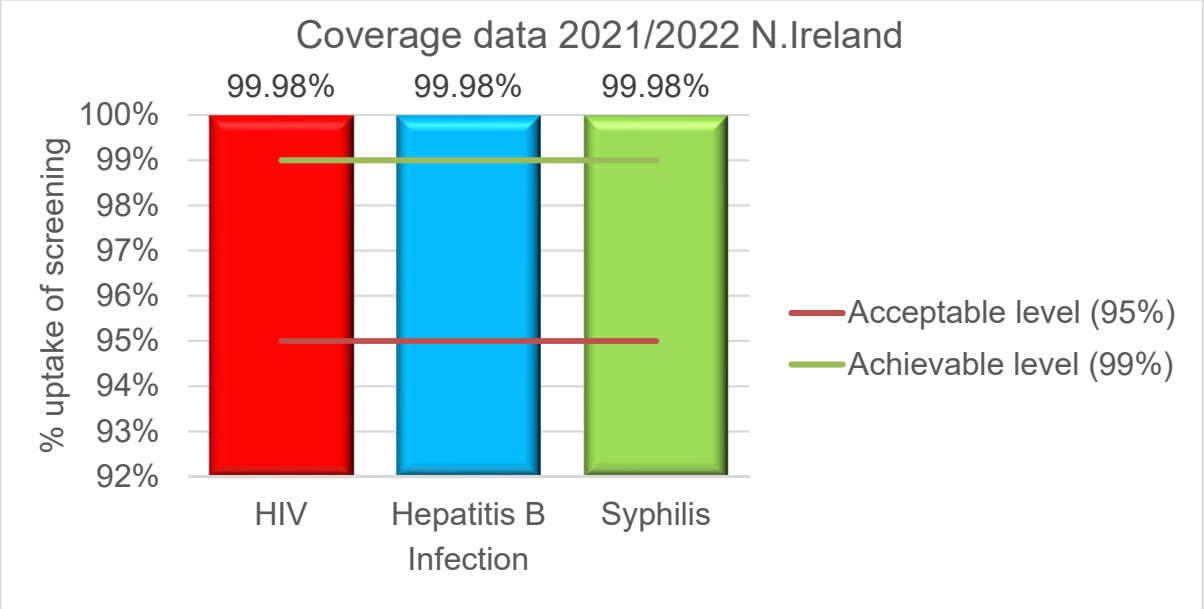
(Acceptable level: ≥ 95.0%, Achievable level: ≥ 99.0%)

- 21,309/ 21,314 (99.98%) of pregnant woman accepted IDPS screening for HIV, hepatitis B and syphilis.

  Achievable level exceeded.

Figure 1 below, show that the Northern Ireland programme has performed above the achievable level for this standard, with only a small number of women declining screening.

Figure 1: Programme coverage 2021/2022



3.2 Standard 4: Test turnaround time (TTT) for HIV, hepatitis B and syphilis.

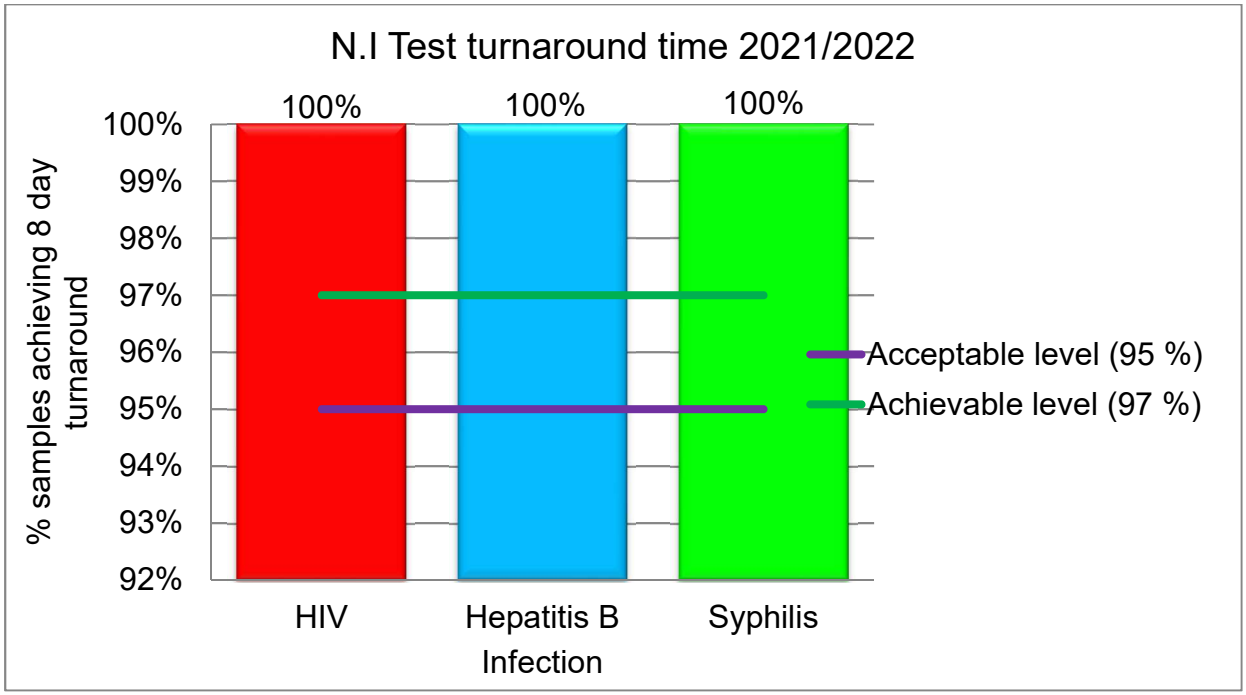
This standard measures the number of results for each infection (confirmed screen positive or negative) reported to maternity services within 8 working days of sample receipt in the laboratory.

(Acceptable level: ≥ 95.0%, Achievable level: ≥ 97.0%)

- 100.0 **%** of all results, both positive and negative, were turned around within eight working days of sample receipt. (Figure 2 below).

  Achievable level exceeded.

Figure 2: Test turnaround time of IDPS samples.



3.3 Standard 5: Referral and timely assessment of screen positive and known positive women (HIV, hepatitis B and, syphilis)

This standard measures the number of women with confirmed screen positive results for HIV, hepatitis B or syphilis who attended for a screening assessment appointment, by an antenatal screening coordinator, within 10 working days of receipt of the result by maternity services.

(Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)

- 100.0% of women screened positive for HIV were seen within 10 working days of receipt of result

  Achievable level exceeded.

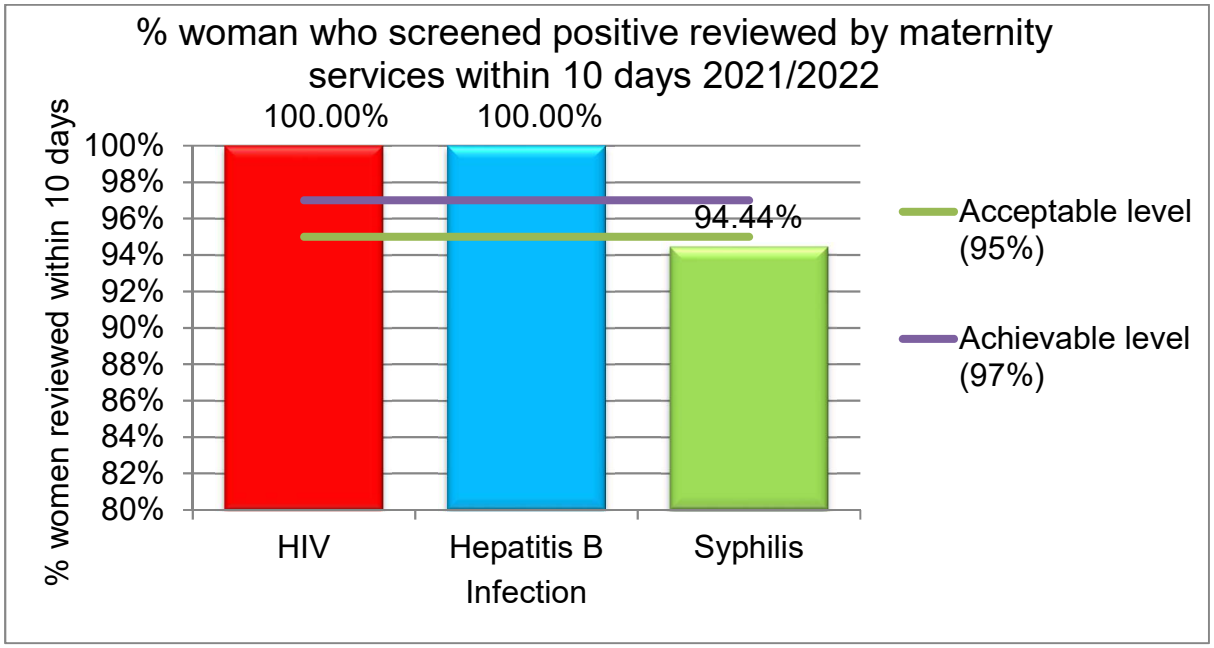
- 100.0% of women screened positive for hepatitis B were seen within 10 working days of receipt of result.

  Achievable level exceeded.

- 94.4% of women screened positive for syphilis were seen within 10 working days of receipt of result (It should be noted that there were very small numbers involved).

  Acceptable level not met. (Figure 3 below)

Figure 3: Review of women with a positive infection screen within 10 working days



3.4 Standard 6: Diagnosis/ intervention - timely assessment by hepatology service of women with hepatitis B.

This standard measures the number of pregnant women who are confirmed as screen positive for hepatitis B, attending for specialist assessment by a hepatologist within six weeks of the positive result being reported to the maternity service including:

- all women who are newly diagnosed as hepatitis B positive.
- women already known to be hepatitis B positive with high infectivity markers detected in the current pregnancy.

(Acceptable level: ≥70.0%, Achievable level: ≥ 90.0%)

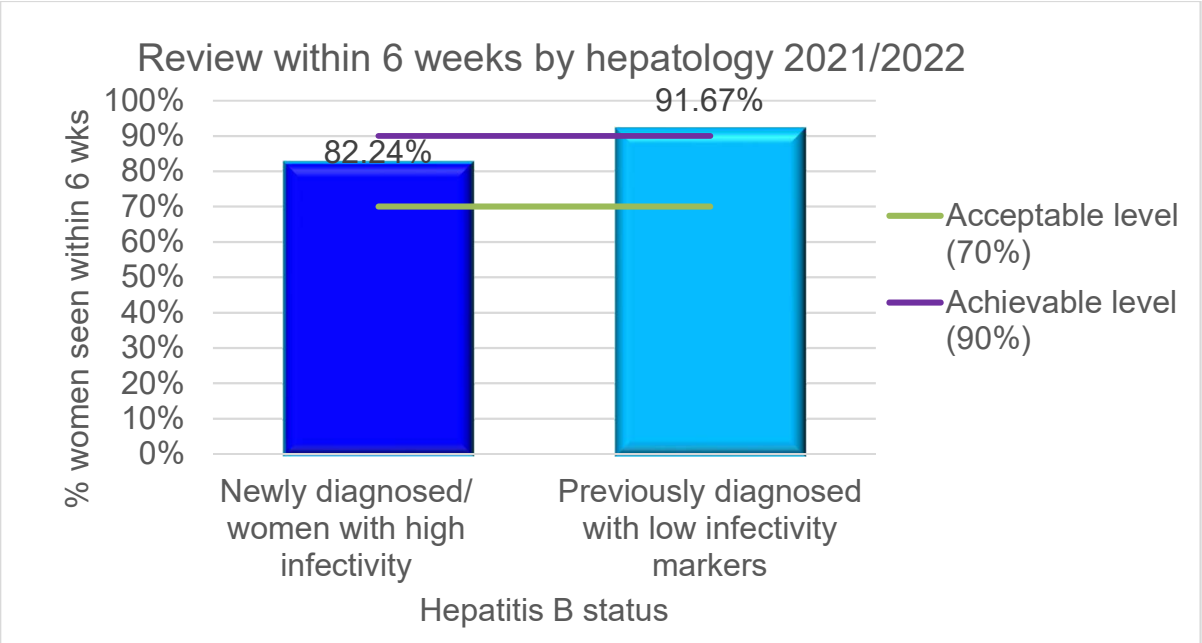
- 88.2% of women, either with a new diagnosis of hepatitis B, or already known to have hepatitis B with high infectivity markers, were seen within 6 weeks of the receipt of the positive result.

Acceptable level exceeded. (Figure 4)

Although not part of the national standards, data for previously diagnosed women with hepatitis B who have low infectivity markers are also monitored.

- 91.7% of women testing positive for hepatitis B, previously diagnosed and with low infectivity markers, were seen within 6 weeks of the receipt of the positive result. (Figure 4)

Figure 4: Diagnosis/ Intervention - specialist review by hepatology within 6 weeks for women with hepatitis.



3.5 Standard 7: Intervention / treatment - timely neonatal hepatitis B vaccination and immunoglobulin.[1]

This standard measures the proportion of babies born in the reporting period, to women with hepatitis B, receiving their first hepatitis B vaccination within 24 hours of birth and the proportion of babies receiving hepatitis B immunoglobulin (HBIG) within 24 hours (if they require it).

(Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)

- 96.0% of babies born to women with hepatitis received the hepatitis B vaccine within 24 hours of birth.

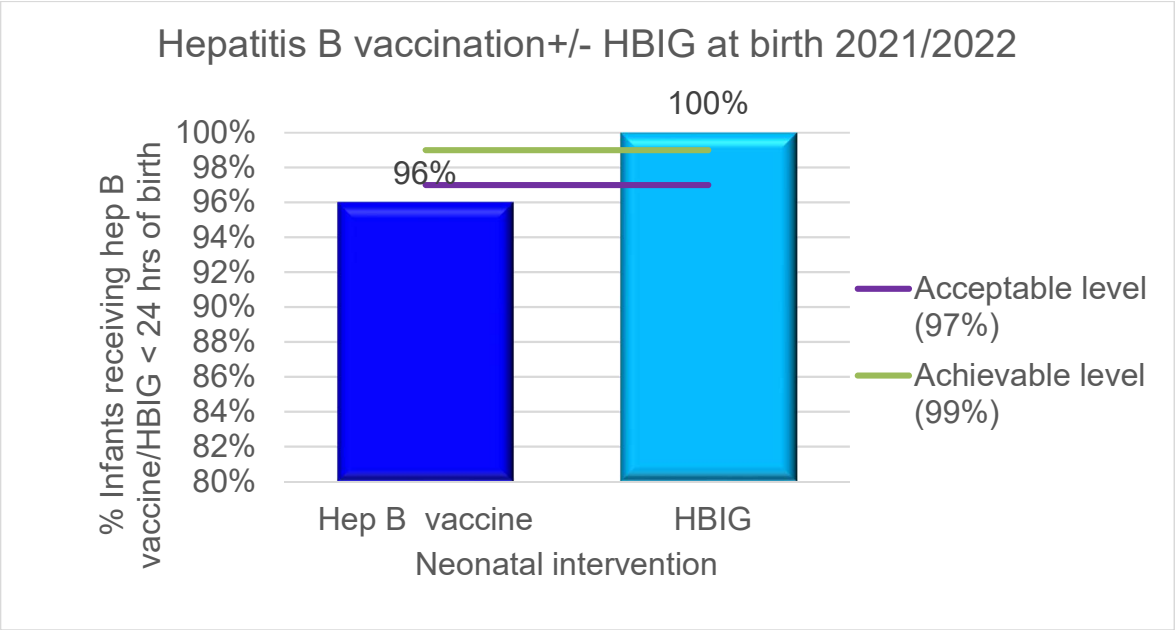
  Acceptable level not met. This was because a small number (n<5) of babies were born deceased and were therefore ineligible for the vaccine. However, they are still included in the denominator for calculating performance. (Figure 5)

- 100.0% of babies born to women with hepatitis B and requiring HBIG had the HBIG within 24 hours of birth.

  Achievable level exceeded. (Figure 5)

[1] In addition to routine childhood immunization with hepatitis B vaccine at 2, 3 and 4 months of age, babies on the selective hepatitis B pathway receive additional hepatitis B vaccination as soon as possible after birth (within 24 hours), at 1 month and 1 year old.

Figure 5: Neonatal hepatitis B vaccination/HBIG administration within 24 hours.



3.6 Rubella susceptibility screening and the offer of the MMR vaccination to all women screened susceptible to rubella following delivery.

Although there are no national standards relating to rubella screening, performance is monitored by the IDPS Programme in Northern Ireland.

- **21,309/ 21,314 (99.98%) of pregnant woman accepted IDPS screening for rubella susceptibility.**
- Of all women screened, 22.96% tested susceptible to rubella at antenatal booking in 2021/2022.
- 22.8% of all women delivered in 2021/2022 were rubella susceptible.
- 54.51% of rubella susceptible women were: given the MMR vaccination following delivery and prior to discharge; provided evidence of a previous full MMR vaccination history, or had a contraindication to MMR.

4.0 Programme developments

The key developments within the IDPS Programme during 2021/2022 include:

- September 2021 - the MMR codes for postnatal vaccination administration were revised on NIMATS to improve data capture and women were actively encouraged to provide evidence of previous MMR vaccinations.
- November 2021 - the first stakeholders meeting was held, bringing together all those professionals involved in the screening pathway. The remit of this

group is to ensure a safe, quality assured programme is provided for all women and that national performance standards are met and maintained.

- November 2021 a pilot was undertaken in the Northern HSC Trust to encourage women, who screened susceptible to rubella, to provide evidence of previous MMR vaccinations in order to reduce unnecessary postnatal MMR vaccinations.

- January 2022 - work commenced on the development of regional guidelines for hepatitis B screening and the selective neonatal immunisation pathway[2][3]

- January 2022 - A new version of the "late booker form" was commissioned and distributed for use across trusts. The form now has a sample bag attached in line with the other screening blood forms. The purpose of the bespoke form is to draw attention to the sample as it enters the Regional Virology laboratory (RVL), so that staff know to expedite the testing of the sample.

5.0 Condition specific performance data

5.1 HIV

Table 1: HIV data

Measure	Value
Number of confirmed HIV positive results *	9
Screen positive women attending for screening assessment within ten working days (Acceptable level: ≥ 97.0%, Achievable level: ≥ 99%)	9/9 (100%)
Prevalence of HIV per 1,000 women screened	0.42

* NB: Some were new diagnoses and some women were already known to have HIV.

5.2 Hepatitis B

Table 2: Hepatitis B data

Measure	Value
Number of positive results (Figure 7)	29

[2] In addition to routine childhood immunization with hepatitis B vaccine at 2, 3 and 4 months of age, babies on the selective hepatitis B pathway receive additional hepatitis B vaccination as soon as possible after birth (within 24 hours), at 1 month and 1 year old.

Newly diagnosed women or women with high infectivity markers (Figure 7)	17
Known positive women with low infectivity markers (Figure 7)	12
Screen positive women attending for screening assessment within ten working days (Figure 7) (Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)	29 (100.0%)
Women with hepatitis B (new positive or high infectivity) seen for specialist assessment within six weeks (Figure 8) (Acceptable level: ≥70.0%, Achievable level: ≥ 90.0%)	15/17 (88.2%)
Known positive women with low infectivity markers seen for specialist assessment within six weeks (Figure 8)	11/12 (91.7%)
Babies born to hepatitis B positive women receiving first dose vaccination within 24 hours (Figure 9) (Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)	96.0% (< 5 babies deceased at birth)
Babies born to hepatitis B positive women receiving immunoglobulin (if required) within 24 hours (figure 9) (Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)	100%
Prevalence of hepatitis B per 1,000 women screened.	1.36

Reasons given for non-attendance with a hepatologist within six weeks were a combination of system related factors such as appointments not being made within the 6-weeks' timeframe and patient related factors, such as women leaving the country and not returning within the 6-weeks' time frame or women cancelling their appointment.

Figure 7 - Hepatitis B data

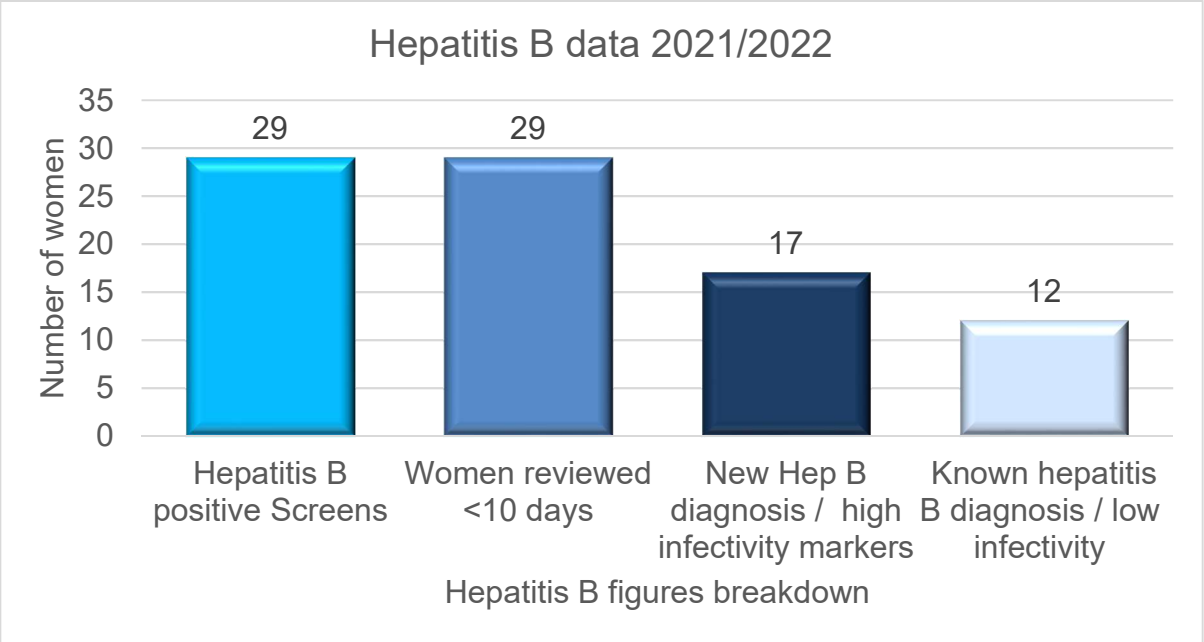


Figure 8 - Diagnosis / Intervention

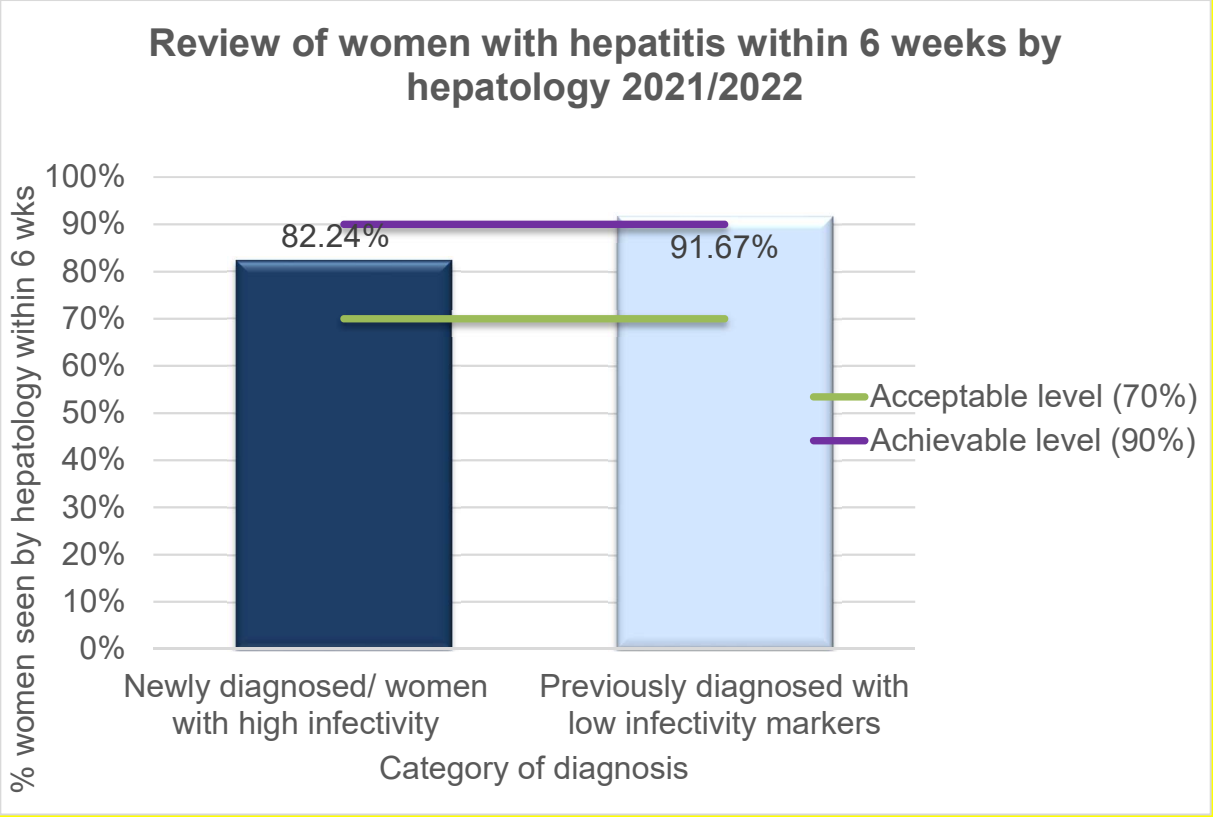
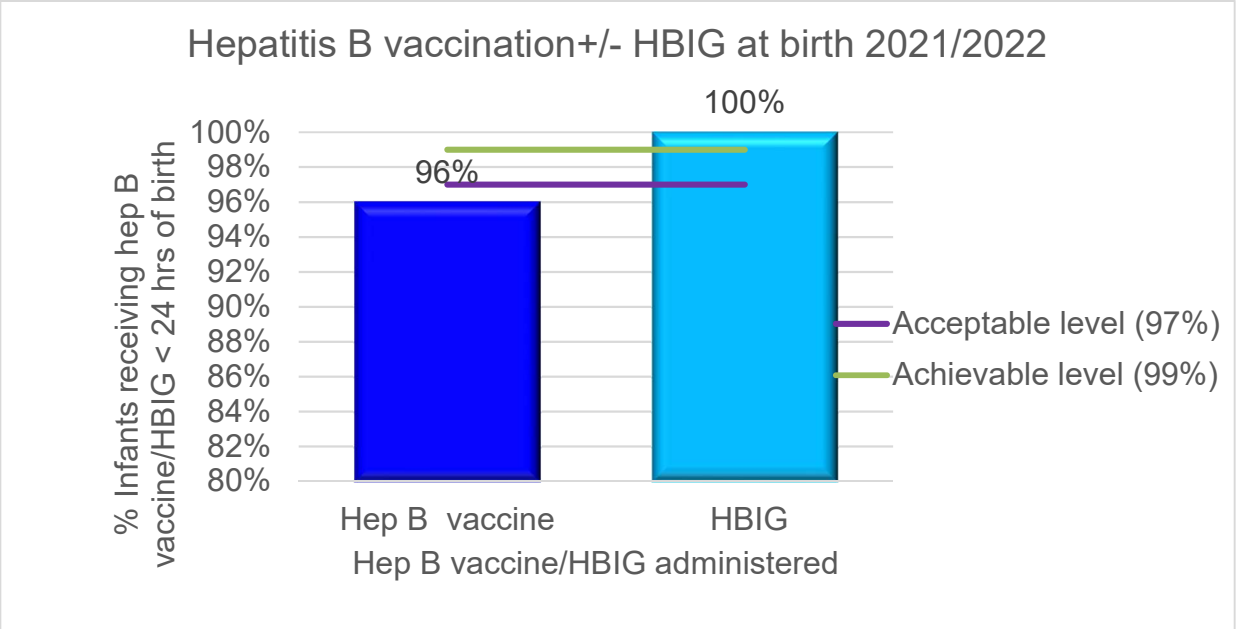


Figure 9 - Intervention / treatment of the neonate



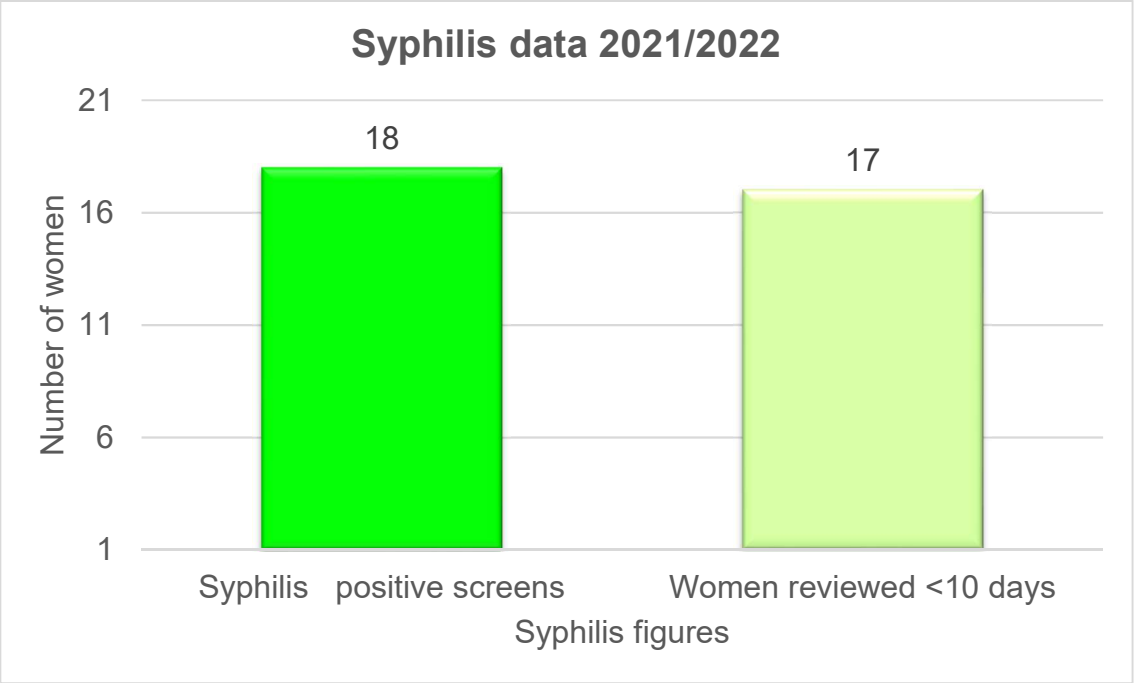
Although the achievable threshold was not achieved for vaccination of the babies at birth, the data relate to a very small number and the reasons for not meeting the threshold were identified (see table 2 above).

5.3 Syphilis

Table 3: - Syphilis data

Measure	Value
Coverage (Acceptable level: ≥ 95.0%, Achievable level: ≥ 99.0%) 5 women declined screening due to woman's choice or reasons unknown.	21,309 / 21,314 (99.98%)
Results reported within eight working days (Acceptable level: ≥ 95.0%, Achievable level: ≥ 97.0%)	100%
Number of positive results (Figure 10)	18
Screen positive women attending for screening assessment within ten working days (Figure 10) (Acceptable level: ≥ 97.0%, Achievable level: ≥ 99.0%)	17/18 (94%)
Prevalence of syphilis per 1,000 women tested	0.85

Figure 10: Syphilis data



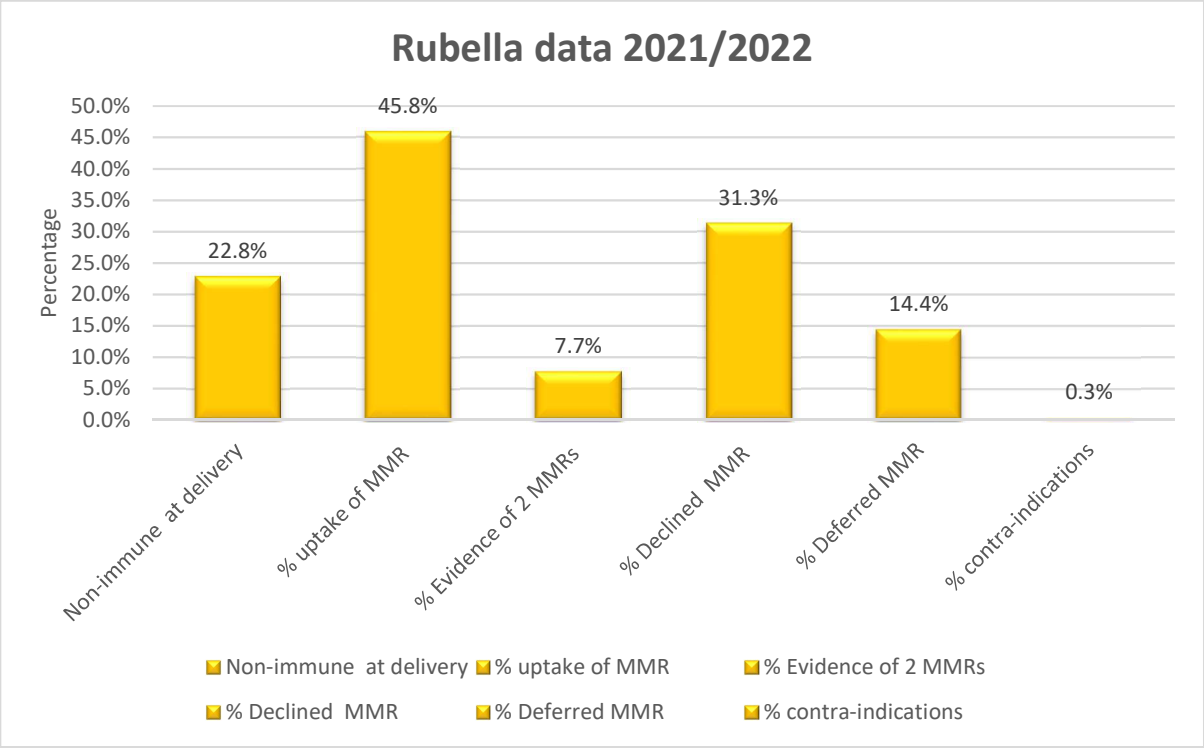
5.4 Rubella

Table 4: Rubella data

Measure	Value
Coverage (Acceptable level: ≥ 95.0%, Achievable level: ≥ 99.0%) 5 women declined screening due to woman's choice or reason unknown.	21,309 / 21,314 (99.98%)
Results reported within eight working days	100.0%
Number of women who booked and screened susceptible to rubella in 2021/2022	4,892 (23.0%)
Number of women delivering in 2021/2022 who had screened susceptible to rubella at booking (figure 11)	4,919/ 21,570 (22.8%)
Number of rubella susceptible women who accepted and were given the MMR vaccine post-delivery and prior to discharge from hospital (figure 11)	2,255 (45.8%)

Rubella susceptible women who provided evidence of 2 MMR vaccinations previously (figure 11)	378 (7.7%)
Women with contraindications to the MMR vaccine (figure 11)	15 (0.3%)
Women who deferred their MMR vaccination (figure 11)	707 (14.37%)
Women who declined the MMR vaccine (figure 11)	1,542 (31.35%)
Prevalence on rubella susceptible women per 1,000 women screened.	229.57

Figure 11: Rubella susceptibility and MMR vaccination data 2021/2022



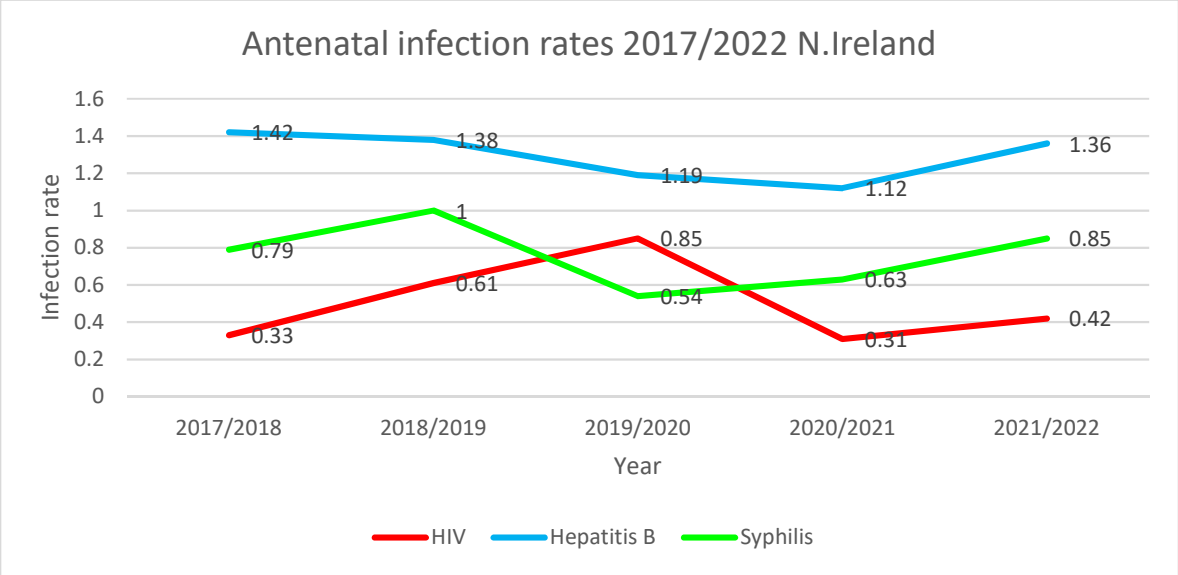
6.0 Trend data

6.1 Infection rates

56 women out of 21,309 screened positive for one of the three infections which equates to a rate of 2.63 per 1,000 women screened. Figure 12 below shows the

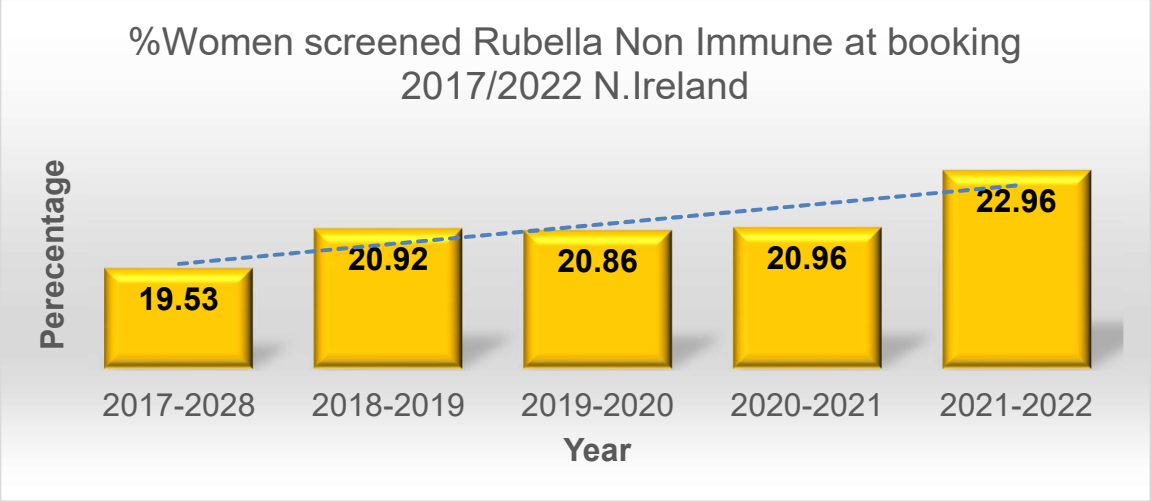
individual trend rates for each infection and the slight fluctuations in the rates over the last five years, with rates increasing slightly for all three infections in 2021/2022.

Figure 12: Antenatal infection rates, for HIV, hepatitis B and syphilis in Northern Ireland from, 2017/2022.



6.2 Rubella susceptibility rates

Figure 13 - Rubella susceptibility at booking trend data

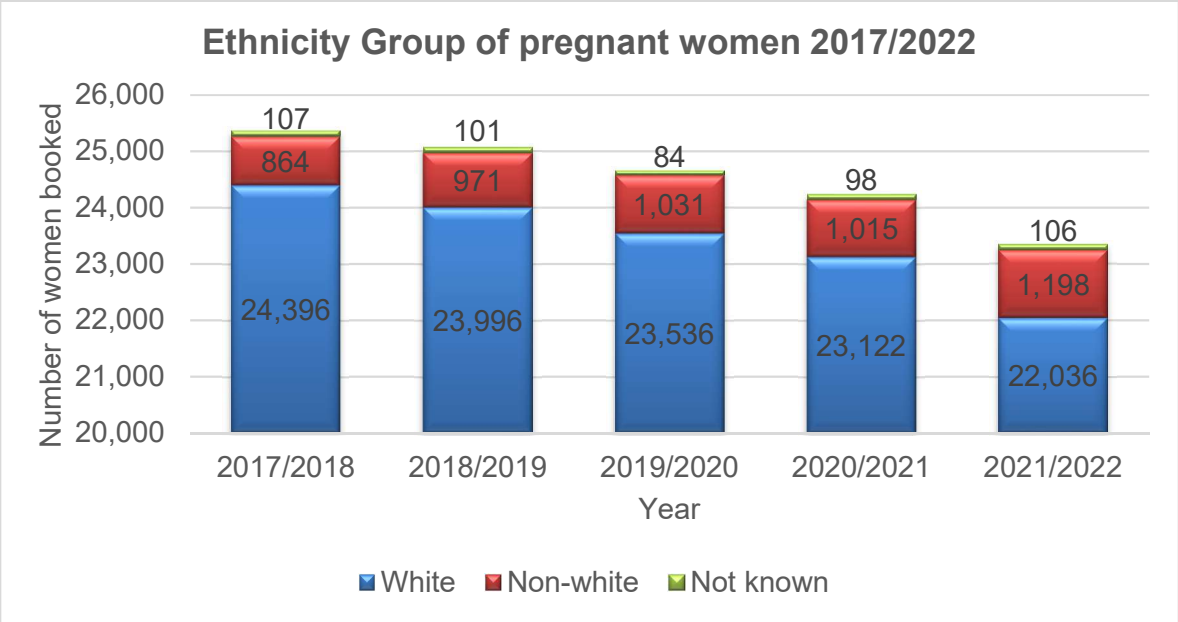


The number of women screened susceptible to rubella in the last 5 years has seen a very gradual increase. This may be due to an increase in the number of women moving into Northern Ireland who may not been vaccinated with MMR.

6.3 Ethnicity trends

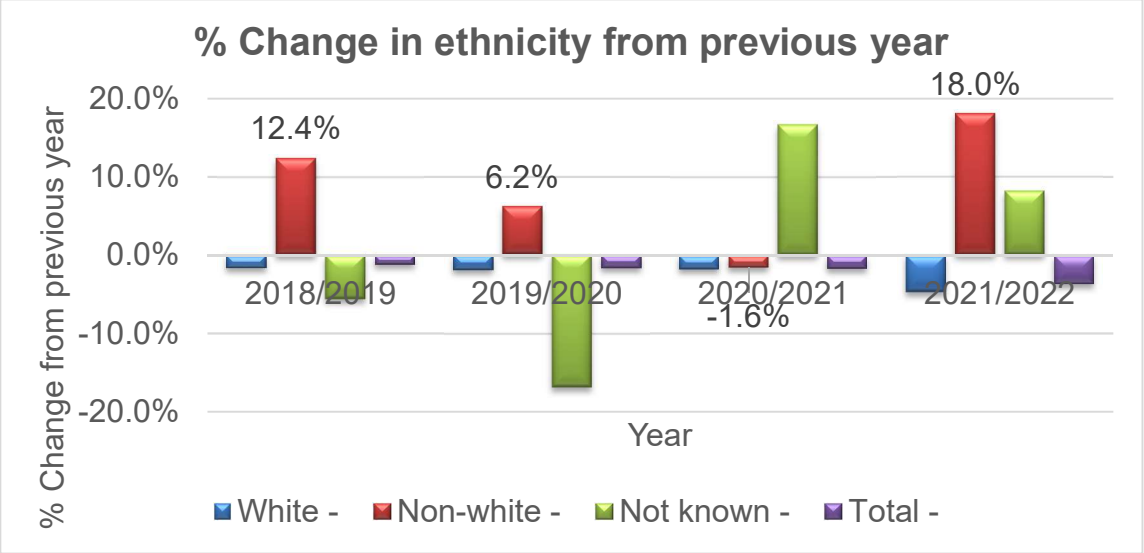
See below for details on ethnicity trends over the last five years.

Figure 14 - Ethnicity of women booking for maternity services



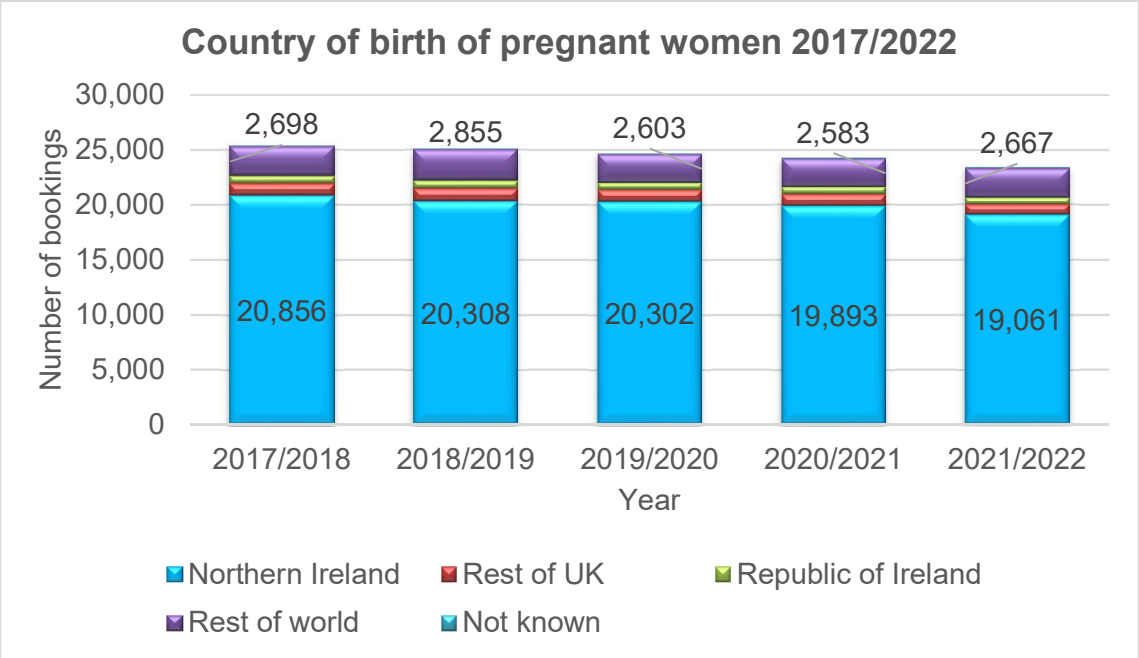
The above figure shows that whilst there is a steady decline in the overall numbers of women booking, there is an increase in the numbers of women whose ethnicity is recorded as non-white booking over the last five years.

Figure 15: Percentage change in ethnicity from previous year



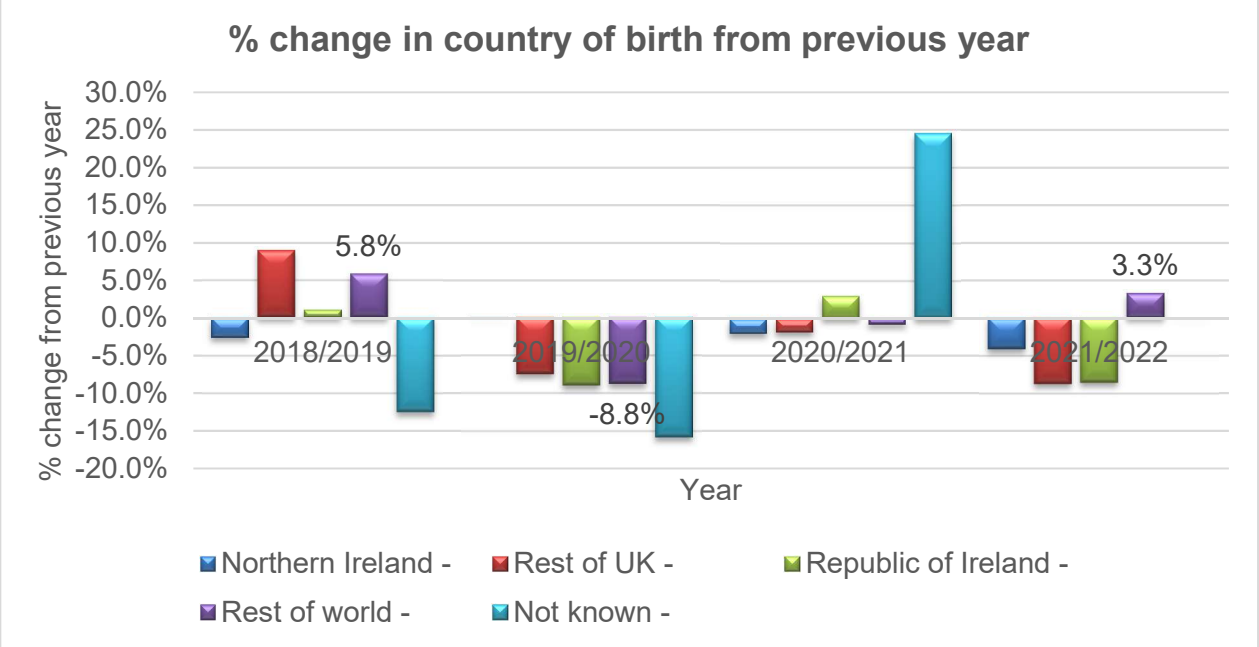
The above figure shows that the percentage of people with non-white ethnicity dropped from previous years during COVID, but then increased again in 2021/2022.

Figure 16 - Country of birth of women booking for maternity services



The above figure shows a slight drop in the number of women booking for maternity services who were born outside of the UK and Republic of Ireland during the pre-COVID and COVID years of 2019/2021 and then a subsequent rise in 2021/2022.

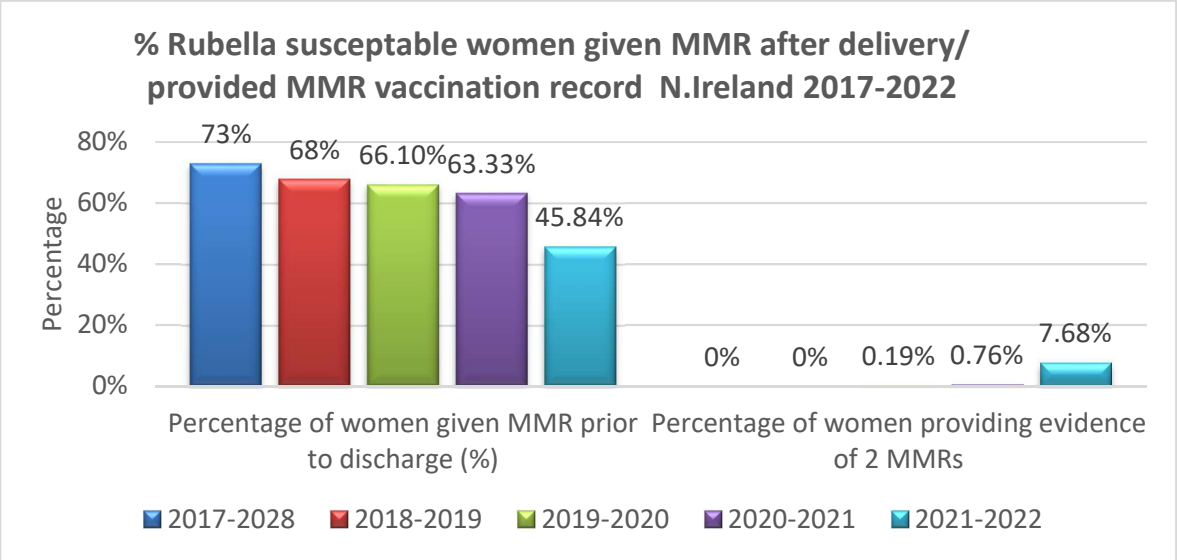
Figure 17: Percentage change in country of birth from previous year.



The above figure confirms that there was a drop in the percentage of women born outside of the UK and Republic of Ireland, booking for maternity services in Northern Ireland from 2019/2021, followed by a rise in 2021/2022.

6.4 MMR vaccination following delivery trends

Figure 18: - MMR vaccination following delivery trend data

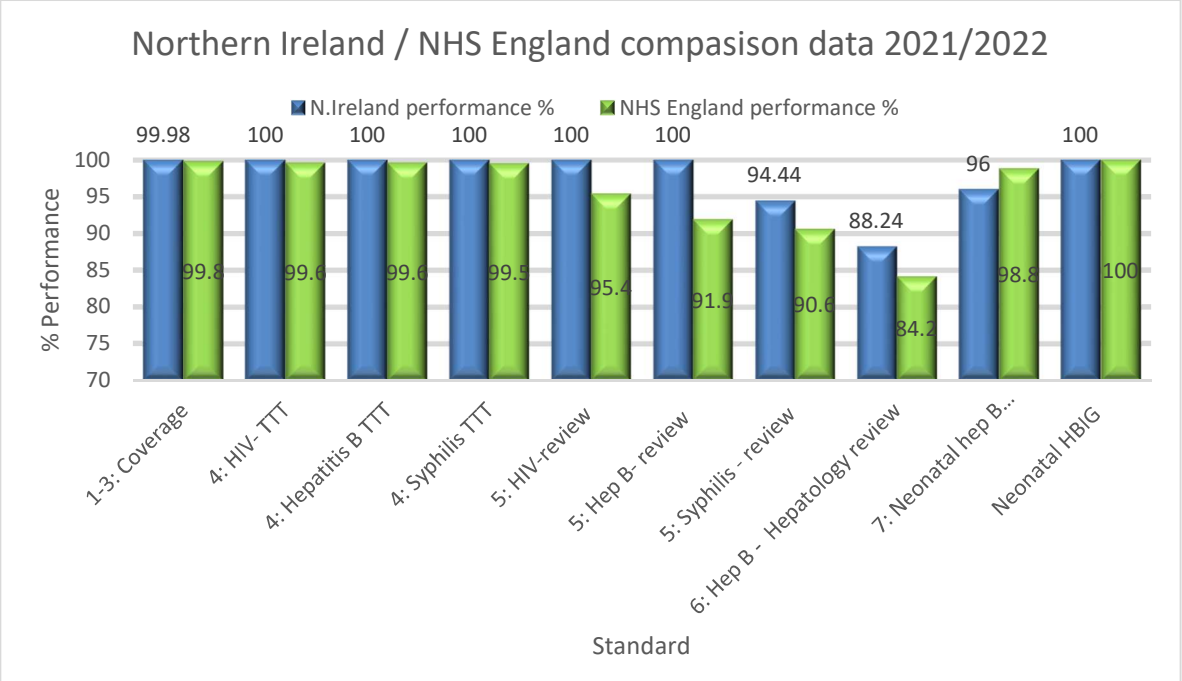


During the five-year period between 2017-2022, there has been a steady decline in the number of women accepting the MMR vaccination postnatally, with 2021/2020 seeing the biggest drop.

Performance compared to England[4]

Northern Ireland's performance against the national standards compares favourably against NHS England's performance. See Figure 19 below.

Figure 19: Performance against NHS England



6.0 Conclusion

This report provides evidence of a high level of programme performance against most of the UK national standards, whilst highlighting some areas for improvement. The NI IDPS Programme achieved higher performance levels than England for all standards, apart from standard 7 - the timely vaccinations of babies born to hepatitis B positive mothers. This was because of the small numbers involved and the fact that a small number (n<5) of babies were born deceased and therefore ineligible for the vaccine, but still included in the performance figure.

Areas for improvement include:

- the review, within ten days, of women screened positive for syphilis infection.
- the review by hepatology, within six weeks, of women screened positive for hepatitis B infection.
- the uptake of postnatal MMR vaccination, for women screened susceptible to rubella.

It should be recognised that sometimes patient related factors, that affect performance against standards, are unavoidable e.g. women leaving the country.

7.0 Next Steps

- The PHA to continue to monitor the quarterly returns for women who do not meet the national standard for review and work with Trusts to take appropriate actions.

- The antenatal screening coordinators (ANSCs) should continue close liaison with women screened positive for hepatitis, and the hepatology service, to ensure women are reminded, and encouraged, to attend their hepatology appointment and that the appointment is made within the six weeks standard.

- Midwives should continue to encourage women to provide evidence of the previous MMR vaccinations.

8.0 References

[1] NICE draft guidance on antenatal care 19th August 2021 Recommendations | Antenatal care | Guidance | NICE

[2] Gov.uk NHS England guidance. Infectious diseases in pregnancy screening standards valid for data collected from 1 April 2018 Infectious diseases in pregnancy screening standards valid for data collected from 1 April 2018 - GOV.UK (www.gov.uk)

[3] Our approach to NHS population screening standards, Public Health England, 26 July 2019. Available at: https://www.gov.uk/government/publications/population-screening-our-approach-to-screening-standards/our-approach-to-nhs-population-screening-standards#performance-thresholds

[4] Gov.uk National statistics. 2021/22 Infectious diseases in pregnancy (IDPS) programme screening report - GOV.UK (www.gov.uk)

Appendix 1: - Glossary

ANSC	Antenatal Screening Coordinator. There is an ANSC appointed in each of the five trusts across Northern Ireland who is responsible for coordinating the care of women who screen positive for infection and their babies.
CHIS	Child Health Information Services are local active clinical care records of all the children in the area, ideally containing information about an individual child's public health interventions, particularly screening, immunisations and outcomes of the 0 to 5 healthy child programme.
HBeAg	The hepatitis B envelope antigen, or HBeAg, is a marker of an actively replicating hepatitis B virus infection. Those with a positive HBeAg have active replication in their liver cells i.e. more of the virus circulating in their blood and as a result they are more infectious, with a higher likelihood of transmitting HBV to others.
HBIG	Hepatitis B immunoglobulin (HBIG) is recommended as a post exposure prophylaxis for babies whose mothers are HBeAg positive and/or have a high hepatitis B viral load. It provides a temporarily induced immunity to hepatitis B infection.
HBV	Hepatitis B virus (HBV) is a viral infection carried in the blood causing inflammation of the liver and potentially long-term damage. The virus is transmitted by contact with an infected person's blood or body fluids. Hepatitis B is vaccine preventable. HBV can be transmitted from mother to child during pregnancy or birth.

HIV	Human immunodeficiency virus belongs to a group of viruses called retroviruses. It attacks the immune system leaving the infected person vulnerable to serious infections and cancers. HIV is present in blood, genital fluids and breast milk. One way of passing on the infection is from a mother to her baby during pregnancy, birth or through breast feeding.
IDPS	Infectious Diseases in Pregnancy Screening Programme - currently screens for HIV, hepatitis B, syphilis and rubella susceptibility in pregnant women in Northern Ireland. The aim is to significantly reduce mother to child transmission (vertical transmission) of HIV, hepatitis B and syphilis by early detection, intervention and treatment to safeguard the health of the baby and the woman's own health.
MMR	Measles, Mumps and Rubella vaccine. The MMR vaccine is a safe and effective combined vaccine. It protects against three serious illnesses: measles; mumps and rubella (German measles) These highly infectious conditions can easily spread between unvaccinated people. Rubella infection in early pregnancy can have serious implications for the baby.
MTCT	Mother to child transmission - also called perinatal or vertical transmission. This occurs when an infection is passed from a mother to her baby either during pregnancy birth; or through breastfeeding.
NIBTS	The Northern Ireland blood transfusion service (NIBTS) is located in Belfast and provides IDPS for women booked prior to 20 weeks gestation. Samples initially screened positive are sent to the Regional Virology Laboratory (RVL) for confirmation.
NIMATS	The Northern Ireland Maternity System is a web based electronic system used regionally to capture geographical and clinical data on pregnant women and their babies. This includes the offer, and acceptance of, infectious diseases in pregnancy screening tests and the test results. Its functionality is being replaced by Encompass as this new IT system is rolled out across Northern Ireland.
PHA	The Public Health Agency is a multi-disciplinary, multi-professional body. Its role is to protect and improve the health and social wellbeing of the population of Northern Ireland and reduce health inequalities.
RVL	The regional virus laboratory is located in the Kelvin Buildings, on the Royal Hospitals site in Belfast. It provides IDPS for women booking at 20 weeks gestation or more and also provides confirmatory testing for samples screened positive in NIBTS.

TTT	Test turnaround time is the time from receipt of a blood sample, in the laboratory, until a result is reported to maternity services. The National Standard states that the IDPS samples should have a result reported within 8 working days.