

Meeting agenda

PHA Board Meeting

Date and time	Venue
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22 October 2026 at 1.30pm Board Room, Tower Hill, Armagh

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 24 September 2026	Chair
4 1.30	Actions from Previous Meeting / Matters Arising	Chair
5 1.40	Reports of New or Emerging Risks Corporate Risk Register as at 30 September 2026 [PHA/01/10/26]	Chief Executive
6 1.50	Raising Concerns	Chief Executive
7 1.55	Updates from Committees: - Governance and Audit Committee [PHA/02/10/26] - Remuneration Committee - Planning, Performance and Resources Committee - HR/OD Committee - Information Governance Steering Group	Chair
8 2.10	Chief Executive and Directors' Report	Chief Executive
9 2.20	Finance Report [PHA/03/10/26] (For noting)	Mrs Scott

10 2.40	Complaints, Compliments and Claims Quarterly Report [PHA/04/10/26] (For noting)	Mr Wilson
11 2.50	PHA Mid-Year Assurance Statement [PHA/05/10/26] (For approval)	Mrs Scott
12 3.05	PHA Assurance Framework [PHA/06/10/26] (For approval)	Mrs Scott
13 3.20	Annual Quality Report [PHA/07/10/26] (For approval)	Ms Roberts
14 3.30	Health Protection Acute Response Activity Report [PHA/08/10/26] (For noting)	Dr McClean
15 3.40	Joint PHA, SPPG and BSO Annual Report on Emergency Preparedness 2025-2026 [PHA/09/10/26] (For noting)	Dr McClean
16 3.55	Updates on Screening: • Update on Progress against the Screening Programmes Internal Audit Recommendations and the Cytology Action Plan [PHA/10/10/26] (For noting) • Presentation on Audit of Invasive Cervical Cancer and Disclosure	Dr McClean
17 4.25	Chairs Remarks	Chair
18 4.30	Any Other Business	Chair
18	Details of next meeting: <i>Thursday 26 November 2026 at 1.30pm</i> <i>Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast</i>	Chair

PHA Board Meeting Minutes

Date and Time

Venue

24 September 2026 at 1.30pm Board Room, Gransha Park House, L'derry

Member

Title

Attendance status

Mr Colin Coffey	Chair	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 John Patrick Clayton	Non-Executive Director	Present
Mr Michael Gibbs	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
Dr Declan Bradley	Director of Population Research and Intelligence	In attendance
Mr Stephen Wilson	Head of Chief Executive's Office	In attendance
Mr Robert Graham	Secretariat	In attendance
Mr Aidan Dawson	Chief Executive	Apologies
Mr Craig Blaney	Non-Executive Director	Apologies

111/26 - Item 1 – Welcome and Apologies

111/26.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr Aidan Dawson, Mr Craig Blaney and Ms Meadhbha Monaghan.

112/26 - Item 2 – Declaration of Interests

112/26.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

113/26 - Item 3 – Minutes of previous meeting held on 27 August 2026

113/26.1 The minutes of the Board meeting held on 27 August 2026 were **APPROVED** as an accurate record of that meeting subject to some amendments from Dr Bradley. In paragraph 94/26.2 “SPPG” should be replaced with “PHA”; the end of paragraph 99/26.6 should be amended to read, “...research funding from external bodies”, and in paragraph 107/26.8 the penultimate sentence should finish, “...diseases, and the same approach could be taken to screening, making use of the same data infrastructure.”

114/26 - Item 4 – Actions from Previous Meeting / Matters Arising

114/26.1 The Chair noted that some of the actions from the previous meeting had been completed while other actions remained ongoing.

114/26.2 The Chair asked for an update on the outstanding action around the paper on assurances. Mrs Scott said that as a first step, she intends to bring an updated Assurance Framework to the Board to obtain some initial feedback and determine what can be added to it.

114/26.3 The Chair said that there are no issues being raised about the skillsets of Directors, but this is about the triangulation of data and how information is pulled together. He asked Dr McClean for her views. Dr McClean agreed that the existing Assurance Framework would be a useful starting point. She added that PHA has to ensure that its staff are appropriately qualified, trained and validated. She suggested that there should be a review of what is brought to the Board and what is not. The Chair noted that, using the examples of the Muckamore Inquiry and the Post Office Inquiry, one of the key findings was that Boards were not inquisitive enough so there is a balance to be found between what is operational decision making and the information that comes to the Board.

114/26.4 Mr Irvine suggested that it is not a case of “no surprises”, but more a case of when business as usual is continuing, the Board receives straightforward reports, but when there is a departure from normality the Board should receive an early notification.

114/26.5 He said that any deviation should be dealt with by the Executive Team. He noted that if everything remains steady then perhaps there is a question of what is going on beneath the surface. He suggested that if there are matters which do not reach the attention of the Board, then there is an issue.

114/26.6 Dr McClean said that PHA has controls such as Internal Audit, External Audit, complaints and incident reporting so perhaps there is a need to look at what is missing. The Chair agreed that this needs to be teased out more and it is about closing the loop so that the Board is not making assumptions.

114/26.7 Mr Wright stated that the Board should not get bogged down in operational detail, and there are matters that the Executive Directors should deal with, but in the overall Assurance Framework there will be a range of issues, and their risk appetites, right across the organisation. He said that the Board needs to look at what assurances it receives, then look at the existing Assurance Framework and then determine what it feels is missing. He added that the Board should expect reporting by exception if there are any “red lights”.

114/26.8 Mrs Scott advised that the Assurance Framework is due to be reviewed. Ms Kelly asked how often this happens and Mrs Scott replied that it is reviewed annually.

115/26 - Item 5 – Reports of New or Emerging Risks

115/26.1 Mrs Scott advised that there were no new or emerging risks.

116/26 - Item 6 – Raising Concerns

116/26.1 Mrs Scott advised that there were no new concerns to report on.

117/26 – Item 7 – Presentation by Cathy McCloskey, Chief Officer, CAWT (Co-operation and Working Together)

117/26.1 Ms McCloskey thanked the Chair for the opportunity to present to the Board and expressed her best wishes, on behalf of the CAWT Management Board to the Chief Executive on a speedy recovery.

117/26.2 Ms McCloskey began her presentation by saying that the CAWT partnership has been in place for 34 years.

At this point Mr Clayton joined the meeting

117/26.3 Ms McCloskey gave an overview of the EU funded work programmes. The Chair sought clarity on whether CAWT work comes from core funding, but Ms McCloskey explained that CAWT makes bids for additional funding in order to test ideas and has a good record in securing EU funding. She advised that from the latest PEACEPLUS funding, there are five successful projects from six applications, and these will look to improve population health and wellbeing and reduce health inequalities.

117/26.4 The Chair asked how CAWT links with PHA and if PHA stands back in an area where CAWT is providing a service or if there is an opportunity to make better use of funding. Ms McCloskey explained that CAWT initiatives are time-specific, for example, 4 years, but if a project was successful it could be mainstreamed by one of the partner organisations. The Chair sought clarity that if PHA identified a need, it could pilot the initiative through CAWT with a view that if the evidence shows that it works, it could be mainstreamed. Ms McCloskey explained that at the outset, there is a strategy group, for example in the area of mental health, and there would be a representative from each organisation who would have the necessary expertise. She added that once an agreement is made it would be submitted to the CAWT Management Board and again PHA and other partners would feed into that process.

117/26.5 The Chair asked if the work of CAWT is key to the delivery of PHA's Corporate Plan. Ms McCloskey replied that CAWT's work is aligned to Department of Health priorities and that CAWT would sift through the priorities of the respective health departments, both in Northern Ireland and the Republic of Ireland. Mrs Scott pointed out that the Corporate Plan does not explicitly reference CAWT and that it cannot reference every body it works with, but PHA is a key partner in CAWT. The Chair said that if PHA is having a say in the direction of travel, then it needs to ensure that the message is out there that PHA is helping move work forward. Mr Wilson advised that in addition to mental health, substance use is another important area PHA has been involved in with CAWT.

117/26.6 Ms McCloskey outlined that in 34 years CAWT has seen 570 staff seconded with 79 projects delivered with over 100 community/voluntary/business partners and a mainstreaming success rate of 85%. She gave a short overview of the five current projects – Community Alcohol Detox+, Early Intervention Support Youth Hubs (EASY), Community Connections and Wellbeing Project, Early Frailty Intervention Project and Healthier Futures Project (HFP). She gave examples of other commissioned (non-EU funded) activity.

117/26.7 In terms of what is working well, Ms McCloskey highlighted frailty and hospital at home. She said that there is strong engagement and a good sharing of ideas. She added that there are challenges in terms of needing to spend funding or PEACEPLUS will de-commit funding, and that there is ongoing reform of the health system in both jurisdictions. Looking to the future, she advised that there will be a new strategic plan and a scoping exercise undertaken with the Ambulance Services on both sides of the border.

117/26.8 Mr Clayton asked if CAWT would have a role in terms of broader alignment and co-operation in the context of acute services and workforce challenges, for example in the issue of maternity services in Newry and cross border contingency arrangements. He also asked about the mainstreaming of employment opportunities and if people are employed on fixed term contracts and the project becomes mainstreamed, how that is

handled in terms of funding and how staff are transitioned. Finally, he asked if projects have been successful after mainstreaming.

117/26.9 Ms McCloskey said that CAWT has had a focus on frailty services and also highlighted the work of the North West Cancer Centre and meetings about dental procedures. She explained that Chief Executives are always looking for opportunities to work in a facilitative role. In relation to mainstreaming, she advised that if a project is based within a particular Trust, then a conversation would take place at either Management Board or Project Board level and it would be up to the Trust to absorb the cost within its core services. She added that in the Republic of Ireland it would go through its Department of Health. Mr Clayton asked how often it occurs where a project is not absorbed into baselines. Ms McCloskey replied that only 15% of projects were not mainstreamed, but added that CAWT does not keep track once services are mainstreamed. She added that her sense is that projects are maintained.

117/26.10 Mr Wright thanked Ms McCloskey for the presentation and asked about CAWT's role in emergency planning and who its key partners are. He asked if this relates to business continuity or pandemic response. Ms McCloskey explained that CAWT delivers training on an annual basis and as part of that, would have undertaken some formal exercises. She noted that the opportunity is not solely about the training, but about relationship building. She said that it is not designed to replace any emergency planning that PHA is doing.

117/26.11 Mr Wright asked whether there is good integration with other "blue light" services. Ms McCloskey replied that An Garda Síochána and the PSNI would attend CAWT courses, but the focus is more on health. Mr Wright asked if PHA is involved and Ms McCloskey said that all partner organisations are offered places.

117/26.12 Ms Kelly noted that there is a lot of focus on community based work with an eye to mainstreaming. She asked about paediatric forensic services and also about the impact of Brexit. Ms McCloskey replied that there are ongoing discussions about paediatric services at department level. With regard to Brexit, she advised that there are no issues at present, but the new Procurement Act presented challenges.

117/26.13 Mrs Henderson said that the presentation was fascinating. Ms McCloskey expressed her thanks for all of the PHA staff involved in CAWT for their expertise.

117/26.14 The Chair thanked Ms McCloskey for attending the meeting.

118/26 - Item 8 – Presentation by Ageing Well Public Health Planning Team

Mr Eamon Farrell, Ms Diane McIntyre, Ms Alison Ferris and Ms Marie-Thérèse Higgins joined the meeting for this item

118/26.1 Mr Farrell thanked the Board for the opportunity to present today and introduced Ms McIntyre, Ms Ferris and Ms Higgins. He began the presentation by showing how the population in Northern Ireland will change over the next 25 years with the number of individuals over the age of 85 doubling, and that this will bring with it a

number of challenges. He advised that there is an increasing level of frailty and therefore there needs to be a focus on prevention and intervention.

118/26.2 Mr Farrell outlined the priorities of the team which will focus on prevention and early intervention, reducing inequalities, making better use of intelligence and evidence, strengthening governance and partnerships, and delivering measurable outcomes for older people across Northern Ireland. He gave an overview of the team structure saying that it is his role to ensure that the team's priorities align with those in the Corporate Plan. He outlined the different expertise that exists within the team and how a whole range of staff are brought together. He added that there are regular meetings and workshops with work ongoing to develop a 3-year plan.

118/26.3 Mr Farrell advised that the team wants to strengthen its use of intelligence and is working closely with colleagues in Health Intelligence to affect a move away from measuring activity and to look at outcomes and impact.

118/26.4 The Chair asked if PHA is looking at how early intervention can reduce the impact on hospitals given that it is likely a higher percentage of elderly people go into hospital. Mr Farrell replied that it is not easy to look at the data and make a correlation, but he noted that it is possible to look at vaccine effectiveness. Dr Bradley advised that PHA would like to be able to follow people's journeys over a period of time, but while the capability is there, the capacity is not.

118/26.5 Mr Gibbs asked how individuals with frailty are identified for support. Mr Farrell explained that individuals are identified by primary care using the Frailty Index, or the Rockwood Frailty Score. He added that the Neighbourhood initiative will target 10,000 of these individuals. Mr Gibbs asked how equitable access is monitored and how PHA ensures there is a level playing field. Mr Farrell explained that PHA requires service providers to outline how they will reach those "hard to reach" groups. Dr Bradley noted that HSC data systems are not good at capturing information about ethnicity and disability, but through SAPPHIRE (Safe Access to Patient data for Public Health, Intelligence, Research and Evaluation), data will need to be pseudo-anonymised. Ms McIntyre advised that providers are asked to obtain Section 75 data but some are uncomfortable doing so.

118/26.6 Mrs Henderson asked if there is funding for SAPPHIRE and if this has been raised at Accountability Review meetings. Mrs Scott noted that at this stage, PHA has not made an approach for additional funding but it does need to cost out a structure for the new digital directorate. Mrs Henderson said that this is part of the outworking of the Reshape and Refresh programme. The Chair asked that this is followed up on (**Action 1 – Dr Bradley**).

118/26.7 Mrs Henderson noted that Advanced Care Planning is listed as a Ministerial priority and asked what PHA is doing. Ms Roberts explained that significant work has already taken place however PHA has now exhausted what can reasonably be achieved within existing resources and capacity. As a result, she said no further substantive progress can be made on the ACP programme at this time without dedicated programme management funding. She added that PHA has raised the issue with the Department and sought clarity around the funding arrangements. She noted that if this work is not taken forward there is a risk that PHA will lose credibility. The Chair asked if Ms Roberts could prepare a short paper summarising the situation (**Action 2 – Ms Roberts**).

118/26.8 Mr Irvine said that this presentation shows that there are excellent foundations in place. He asked how PHA can collect data and identify issues going forward and influence the Department's direction of travel for service provision. For example, he used the issue of joint replacement and mobility saying that if this is caught early then it would prevent subsequent spend to treat. He added that this is about reduction and intervention. The Chair agreed saying that is about investing to save. Mr Clayton also referenced projecting the future and asked about care in the community. He noted that going forward there will be issues around paying staff who work in that area and being able to retain them. He queried whether PHA has any intelligence and can inform policy decisions to ensure there is a sustainable plan for that workforce going forward. He declared an interest as his Trade Union organisation supports staff who work in that sector. Dr Bradley said that PHA has a population health model that is informed by observing real data and with SAPPHIRE, PHA can incorporate more data and simulate a scenario where if there was a particular intervention, then it can see the consequences. However, he advised that PHA needs health economics expertise.

118/26.9 Mrs Henderson asked if PHA's horizon scanning carries any traction with either the Department or the Executive and if it can influence the decision makers. Ms Roberts said that this is where the joint planning teams with SPPG would have a role and that PHA provides professional advice and it can influence those teams who can in turn influence the Department. Mr Farrell added that within PHA all of the planning team chairs would meet regularly.

118/26.10 Ms McIntyre used the example of the Strength of Balance training and explained that it costs £31k per fractured neck of femur procedure so this training could reduce that cost. The Chair said that PHA needs to obtain more recognition to show how it is making a difference and this is about prioritisation of resources.

118/26.11 Mr Farrell gave an overview of the governance arrangements in the team and said it is important that the team is focused on the right areas. Ms McIntyre outlined the range of partners and stakeholders that the team works with and what work the team completed during 2025/26 with its budget of £2.6m. She presented a range of data showing the impact of the work of the team and then set out the priorities for 2026/27 which include four key actions – Age Friendly Communities, Safer Mobility and Falls Prevention, Advance Care Planning, and Frailty Prevention and Neighbourhood Care. She suggested that the Board may be interested in attending the upcoming Age Friendly event.

118/26.12 Ms Ferris outlined how there are opportunities for the team to have a greater impact in areas such as Neighbourhood, Partnerships, Intelligence and Prevention. She said that the team has been involved in winter planning for care homes and Age Friendly networks. She set out the next steps for the team which include developing a 3-year plan, building on existing work, looking at data, establishing sub-groups, getting service user and carer input and looking at the Health Inequalities framework. She advised that there are examples of report cards which will be shared with members.

118/26.13 The Chair said that the presentation was excellent and he hoped that the team would be back to a future meeting to complete the loop and show what work has been achieved. He added that he could see how this team could make a difference.

118/26.14 Ms Kelly asked about getting data for Equality Impact Assessments. She noted that there are vulnerable people who are not engaged with PHA and asked how

they are being picked up. Mr Farrell replied that PHA does have access to some data where it can identify communities at risk and target them, but said that there is more that PHA could do. Ms Ferris added that the Personal and Public Involvement (PPI) team are also keen for PHA to engage more widely, rather than with those who engage with PHA because they know what to say.

118/26.15 The Chair thanked Mr Farrell, Ms McIntyre, Ms Ferris and Ms Higgins for attending the meeting.

At this point Mr Irvine left the meeting.

119/26 - Item 9 – Presentation on Right Care Right Person

Ms Roisin Laverty and Ms Kelly Carolan joined the meeting for this item

119/26.1 Ms Roberts said that this area of work is presenting a number of challenges and raising concerns across the HSC. She invited Ms Laverty and Ms Carolan to update the Board.

119/26.2 Ms Laverty began her presentation by saying that PHA leads on the delivery of Protect Life 2 and recommendations 12 and 27 of the Mental Health Strategy. She explained that Right Care Right Person was introduced by PSNI, but its implementation needs to align with the existing strategic direction. She added that it is a significant multi-agency change and PHA is involved to support its underlying assumptions that individuals should get a response from a service when in need.

119/26.3 Ms Laverty advised that Right Care Right Person is an initiative intended to ensure people with health or social care needs are managed by the most appropriate service. She said that it has been implemented in some parts of England, but noted that there is a different context in Northern Ireland. She advised that Phase 1 was implemented on 1 September 2026 and other phases to be implemented in 2027. She explained that the issue for PHA is the scenario when a call does not meet the PSNI or Northern Ireland Ambulance Service (NIAS) threshold, but the individual requires support. She advised that Mr Ryan Henderson from PSNI met with the Chief Executive and Dr Denise O'Hagan from PHA.

119/26.4 The Chair asked where the driving force behind this is, and Ms Laverty replied that it is the PSNI. Ms Laverty said that Phase 2 is the one of concern, but highlighted the work of "NIAS Hear and Treat". She gave an overview of the governance structures in place around this work and PHA's role in this. In terms of readiness, she set out what work has progressed but also areas where assurance is required.

119/26.5 Ms Laverty outlined the concerns that PHA has. She highlighted that scenario modelling indicates a 15% growth in demand on NIAS. She reiterated the concern about calls not deemed to meet the right thresholds and the impact on individuals, and also highlighted issues around referrals and escalations. She said that concern for health and safety is not solely a mental health issue and the impacts could be far reaching.

119/26.6 Ms Laverty gave an overview of NIAS statistics around mental health related calls. She explained that one mitigation is the Hear and Treat Service that PHA has provided £155k of funding for, but this is only available at night times and weekends. She advised that funding has transferred to SPPG and a business case is being developed to enhance the service. She stressed that sustainable commissioning and funding arrangements need to be in place. She concluded her presentation with a summary of the main points.

119/26.7 Mr Gibbs thanked Ms Laverty for an amazing presentation, but said that it was overwhelming and it would have been useful to have had a paper in advance. He asked for clarity about PHA's positioning in this. Ms Laverty explained that this work sits between the Department of Health and the Department of Justice and that PHA has been brought in as experts to identify any issues and concerns that it has in supporting these structures.

119/26.8 The Chair asked if this is a public health issue. Dr McClean said that there are many individuals who are not receiving an appropriate response so PHA is advocating for the PSNI to hold off implementing this. The Chair asked what would happen if PSNI ignored PHA's concerns. Ms Roberts replied that the PSNI has been patient to date however it is felt that the health service is not yet in a state of readiness to implement phase 2. Mr Gibbs said that the lack of preparation is a big issue and that in England a huge amount of resource was put into this. He added that Trusts will have to take an increase in work and he does not see how it can be done.

119/26.9 Mrs Henderson said that PHA is aiming to support the design of a service that is robust. Ms Roberts advised that PHA has been vocal in multiagency discussions, but pointed out that PHA does not own the risk rather supports the overarching HSC and general public risk. The Chair expressed his view that PHA needs to say that enough is enough because the new service is not ready.

119/26.10 Mr Clayton noted that PHA is playing an advisory role and that there is a shortage of resource in the PSNI. He asked if the Agreement in place sets out the timescales and if the PSNI has acted unilaterally and if there needs to be an escalation within both Health and Justice departments, perhaps at Ministerial level. Ms Laverty replied that there have been ongoing discussions and calls for concern should be answered by the appropriate service. She explained that NIAS does not have power of entry.

119/26.11 Mrs Scott said that there was a lot of discussion at Executive level when this issue was added to the Corporate Risk Register. She outlined that there is a lack of clarity around PHA's role in commissioning, but PHA is showing professional leadership and there is no clear mechanism for escalation. The Chair said that the Board is not aware of the issue and needs to act. He asked whether he should request a meeting with the Permanent Secretary to discuss this. Ms Kelly agreed that the Board now has knowledge and needs to take action. She referenced Article 2 of Human Rights Act concerning Right to Live and said that this needs to be escalated to Permanent Secretary level.

119/26.12 Mr Wright stated that it is clear that PSNI is driving this and it is an operational decision. He echoed the views of other members that the Board must act as there is a reputational issue. In terms of mitigating the risk, there is now a clear audit trail that the Board had discussed this issue and is pushing for action. Ms Kelly

suggested that if this is a policy decision it may fall within the remit of the Policing Board. The Chair proposed that Ms Roberts join him at a meeting with the Permanent Secretary and that he would also speak to the Chair of the Policing Board. The Chair requested Ms Roberts to work with the team to develop a briefing paper in advance of the meeting **(Action 3 – Chair) (Action 4 Ms Roberts)**.

119/26.13 The Chair thanked Ms Lavery and Ms Carolan for attending the meeting.

120/26 - Item 10 – Finance

Verbal Update on Financial Plan 2026/27

120/26.1 The Chair reported that he had briefed all of the Non-Executives on the current situation with regard to the PHA budget and that he was not intending that the Board should make any formal proposals at this meeting. He advised that he had met with senior Department officials during the week who were due to brief the Minister but had not yet received any feedback. Mrs Scott said that the Department is now seeking further information regarding PHA's programme spend. She added that PHA will commence budget planning for 2027/28 in the near future.

120/26.2 Ms Kelly sought clarity on whether savings can be made against Trust spend. Mrs Scott explained that Trust expenditure has been excluded from the savings targets and explained further challenges if Trust spend was to be included in the calculations. Mr Clayton noted that if PHA were to reduce Trust spend it would impact in areas such as screening programmes and smoking cessation. Ms Kelly noted that the presentations earlier in the meeting all highlighted the importance of the community and voluntary sector.

120/26.3 Mr Wright noted the requirement for PHA to present a balanced budget and therefore plan for £1.6m of savings which will need to be approved by DoH. He acknowledged the challenges to develop savings noting limitations in Trust spend, community and voluntary sector budgets, and highlighted the impact on the workforce as ~~so~~ staff are under pressure ~~trying~~ to find savings.

120/26.4 Mrs Scott said that the role of Accounting Officer is important in this situation. The Chair agreed but noted that members are also concerned that PHA has other duties to balancing its budget. Ms Kelly agreed that PHA has other statutory duties.

Finance Report [PHA/01/09/26]

120/26.6 The Board noted the Finance Report.

121/26 - Item 11 – Board Assessments [PHA/02/09/26]

121/26.1 The Chair asked if any of the longer serving Board members, and also the recently appointed members had any comments on the Self-Assessment.

121/26.2 Mr Clayton noted that while the template being used is sleeker than the previous one, there are areas which needed to be included, for example around equality and the diversity of the Board. He said that the Governance and Audit Committee

completes a self-assessment and it should feed into this one. He advised that the Board should have an independent assessment carried out and this has not happened for some time. The Chair acknowledged this and said that he wished to wait until there was a full complement of members.

121/26.3 Mr Wright asked how PHA can influence the issue of diversity of Board members given that there is an open and transparent public appointments process. The Chair acknowledged this, but said that he has asked the Chief Executive to look at establishing an advisory group after the excellent presentation the Board received last year from the group of young people from VOYPIC and NICCY. Ms Roberts advised that this group had met with the Starting Well Planning Team so there has been continued engagement.

121/26.4 Ms Kelly highlighted the action point around the Board's wish to obtain clarity around commissioning and said that this needs to be taken forward. Mrs Scott advised that she and Mr Wilson had met recently to discuss this.

121/26.5 The Board noted the Board Assessments.

At this point Mr Gibbs left the meeting.

122/26 - Item 12 – Updates from Board Committees

HR/OD Committee Terms of Reference [PHA/02/08/26]

122/26.1 The Chair said that he was not seeking Board approval today of the terms of reference for the HR/OD Committee as he would like all of the Committees to review their terms of reference at the same time.

122/26.2 Mr Clayton asked about the people management arrangements referenced in the terms of reference. He noted that PHA's HR function is delivered through BSO and queried how the Committee can look at how that is delivered. Mrs Scott suggested that the Committee could have oversight of the Service Level Agreement. Mr Clayton asked if Trade Unions need to be involved in the Committee and if not, then to give that clarity. Ms Kelly suggested that if there is a replacement Non-Executive with a Trade Union background they could join that Committee.

122/26.3 Ms Kelly asked about the process for approving the terms of reference of the Committee and the appointment of Chairs, making reference to what is outlined in Standing Orders. The Chair said that he would be would appoint the Chairs.

Constitution of Board Committees

122/26.4 The Chair went through the lists of members for the Committee and noted that Mr Gibbs should be added to the HR/OD Committee.

123/26 - Item 13 – Partnership Agreement between Department of Health and Public Health Agency (revised August 2026)

123/26.1 The Chair asked if the Executive Directors were content with how PHA is interacting with the Department through the Agreement. Ms Kelly asked if the Board is updated on how the Agreement is working. Mrs Scott replied that it is not, but noted that it took a long time to sign off the Agreement.

123/26.2 The Chair asked about PHA's role in leading certain areas of work and suggested that he, Mrs Scott and Mr Wilson should meet to discuss this (**Action 5 – Chair**). He asked if the Engagement Plan was appropriate. Mr Clayton said that with regard to the Engagement Plan it references joint working, but noted that there are areas where PHA requires clarity from the Department and there are instances where PHA has submitted business cases and has not got a response. He suggested that it would be helpful to articulate what is meant by joint working. When reviewing the plan, he said that PHA needs clarity and asked if the Partnership Agreement gives that clarity. The Chair stated that he felt PHA's relationship with the Department to be very good.

123/26.3 The Chair said that members will be aware of why the Memorandum of Understanding (MOU) with the Safeguarding Board for Northern Ireland (SBNI) has been changed. Ms Kelly asked why it was not approved by the Board, but Mrs Scott replied that it is signed off by the Chief Executive and not the Chair. The Chair advised that changes were made because it needed strengthening in areas where the Chief Executive felt exposed. He asked if appraisals are now happening and Mrs Scott replied that they are now included in PHA's HR information.

123/26.4 Mr Clayton noted that a difficulty with the MOU is that PHA continues to carry risk and although some of the risk has been mitigated, it has not been removed. Mrs Henderson advised that if there is irregular spending by SBNI it is a finding in PHA's accounts. She said that these issues were raised during the Reshape and Refresh programme. Mrs Scott agreed and noted that there was no agreement of where a suitable hosting arrangement for SBNI was. Mr Wright asked how PHA is aware that SBNI is compliant with financial legislation. Mrs Scott replied that PHA would know because SBNI is part of PHA. The Chair noted that there has been changes in personnel in SBNI recently.

123/26.5 The Board noted the updated Partnership Agreement.

124/26 - Item 14 – Chief Executive and Directors' Report

124/26.1 There were no queries raised on the Chief Executive and Directors' report which was shared with members.

125/26 - Item 15 – Chair’s Remarks

125/26.1 The Chair advised that the Minister is due to visit PHA on 27 October and that members should consider if they would like to attend.

125/26.2 The Chair said that he had attended the Belfast Mela event and had met with Ms Nisha Tandon to discuss how PHA can work with those the same groups who had attended the Mela event.

126/26 - Item 16 – Any Other Business

126/26.1 Mr Clayton noted that at the last meeting of the Information Governance Steering Group, it was reported that PHA has a number of complaints sitting with the Information Commissioner and this is a route that individuals can take. He said that this is an unprecedented situation for PHA and is a risk to the organisation. He suggested that this could be factored into future complaints reports.

126/26.2 The Chair advised that this was Mr Clayton’s last meeting and said that it had been a pleasure to work with him. He said that Mr Clayton was an honourable and diligent member of the Board and thanked him for his support during his first few years as Chair. He added that Mr Clayton was a member of the Governance and Audit committee for the last 8 years and had a phenomenal level of attention to detail. Mr Clayton thanked the Chair for his comments.

127/26 - Item 17 – Details of Next Meeting

Thursday 22 October 2026 at 1.30pm

Board Room, Tower Hill, Armagh

Signed by Chair:

Date:

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Corporate Risk Register as at 30 September 2026

Reference PHA/01/10/26

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 September 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 30 June 2026 and the Corporate Risk Register was approved by AMT on 3 August 2026 and forwarded to the Governance and Audit Committee for approval at its meeting which took place on 13 August 2026.

The attached Corporate Risk Register reflects the review as at 30 September 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 31 December 2026.

The Corporate Risk Register was approved by the Agency Management Team at its meeting on 5 October 2026, and by the Governance and Audit Committee at its meeting on 16 October 2026.

3 Outcome

- No new risks have been added to the register this quarter
- One risk has been removed from the register this quarter
CR 71: Public Inquiries – PHA ability to respond to requests from various Public Inquiries
- No risks have had their rating altered this quarter:

4 Next Steps

The next review of the Corporate Risk Register will be undertaken after 31 December 2026.

PHA Corporate Risk Register

**Date of Review:
30 September 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 September 2026

Number of new risks identified	0
Number of risks removed from register	1 CR71 Public Inquiries – PHA ability to respond to requests from various Public Inquiries
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

CONTENTS

Corporate Risk		Lead Officer/s	Risk Grade	Page
39	Cyber Security	Director of Finance and Corporate Services	→ HIGH	6
59	Quality Assurance and Commissioning of Screening	Director of Public Health	→ HIGH	12
64	Cyber Security (compromise of HSC network due to cyber-attack on a supplier or partner organisation)	Director of Finance and Corporate Services	→ HIGH	17
~~71~~	~~Public Inquiries — PHA ability to respond to requests from various Public Inquiries~~	~~Head of Chief Executive's Office~~	~~→ LOW~~	~~21~~
73	Financial Planning Context 26/27	Director of Finance and Corporate Services	→ HIGH	21
74	Impact of the introduction of a new HSC system wide planning, delivery, performance monitoring and governance system on the PHA.	Chief Executive	→ MEDIUM	24
75	Pandemic Preparedness	Director of Public Health	→ HIGH	26
76	Delay with Child Health System Migrating to Encompass	Interim Director Population Health	→ HIGH	30
77	2011 Department of Health Framework document out of date	Interim Director Population Health	→ HIGH	34
78	Right Care, Right Person (RCRP)	Interim Director of Population Health and Wellbeing	HIGH	37

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

1 st , 2 nd & 3 rd 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 3 rd 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	
Current		Possible		Major	
Target Risk Score		Possible		Moderate	
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		1 st , 2 nd & 3 rd 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 including firewalls, threat detection, email and web filtering. protect hardware (eg firewalls);		1 st and 2 nd line - SLA - BSO ITS provides PHA IT services under a SLA		<u>Gaps in Assurance:</u> Level of corporate recognition and ownership of cyber security threat as a service delivery risk.	
PHA IT services are provided under a BSO managed ITS provides PHA IT service. PHA will continue to:		Sept Dec 2026			

• ~~HSC security software (threat detection, antivirus, email & web filtering);~~ • Server/client patching; • ~~3rd party~~ Secure Remote Access; • Data & system backups Policy, Process: • Regional & local ICT and information security policies; • Data protection and IG Frameworks policy; • User access and Change Control Processes; • ~~User Account Management processes;~~ • Disaster Recovery and ~~Plans; Emergency Planning & Service/Business~~ Continuity Plans; • Corporate Risk Management Framework, ~~processes & monitoring;~~ • Regional Cyber Security Programme Board Oversight & ~~local incident management & reporting policies & procedures;~~ • PHA is a member of the Regional HSC Cyber Security Business Continuity Group	• Technical risks assessments and penetration tests; • Reports to GAC/PHA board on reported incidents as appropriate. • PHA represented on cyber programme board • ~~Cyber incident exercises and Business Continuity Testing~~ • ~~Monitoring of mandatory cyber training completion rates.~~ • ~~External security review carried out by ANSEC (external security company)~~ 3rd line • Internal Audit reviews • BSO ITS self-assessment against ~~10 Steps towards~~ NCSC cyber essentials; ~~An HSC Cyber Gap analysis (ISO 27001) was~~	• ~~An HSC Cyber Gap analysis (ISO 27001) was carried out. (external carried out by DXG Technology) need to work through the recommendations~~ • ~~External security review carried out by ANSEC (ext security co)~~ • Assessment of the impact of Network and Information Security (NIS) and PHA role under BSO ITS Managed Service. • Continued reliance on regional assurances where key cyber services are delivered through BSO ITS. • Limited assurance regarding future funding for strategic cyber enhancements beyond currently approved resource Gap in Controls: – • ~~Regional Cyber security programme not fully implemented delivered yet (all bar SOC/SIEM).~~ • ~~Strategic outline Case sent to DoH for consideration which shows gaps:~~ • SOC/SIEM (Security Operations Centre/Security Incident and Event Management system) remain outstanding due to affordability and resource constraints	• Participate in the implementation of SOC/SIEM subject to funding availability • Complete NIS assessment • Implement HSC Cyber Security Strategy in conjunction with the Regional Cyber Security Programme Board including interim mitigation pending establishment of full SOC capability. • Continue staff awareness programme and mandatory cyber training • Continue regional cyber incident testing, Business continuity exercises ~~work with BSO ITS, DHCNI and through the HSC Cyber Security Programme Board. 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~~	
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User Behaviours – influenced through: • ~~Induction/ Annual Appraisal~~ • Mandatory cyber security training including meta compliance and ongoing phishing awareness programme. Training; • ~~HR Disciplinary Policy;~~ • ~~Contract of employment;~~ • ~~3rd party contracts/data access agreements~~ • Metacompliance monthly training now operational • Cyber security responsibilities embedded through induction, appraisal, contract of employment and disciplinary policies Training for PHA Board Members, facilitated by Regional Cyber Security Programme Board, completed 6 November 25. ~~BSO cyber project manager co-ordinating regional cyber security work.~~ ~~Regional cyber security programme board (BSO representing PHA) taking forward actions arising from~~	~~carried out (externally carried out by DXG)~~	• Privileged Access Management (PAM) capability ~~deferred to be carried forward to 27/28 due to affordability and capacity within the BSO Project Team.~~ • Full funding has not been secured for delivery of the BSO led Cyber strategic plan 2026 – 2031. The Cyber Programme Board continue to consider interim measures. ~~developed for implementation over next 4 years to deliver outputs of the cyber security strategy, however funding via DHGNI not yet secured.~~	~~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 (complementary to the mandatory eLearning cyber security training).~~	
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~~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.~~ ~~Dec 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~~ ~~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~~				
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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, incl Cyber Security e-learning				
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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) .				
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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? If no, add comment:	YES

LEAD OFFICER: Director of Public Health					
Existing Controls	1 st , 2 nd & 3 rd 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 visits re-established in breast and cervical~~ ~~Desktop QA reviews in bowel screening~~ - Ongoing meetings between the Encompass team and screening leads for newborn screening programmes to plan for transition of the Child Health System. ensure integrity of interfaces is maintained with Encompass going live. - PHA CEX represented on encompass Programme Board ~~A programmed series of messaging to media/~~	<u>Gaps in Controls:</u> - 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 limited to 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 <u>Gaps in Assurances:</u>	Control Effectiveness RAG rating AMBER	Seek approval of the revised Screening Governance Framework via the Joint PHA/SPPG Assurance Meeting – Dec 2026 Roles and Responsibilities (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). – March 2026 ~~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~~	September December 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 s~~ Screening leads 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	~~public is ongoing to ensure that public confidence is maintained in the cervical screening 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.~~ • Proof of concept completed for breast and cervical screening with the Encompass team. Further scoping across other screening programmes completed to inform an addendum to the Encompass business case. • ~~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~~	• ~~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 (such as annual reports) as prioritisation given to responding to significant and urgent issues which may impact patient safety or programme delivery • Absence of cross organisation strategic approach to screening IT systems	~~2025) of GSP 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 feature. Need for additional recurrent funding continue to be raised as inescapable into 2026/27/ June 2026.~~ • A business case to secure recurrent funding for DESP is being developed in year. In the interim finance colleagues have earmarked nonrecurrent 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.~~	
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New post of AD for commissioning public health screening and immunisation recruited under Reshape and Refresh. ~~Will provide~~ Provides 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~~ is supporting and providing 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~~	~~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 on issues relevant to cervical screening		Project structure to be established for development of a lung cancer screening business case with BC to incorporate digital and QA needs – Dec 2027 Deliver against recovery plan for production of annual reports for all screening programmes – with aim of being up to date by end March 2027.	
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screening delivery with review of progress against audit action plan and SLA. Final phase decommissioning of NHAIS and move to NIDIS is underway.				
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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	1 st , 2 nd & 3 rd 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)	1 st & 2 nd line: Assistant IG Manager appointed to support Service Leads in • A review of new and existing contracts in line	<u>Gaps in Control:</u> • 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	Sept Dec 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	with UK GDPR (working with Cyber Security colleagues, PaLS and DLS ~~as appropriate~~) ~~has been completed and revised contract documentation is in place.~~ • Technical risks assessments and penetration tests; • HSC SIRO Forum for shared learning and collaborative action planning and delivery; • IGAG oversight - Reports to GAC/PHA board on reported incidents as appropriate. • 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~~ Dec 26).	
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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 implemented in ~~(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~~			(but as 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 ~~Sept Dec 2026 (no meeting in April).~~	
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~~2025).~~ Standardized clauses documentation issued by PHA Health Improvement July 25 and signed contracts returned during July/August 25. PHA Business Continuity Plan in place, reviewed and tested annually. , 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. Legal binding agreements are in place with 3rd parties where contracts not required				
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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	1 st , 2 nd & 3 rd 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~~ is informed by AMT oversight 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 draft Financial plan in advance of confirmation of final allocations. agreement of budgets. Monthly financial monitoring and reporting through AMT and Board Regular 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 are receiving updates on funding and 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 limits the ability of the PHA to finalise the Financial Plan 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 Reliance on indicative allocations and planning		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. The Board receives regular updates regarding the financial position and has highlighted concerns regarding the potential impacts of further reductions on	Sept 2026 Dec 2026

recurrent savings from April 2027. Engagement with Minister and SPAD on the impact of funding decisions and the importance of PHA to the public health outcomes.		assumptions pending confirmation of final funding. Uncertainty regarding future DoH expectations for savings delivery beyond 26/27	commissioned services, C&V sector funding and delivery of statutory functions. Ongoing engagement will continues with DoH, Permanent Secretary and the ministers office to secure clarity regarding funding allocations and savings expectations. A further submission was provided to the ministers office in Sept 2026 setting out the impact and feasibility of implementing additional reductions during the current financial year.	
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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 Chief Executive sits on the regional project board for ICS and AIPBs The senior officers of the PHA were involved in	1 st and 2 nd 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	Sept 26 Dec 26

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 - Joint Assurance meeting (Senior Leaders) 11 November discussed progress to date and agreed governance issues that remain outstanding.	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. 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. A Board workshop is planned for Q3 to review the extant commissioning arrangements and provide further insight into how this can best fit within the PHA's new Operating model.	
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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 largescale 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 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). PHA representation on UKHSA 4 Nations planning groups as appropriate. PHA represented as observers on Rol National co-ordinating Group for HPAI. In preparation for exercise Pegasus, PHA pandemic 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.	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 Rol 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 DoH, permanent funding required to progress.	June 2026

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) in relation to border response for a pandemic including a 4 nations approach for the management of travel with respect to data sharing around passenger locator forms • 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 - Staff Mobilisation T&F group which was established in April 2026 through the Protecting Health PHPT 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	
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			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.	
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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 made significant progressed however ~~the proposed Go Live date has been proposed to be extended to a phased approach from August 2026~~ Go Live has been delayed due to the requirement for a new solution for the pre-school vaccination and immunisations. No go live date agreed

(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 extended time scale
- Ability to build the vaccine and immunisation workflow system that can effectively and safely schedule and record pre-school vaccinations. ~~replicate the full functionality of the current system~~
- Project delayed due to no viable solution for scheduling / recording pre-school vaccination and immunisations.
- Majority of risks are now low with Newborn bloodspot, reporting and Pre-school V&I remaining high risk areas.
- Rigorous testing and the time for assurance ~~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

DATE RISK

ADDED:

December 2024

REVISED:

CLOSED:

N/A

• 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~~						
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~~ for full access 27/28 and read only until 29/30. Awaiting approval for funding from DHCNI Working group aware of interface challenges of write back between GP systems and Encompass Dedicated project group led by PHA to progress.		1 st – Early Years and Family Nurse Partnership Nurse Consultants, CHS Encompass Senior Project Manager AD SPH Starting Well and Interim Director from Population Health. 2 nd – Subgroups include, Screening and Service Development Nurse	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-		Ongoing review of the work by all stakeholders will inform a Go Live date. 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, business change management, training,	Sep December 26

~~Additional resource has been provided by Encompass to support CHS managers and BSO programme manager support. Extended until September. Awaiting confirmation on funding from encompass to extend further~~ 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~~ ~~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. ~~Representation from five trusts and other organisations to inform and support the testing across all 8 FDGs and working group.~~	Consultant and Senior Systems and Business Analysts and Operations Service Manager. 3rd – Encompass, senior trust reps, labs, BSO, NIGPC, SPPG medical advisors	School Vaccination Programme Gaps in Assurance: Delay in 10th Aug go live date due to lack of readiness assurance. ~~No new date has been agreed as yet~~	provisioning, roles and responsibilities, manual data migration and reporting will become a focus. ~~Review progress September 26~~ Progress reviewed Sept 26. On hold until Pre school V&I has a solution. 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. Further work required to develop a new solution for Pre-school V&I. T&F Group being established to develop~~ A full review is underway in relation to governance structures with clear paths for escalation. ~~Review progress Sep 26.~~ Hope to recommence focus design groups November 26 ~~A Task and Finish Group is being established to explore~~	
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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. Regular workshops being held to quality assure and test. Request submitted to Clinisys (lab supplier), an alternative solution is now in place. This is still an improvement from current process. Additional piece maybe considered as part of optimization Review of Governance Structure and group membership by all stakeholders has taken place Sept 26 with view to recommencing groups in November 26.			and develop a new solution which will modernise and improve the workflow for all stakeholders Risks continue to be monitored by groups on a regular basis.	
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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: Interim Director of Population Health and Wellbeing					
Existing Controls	1 st , 2 nd & 3 rd 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.	<u>Gap in Controls</u> Ability to update the HSC Framework 2011 remains with the DoH as outlined in the 2009 Health & Social Care Act.		Whilst approved at JAG the framework will continue to be subject of review given the emerging landscape in relation to Safety & Quality, including	Sept Dec 26

DoH HSC Framework 2011 outlines PHA roles and responsibilities – whilst 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 <u>Gaps in Assurance:</u> - 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.	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. The Memorandum of Understanding between PHA and SPPG in relation to joint Safety & Quality processes has been reviewed. An addendum has been added which describes the PHA role in providing professional public health advice to SPPG. This will be approved through JAG within the coming weeks. 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. This will be an ongoing area of work and until a new Framework	
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			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. Feedback has been provided to the DoH in relation to proposed oversight roles for PHA & SPPG relating to the implementation of the new PSI Framework. A follow up meeting is planned for coming weeks. The System Learning, Transformation and Governance ADs continue to work with other Directorates and organisations to update internal processes. 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. Recruitment process has been initiated to support Safety & Quality data posts which will operate within the new Population Research & Intelligence Directorate and replacement posts within the System Learning Transformation & Governance team.	
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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	1 st , 2 nd & 3 rd 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, right place and right time”	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 it's subgroups, Operational Readiness Group, Oversight 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~~ went live on the 1st September 2026 which clarifies responsibilities of HSC professionals, PSNI and other agencies when responding to people	September 2026 December 2026

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 BHSC and SEHSC. 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 such as Lifeline, SHIP, C&V	- Regular RCRP sub group meetings between Trusts, NIAS, SPPG and PHA - SPPG ~~establishing has established an~~ Operational Readiness group and ~~arranging~~ meetings ~~arranged~~ with senior leaders within Trusts to ensure 'operational readiness' and provide assurances re same before implementation. PHA ~~to be~~ ~~are~~ 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 ~~however concerns have been raised in relation to roles and responsibilities within the code.~~ 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	experiencing mental ill health. ~~Go-live planned for 1 Sept when training delivered.~~ Presentation to Board 24TH September, Chair of the Board and Director of Nursing agreed to meet with Deputy Perm Secretary to discuss concerns in relation to roll out of phase 2, Concern for Welfare / Safety, scheduled to Go Live 31st Oct 2026.	
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sector and Mental Health Crisis and Liaison Teams continue to support people at risk.		impact of RCRP and roles and responsibilities within same. Limited assurance on interface with NIAS control and PSNI call management Limited assurance regarding consistent application of RCRP thresholds across agencies.		
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APPENDIX 1

RISKS ADDED TO CORPORATE RISK REGISTER AS AT 30 September 2026

APPENDIX 2

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 30 September 2026

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	Unlikely	Minor	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	1 st & 2 nd line — Resourcing available at AfC Band 8A and Band	<u>Gaps in Assurance:</u>		Update as at June 2026	Sept 26

~~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.~~	~~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~~	<u>Gaps in Control:</u> ~~•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.~~	~~The Agency's proposed safety and quality framework has now been discussed at AMT and is under implementation. The 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.~~ ~~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 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~~	
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			and impact of this risk has been diminished.	
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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 Concepts¹ and its supporting Risk Appetite Guidance Note, 2021²:

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**

13 August 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 Tom Wright

Non-Executive Director

Present

Mr John Patrick Clayton

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

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 Alastair Ross

Senior Planning & Performance
Manager

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 noted that Mr Irvine is attending via Teams.

2/26 - Item 2 – Declaration of Interests

2/26.1 None to declare apart from Mr Clayton's ongoing public inquiries work with Unison.

3/26 - Item 3 – Minutes of previous meeting held on 11 June 2026

3/26.1 The minutes of the previous meeting, held on 12 June 2026, were **APPROVED** as an accurate record of the meeting.

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, she advised that a team is currently working on a comprehensive report, which will be presented to GAC to facilitate the closure of the action. A number of responsibilities sit within this action, and these have been progressed through the Cyber Security Board and BSO.

4/26.2 Ms Scott also provided an update on the action relating to the Standing Orders. She advised that strategic discussions have taken place with SPPG. It has been acknowledged that there is a resolution in place, and work is underway to develop a plan and framework to address the issue. Anne recommended the action be combined into Corporate Risk Register 77 (Safety & Quality) and action to be closed.

4/26.3 Ms Henderson stated that the status of these open actions should be highlighted and reported to the Board at the September meeting. Ms Henderson also asked for an update on the Memorandum of Understanding (MoU) with SBNI and queried whether it required Board approval. Ms Scott confirmed that the MoU has been incorporated into the Partnership Agreement and will be presented at the next Board meeting.

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/01/08/26]

6/26.1 Ms McKeown presented the Internal Audit Progress Report, she outlined a proposal to defer the Management of People Plan from the 2026/27 to 2027/28 and bring forward the IT Audit. The proposal effectively involved swapping the timing of the two audits.

6/26.2 A discussion took place regarding the proposed deferral. Mr Wright advised that, if this was the recommendation to AMT then he had no objections. Mr Clayton also confirmed that he had no objections to the proposal but requested further clarification on the rationale for changing the audit schedule.

6/26.3 Ms O'Hare provided additional context, explaining that the rationale for this proposed change is that many aspects of the 25/26 People Plan were examined as part of the Governance Audit last year. With the new People Plan coming into effect on 1 April 2026, alongside the establishment of a new HROD Committee, it is felt that additional time for the new plan/arrangements to become embedded would enable a more meaningful and robust audit review at a later stage.

6/26.4 Members were happy to approve the swap of the two audits.

6/26.5 Ms McKeown presented a summary of the Internal Audit Key Performance Indicators (KPIs). She reported that overall performance remained positive. While the target of 85% had not quite been achieved, she outlined additional steps that had been introduced as part of a new process, including the sharing of findings with management in advance of exit meeting.

6/26.6 Ms Henderson asked how many audit days were allocated to the PHA. Ms McKeown confirmed that the allocation was 104 audit days.

6/26.7 Ms McKeown then drew Members' attention to page 4 of the Progress Report, which detailed the outcome of the audit of the Duty Room. She highlighted that the audit had received a Satisfactory Assurance rating and provided an overview of the procedures and processes currently in place. She noted that the controls identified within the risk register were operating effectively. While the overall assurance rating was satisfactory, Ms McKeown highlighted a number of findings of note, particularly in relation to routine governance and reporting arrangements.

6/26.8 Ms Henderson commented that she found the audit and accompanying report to be particularly useful. Mr Clayton agreed, noting that this was the first audit of the Duty Room in a considerable period of time. He stated that it was valuable for both the Governance and Audit Committee and the Board to have visibility of the risks associated with staffing capacity and the ability to scale up resources in response to incidents. He further noted that, while risks are reflected within Directorate risk registers, governance-related issues do not always emerge as clearly through those mechanisms. As such, he considered the audit report to be both helpful and noteworthy in highlighting the current position of the Duty Room. Ms Henderson agreed and stated that the importance of the audit and its findings should be highlighted to the Board.

6/26.9 Ms McKeown advised on the Information Governance Audit, demonstrating that appropriate governance and assurance structures were in place. Ms Henderson commented that the report provided a positive level of assurance and noted that it was encouraging to see Information Governance training completion rates remaining high.

6/26.10 Mr Clayton stated that the Information Governance Team should be commended for the positive findings, noting that the report provided reassuring assurance regarding the organisation's Information Governance arrangements. Mr Clayton highlighted the recommendation relating to Freedom of Information (FOI) requests and the need to better understand the causes of delays. He suggested that this issue should be considered further by the Information Governance Steering Group (IGSG) and that updates on the audit recommendations would be beneficial for the Group's oversight.

6/26.11 Ms Henderson asked about the reporting of near misses, noting that these were generally low-level unless involving a significant issue. Ms Scott advised that all near misses are reviewed to identify lessons learned and that any resulting improvements are incorporated into processes and systems as appropriate.

6/26.12 Mr Wright noted that a range of Information Governance controls were in place across the organisation but queried whether the introduction of an overarching Electronic Document and Records Management System (EDRMS) had been considered. Ms Scott confirmed that this had been discussed extensively. She advised that there are currently a range of compensating controls in place; however, progress towards a formal electronic records management solution is constrained by several factors. These include the need for sponsorship from the Department of Health, limited funding availability, and capacity pressures within IT Services, which would require additional resources to support implementation.

6/26.13 Mr Wright acknowledged that the risk had been identified and that a potential solution existed. He suggested that further value could be gained through documenting the scope of the work required, as this would provide a stronger audit trail and demonstrate that the organisation had fully considered the issue, even where implementation remained challenging. Ms Scott responded that there would be limited value in undertaking extensive scoping work where investment was not currently available. However, she confirmed that discussions were planned with BSO regarding opportunities to make more effective use of existing electronic records management systems and that the matter remained on her agenda. Ms Henderson requested that the Committee be kept updated on the outcome of those discussions. Mr Wright concluded that, from a risk management perspective, maintaining a clear audit trail of discussions, decisions and considerations would be beneficial.

6/26.14 Members Noted the Internal Audit Progress Report.

7/26 - Item 7 – Corporate Governance

PHA Internal Audit Follow Up Progress Report [GAC/02/08/26]

7/26.1 Ms Henderson introduced the PHA Internal Audit Follow-up Progress Report. She noted that the report provided a comprehensive update on audit recommendations, their implementation status, and the associated action plans. Ms Henderson highlighted that a significant number of recommendations related to Population Screening, with eight of the 33 recommendations currently awaiting implementation. She noted that the oldest outstanding recommendation dated back to 2022/23. Ms Henderson queried whether it would be helpful for a presentation on the status of the screening recommendations to be provided to the Board. She suggested that the area would benefit from a more detailed review and that an update should be presented directly to the Board. **(Action 1 – Cara Anderson)**

7/26.2 Mr Clayton agreed that this was a useful proposal. While acknowledging that screening encompasses a number of highly specialised programme areas within the PHA, he felt that a status report to the Board would provide valuable assurance and oversight. Mr Clayton also sought an update on the PPI Strategy and the associated action plan that had been approved by AMT. He asked whether implementation of the action plan would enable the related audit recommendation to be closed. Ms O'Hare advised that, in relation to the PPI recommendation, Internal Audit had requested additional structure and supporting evidence around the strategy. She confirmed that further evidence would be included within the next Follow-up Progress Report and expressed the expectation that the recommendation would be implemented and accepted in the near future.

7/26.3 Mr Clayton also asked about the Business Continuity recommendation relating to the Training Needs Analysis. He queried how attendance at training session was being monitored and how participation levels would be identified and reported. Ms O'Hare explained that Business Continuity training is being promoted through the organisation's *First Tuesday* programme. The training is targeted at all staff to raise awareness of business continuity arrangements; however, as attendance is not mandatory, achieving high levels of participation can be challenging. She advised that Internal Audit is keen to see evidence of increased uptake and that participation levels will need to be reviewed over time. Ms O'Hare further advised that an update on the uptake of Business Continuity training should be available for consideration as part of the Mid-Year Progress Report.

7/26.4 Members Noted the PHA Internal Audit Follow Up Progress Report

Corporate Risk Register as at 30 June 2026 [GAC/03/08/26]

7/26.5 Miss Scott presented the Corporate Risk Register as at 30 June 2026. She advised that a comprehensive review of the register had been completed, with the next review scheduled for the end of September 2026. Ms Scott noted that one risk had been added, one risk had been removed, and the status of one risk had been amended since the previous reporting period. She outlined the changes and sought the Committee's approval of the Corporate Risk Register.

Mr Robert Irvine left the meeting at this point.

7/26.6 Ms Scott advised that the new risk added to the register was Corporate Risk 78 Right Care, Right Person (RCRP). The risk removed from the register was Corporate Risk 55, relating to consultant staffing shortages, which had been de-escalated to the Public Health Directorate Risk Register. She also highlighted that the Public Inquiries Risk had been reduced from Medium to Low following PHA ability to respond to requests from various Public Inquiries.

7/26.7 Mr Wright asked whether the Pandemic Preparedness Risk reflected an acknowledgement that the organisation was not fully prepared for a future pandemic event and whether this had been clearly communicated.

7/26.8 Ms Henderson noted that five risks remained outside the Agency's agreed risk appetite. She acknowledged that the organisation was operating in a challenging environment, particularly in relation to financial pressures, but commented that the Pandemic Preparedness Risk was clearly articulated and that ongoing engagement was taking place with the Department of Health and other key stakeholders.

7/26.9 Mr Clayton also highlighted the Pandemic Preparedness Risk, particularly in relation to cross-border and multi-jurisdictional arrangements. He suggested that further discussion would be beneficial to provide greater clarity regarding the challenges and dependencies associated with preparedness planning. Ms Scott advised that there had been some changes to the previous five-nation approach, which was now being considered within a four-nations framework. She agreed that additional clarity on the arrangements would be helpful. Ms Henderson suggested that the Board should consider the Pandemic Preparedness Risk in greater detail when reviewing the Corporate Risk Register.

7/26.10 In response to questions regarding assurance arrangements, Ms Scott explained that Pandemic Preparedness is a system-wide responsibility. While the PHA holds some responsibilities, accountability is shared across a range of organisations. She confirmed that appropriate arrangements are in place and that preparedness activity continues, although there are opportunities to strengthen mitigations further.

7/26.11 Mr Clayton commented that the risk appetite framework provides a useful indicator of the Agency's tolerance levels and helps inform discussions on areas of concern. Mr Clayton also queried the removal of Corporate Risk 55, Staff Shortages, noting that recent Internal Audit work had highlighted governance and staffing capacity issues within the Duty Room. He questioned whether the risk should have been removed entirely or reframed to reflect wider workforce challenges.

7/26.12 Ms Scott clarified that Corporate Risk 55 specifically related to consultant staffing shortages and that workforce pressures in other areas continued to be managed and monitored through Directorate Risk Registers. She further advised that proactive recruitment activity is underway, a new workforce model is being implemented, and a number of substantive vacancies have recently been filled. She reminded members that the Corporate Risk Register is subject to quarterly review.

7/26.13 Mr Wright noted that the Pandemic Preparedness Risk narrative clearly identified gaps in assurance and control. He asked how the Committee could be assured that the PHA would be able to mount an effective response in the event of a future pandemic and what assurances could be provided regarding organisational readiness. Ms Henderson reiterated that the risk appetite analysis was particularly helpful in highlighting those risks that fell outside the Agency's agreed tolerance levels and that these should continue to be prominently reported to the Board. Mr Clayton suggested that additional clarity would be beneficial regarding roles, responsibilities and partnership arrangements during a surge response, including the relationship between the PHA and other responding organisations.

7/26.14 Ms Henderson proposed that a more detailed overview of the Pandemic Preparedness Risk should be presented to the Board and requested that this be progressed as an action. Ms Scott advised that specific work is ongoing in relation to surge mobilisation arrangements and wider preparedness planning. She noted that some elements of this work are dependent upon collaboration with the Department of Health and other partner organisations. Mr Wright referred to lessons emerging from the COVID-19 Inquiry and emphasised the value of demonstrating how recommendations and learning from the Inquiry are being considered and incorporated into preparedness planning.

7/26.15 Ms Henderson noted that the risk rating on the Public Inquiries risk had been reduced and asked whether a summary of the Muckamore Abbey Inquiry Report would be presented to the Board. Mr Ross confirmed that a report would be brought forward to the Board summarising the scope of the Inquiry report and outlining any relevant recommendations arising from it.

7/26.16 Ms Henderson commented that the Budget Risk was clearly articulated within the Corporate Risk Register and provided the Board with a good understanding of the challenges currently facing the organisation. Ms Scott advised that the Planning, Performance and Resources Committee (PPR) would be meeting the following week and that a further report on the Budget Risk would subsequently be provided. She noted that the report would present a range of proposals currently under consideration. Ms Henderson acknowledged that the Budget Risk remained outside the Agency's risk appetite but noted that significant work was ongoing to reach an acceptable position with the Department.

7/26.17 Members also discussed the newly added RCRP Risk, noting both the strong narrative within the risk description and the identified gaps in assurance and control. Discussion included the implications of partner organisations stepping back from aspects of operational responsibility and the potential impact on public health outcomes.

7/26.18 Ms Henderson stated that a report on the new RCRP Risk should be presented to the Governance and Audit Committee. Members also expressed concern that target implementation dates have been missed within Child Health System risk and new target dates should be included in a presentation to the Board.

7/26.19 Agreed Actions for risks falling outside risk appetite

- A presentation on Pandemic Preparedness Risk, including Pegasus de-brief to be provided to the Board. (Further clarification to be provided on preparedness arrangements, assurance mechanisms, roles and responsibilities during a surge response. **(Action 2 – Ms McClean/Nominated Deputy)**)
- A report on the financial planning and budget context to be brought to the Board **(Action 3 – Ms Scott)**
- A report on the RCRP Risk to be presented to the Governance and Audit Committee **(Action 4 – Ms Roberts/Nominated Deputy)**
- A report on the Child Health System (CHS) risk to be brought to the board. **(Action 5 – Ms Roberts/Nominated Deputy)**

7/26.20 Members Approved the Corporate Risk Register as at 30 June 2026

Chief Executive Office Directorate Risk Register [GAC/04/08/26]

7/26.21 Mr Ross presented the Chief Executive Office Directorate Risk Register on behalf of Mr Wilson. He advised that two new risks had been added to the register since the previous reporting period. No risks had been removed and no risk ratings had been amended. Mr Ross explained that the two new risks related to, team capacity within the Communications, and a reduction in reactive capacity to deliver social marketing activity. He noted that the three existing risks remained aligned to issues relating to the PHA website. Mr Ross provided an overview of the existing risks before giving a more detailed explanation of the two newly identified risks. He outlined the controls and mitigating actions in place and advised that progress was being made to address the risks, with the aim of achieving significant improvement during the current year.

7/26.22 Ms Henderson requested an update on the organisational chart. Mr Ross advised that work was ongoing to identify an appropriate software solution and that implementation remained in progress. Ms Henderson stressed the importance of having an up-to-date organisational chart, noting that it can be difficult to identify reporting structures, areas of responsibility and key contacts across the organisation. She also acknowledged the ongoing website-related risks and the challenges associated with them.

7/26.23 Members discussed the two newly added risks, particularly the impact of losing experienced staff within the Communications Team. It was noted that the departure of experienced staff had resulted in a loss of expertise and organisational knowledge. Mr Ross confirmed that recruitment activity was currently underway to address these gaps.

7/26.24 Mr Wright noted that the discussion linked to an earlier debate regarding the removal of workforce-related risks from the Corporate Risk Register. He questioned whether workforce capacity and staffing shortages should remain visible at Corporate Risk Register level, even at a lower risk rating, to ensure that the issue remains

prominent and subject to ongoing scrutiny. Mr Clayton agreed, commenting that if workforce risks are not reflected within the Corporate Risk Register, they may receive less attention at Board level. He stressed the importance of ensuring that the Board maintains appropriate oversight of recruitment and workforce capacity challenges. Ms Scott advised that the newly established Human Resources and Organisational Development (HROD) Committee would provide enhanced oversight of workforce matters and that information relating to recruitment, vacancies and staffing pressures would be reported through that governance structure.

7/26.25 Mr Clayton also sought clarification regarding the risk relating to reduced capacity to deliver social marketing activity. He asked what resources were currently available and whether alternative providers were being considered. Mr Ross advised that the Directorate was currently reviewing existing arrangements and assessing the effectiveness of current providers. He confirmed that opportunities to test alternative approaches and potential future providers were also being explored.

7/26.26 Mr Clayton queried whether reduced mass media activity was increasingly being compensated for through social media channels and whether reduced social marketing capacity could therefore present a greater risk. Mr Ross confirmed that the necessary capability remained in place; however, available capacity could become stretched if demand increased significantly.

7/26.27 Mr Wright requested clarification regarding the risk appetite narrative associated with the two newly added risks. Mr Ross acknowledged that both risks currently sat outside the desired position and remained open. He advised that they would be subject to further review as part of the next reporting cycle in September, at which point progress against mitigating actions would be reassessed.

7/26.28 It was agreed that given the pressures within the Agency's communications function it would be helpful if Mr Wilson included a brief update within his monthly submission to Board for the benefit of wider members. **(Action 6 – Mr Wilson)**

7/26.29 Members Noted the Chief Executive Office Directorate Risk Register.

8/26 - Item 8 – External Auditor's Report to those Charged with Governance (Draft)

External Auditor's Report to those charged with Governance (Draft) [GAC/05/08/26]

8/26.1 Ms Murphy presented the External Audit Report to Those Charged with Governance. She provided a brief overview of the report and reminded members that a draft version had been presented to the Committee in June. She advised that the document had since been finalised and updated to reflect any amendments arising from that discussion. Ms Murphy noted that the final report and accounts had now been published on the PHA website and confirmed that the external audit process for the year was complete.

8/26.2 Ms Henderson drew members' attention to one of the External Auditor's recommendations regarding the timing of Governance and Audit Committee meetings. She noted the recommendation that the Committee meeting currently scheduled for April 2027 should be moved to May 2027 to better align with the completion of audit work and the presentation of audit findings and reports. Members considered the recommendation and agreed that the April 2027 Governance and Audit Committee meeting would be rescheduled to May 2027.

8/26.3 Members Noted External Auditor's Report to those Charged with Governance.

9/26 - Item 9 – Any Other Business

9/26.1 Ms Henderson invited members to raise any items of Any Other Business.

9/26.2 Mr Clayton asked Ms Murphy whether the Northern Ireland Audit Office had any views on the current budget position and whether financial pressures were influencing its approach to public bodies. Ms Murphy advised that the Northern Ireland Audit Office was closely monitoring the position and recognised the challenges that budgetary constraints may present for organisations. She noted that, as the financial planning cycle progresses, this would remain an area of focus. However, she stated that it was too early to comment on any specific future approach or actions at that stage.

9/26.3 Ms Henderson then requested an update on the Equip Programme. Ms Scott advised that a Change Readiness Lead had now been appointed. She provided an overview of the programme progress, including preparations for the planned go-live date in November 2026. Ms Scott explained that the transition would include the implementation of Finance and HR systems, with the HR Lite system providing the core HR information required to support the new financial systems. She also outlined the communication and engagement activities planned for staff, including training arrangements and preparations for data migration.

9/26.4 Ms O'Hare highlighted that the principal risks for the PHA related to the compressed timescales associated with the programme and the challenges of data migration. She noted that these factors had resulted in a heightened level of risk and would continue to require careful monitoring as implementation progressed. Mr Wright asked whether parallel running arrangements would be in place between the existing systems and the new platform during the transition period. Ms O'Hare advised that the approach would depend on the individual system involved. She explained that parallel running may be considered for Payroll, but it would not be possible in all cases due to the nature of financial data processing and the volume of system inputs. Ms O'Hare further noted that many of the programme risks currently sat with BSO, whose specialist teams were heavily involved in the implementation and oversight of the programme.

9/26.5 There being no further business, Ms Henderson thanked members and attendees for their contributions and closed the meeting.

10/26 - Item 10 – Details of Next Meeting

Friday 16th October 2026 at 10am

Fifth Floor Meeting Room, 12/22 Linenhall Street

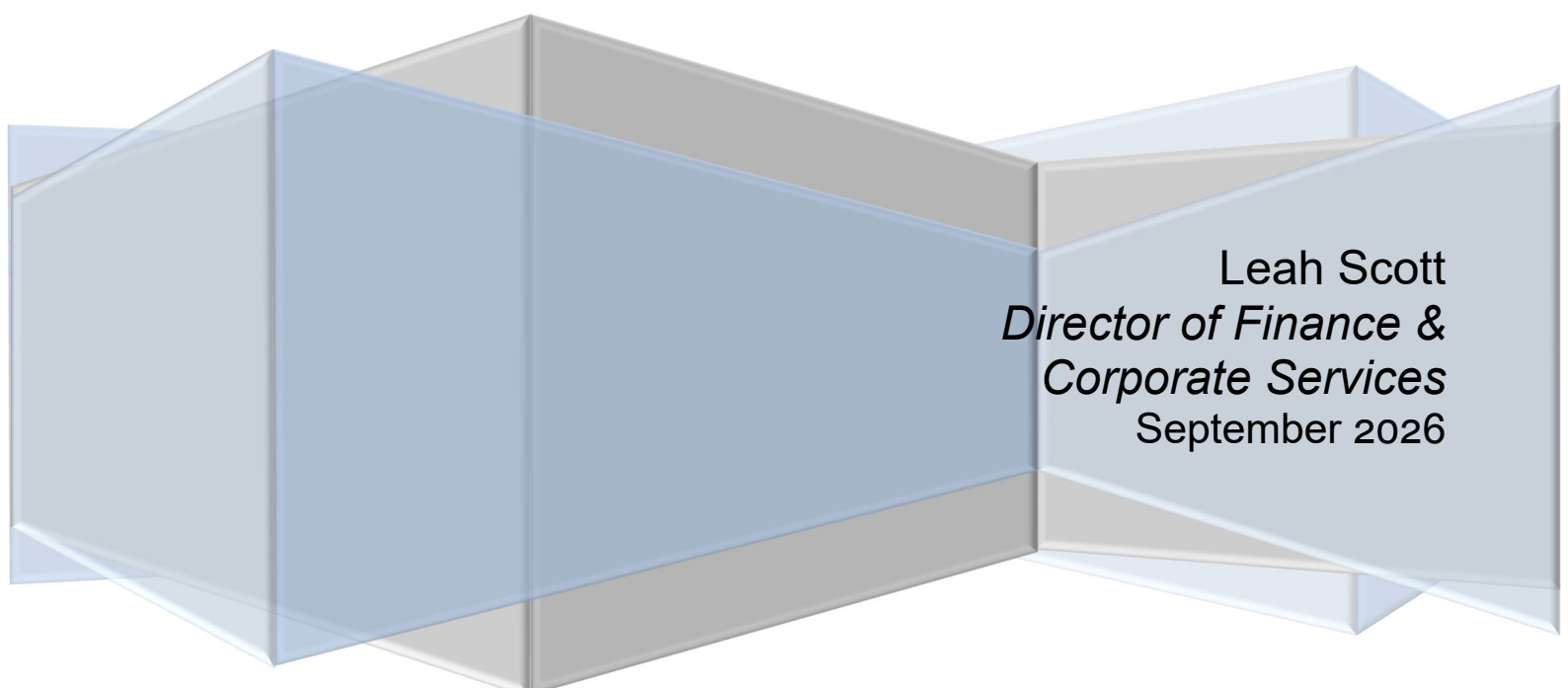
Signed by Chair:

Anne Henderson

Date: 16 October 2026

Finance Report

Month 5 - August 2026



Leah Scott
*Director of Finance &
Corporate Services*
September 2026

Introduction

This summary report outlines the Agency's statutory duties and provides an update on the financial position at month 5. However, uncertainty regarding HSC savings targets and the continued absence of an agreed Northern Ireland Executive Budget mean that the PHA is currently operating on the basis of an indicative 2026/27 allocation. Consequently, the 2026/27 Financial Plan has not yet been presented to the Board for final 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 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 position at 31 August 2026 (Month 5) reflects a year-to-date (YTD) **underspend of £306k** and a forecast full year **deficit of £1.682m**, as shown on **Table 1** below. The deficit 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.

Appendix 1 sets out further detail on the PHA **indicative** funding allocation of £144m.

Table 1: PHA Summary Revenue position – Aug 26

Table 1: PHA Summary Revenue position – Jul 2026	Aug 26 Budget £'000	Aug 26 Actual £'000	Aug 26 Variance £'000	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast Expenditure £'000
Programme Expenditure by Trust	4,034	4,034	(0)	20,169	20,169	(0)	49,358
Programme Expenditure by PHA	9,251	9,670	(419)	20,002	20,494	(492)	61,426
Total Programme Expenditure	13,285	13,704	(419)	40,171	40,664	(492)	110,784
Management & Admin	2,940	2,654	286	14,484	13,726	759	34,142
Ringfenced by Trust	-	-	-	-	-	-	-
Ringfenced by PHA	52	36	16	256	217	40	764
Total Ringfenced	52	36	16	256	217	40	764
Other Revenue Income	(47)	(47)	0	(48)	(48)	0	(48)
PHA Total	16,230	16,347	(117)	54,864	54,558	306	145,643
Total Funding Available 2026-27 (Appendix 1)							143,961
Forecast Surplus/(Deficit)							(1,682)

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. While the PHA developed and submitted proposals capable of achieving a breakeven position, including a reduction in programme spend within the Community & Voluntary sector, approval to implement these proposals has not been confirmed.

Early signals from DoH colleagues indicated that a 4% saving would be required from PHA, however the 6% savings target reflected in the indicative allocation letter is now expected to be fully achieved.

In the absence of approval to reduce the proposed savings, the PHA has reviewed 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 would be required to be achieved from Management & Administration budgets. However, these opportunities are limited and may introduce further operational, workforce and organisational risks for the Agency.

The Agency continues to engage closely with DoH while maintaining robust financial monitoring throughout the year to manage financial risks and maximise opportunities to achieve financial balance.

Section C: Expenditure to month 4

Based on the indicative allocation of £144m, 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 £145.6m by budget area.

Table 2: Breakdown by Budget Area	Aug 26 Budget £'000	Aug 26 Actual Exp £'000	Aug 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	2,830	2,830	(0)	14,149	14,149	0	34,386
Population Health & Wellbeing	1,204	1,204	(0)	6,020	6,020	0	14,972
Chief Executive & Board	-	-	-	-	-	-	-
Sub Total By Trust	4,034	4,034	0	20,169	20,169	0	49,358
PHA Internal							
Public Health	6,387	6,411	(24)	12,090	12,059	31	32,333
Population Health & Wellbeing	2,968	3,121	(153)	8,044	8,039	4	24,169
Population Data & Intelligence	60	61	(1)	497	455	41	4,322
Chief Executive & Board	(70)	30	(100)	25	(107)	132	556
balance of savings	(140)	-	(140)	(701)	-	(701)	-
Sub Total By PHA Internal	9,204	9,623	(419)	19,955	20,447	(492)	61,379
Sub Total Trust + PHA Internal	13,238	13,657	(418)	40,124	40,616	(492)	110,737
Management & Admin							
Public Health	1,279	1,142	137	6,328	6,040	288	14,519
Population Health & Wellbeing	743	673	71	3,716	3,391	326	8,562
Finance & Corporate Services	427	382	45	2,022	1,877	146	4,581
Population Data & Intelligence	251	234	17	1,238	1,198	40	3,300
Chief Executive & Board	193	168	25	950	854	96	2,125
Other	(41)	-	(41)	(204)	-	(204)	-
SBNI	87	55	32	434	366	67	1,057
Sub Total - Management & Admin	2,940	2,654	286	14,484	13,726	759	34,142
Ringfenced							
Trust	-	-	-	-	-	-	-
PHA Direct	52	36	16	256	217	40	764
Sub Total	52	36	16	256	217	40	764
PHA TOTAL	16,230	16,347	(116)	54,864	54,558	306	145,643

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 overspend of £492k is shown on PHA Internal programme budgets (i.e. Non-Trust) for the year-to-date. This variance reflects the difference between the 4% reduction applied to programme budgets and the 6% reduction applied to the PHA allocation. The balance of savings target is held centrally and is generating a deficit of 701K YTD and a projected full year deficit of £1.682m.

Management & Administration - A surplus of £759k is shown on the Management & Administration budget at month 5, primarily reflecting underspends generated by the

current level of vacancies across the Agency. This position is broadly 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, however it will be kept under close review for the remainder of the year. The staffing budget is based on the approved Reshape & Refresh structure, which has an estimated full-year cost of £0.5m above the available Administration funding. The resulting funding gap is shown in the *Other* line, and is expected to be managed through normal vacancy-related slippage.

Ringfenced Funding – a small underspend of £40k 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: Programme Expenditure by Trust

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	1,252	580	694	560	505	-	3,591
	12,447	6,897	3,500	5,383	5,732	-	33,959
Population Health & Wellbeing							
Ageing Well	274	69	204	110	37	-	693
Early Years	1,407	1,320	931	1,823	1,594	-	7,074
MH&LD	4,300	1,129	249	530	249	30	6,487
Partnership & Engagement	32	32	32	32	32	32	193
	6,013	2,549	1,416	2,494	1,912	63	14,447
Other - Yet to be allocated	359	427	124	-	-	43	952
Total Core Funding	18,819	9,873	5,040	7,877	7,644	105	49,358
Ringfenced - Covid	-	-	-	-	-	-	-
Total Current RRLs	18,819	9,873	5,040	7,877	7,644	105	49,358

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 31 August 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 <i>Engagement with DoH is ongoing regarding the final 26/27 allocation & saving requirements. A further sub is due to go to the minister late Sept.</i>
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 <i>Both vaccines and NRT Smoking Cessation continue to be closely monitored throughout the year.</i>
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 <i>Month 5 reports M&A slippage of £759k, with increased spend anticipated in the second half of the year.</i>
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 recent appointment of the Director.	On-going <i>Director now formally appointed and recruitment of remaining staff members will be progressed during the year, pending confirmation of funding.</i>

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 <i>Further engagement will be required with DoH to ensure a viable recurrent budget is retained for future years</i>

Section E: Prompt Payment

Prompt Payment performance for August shows that PHA is above the 95% prompt payment target on volume, and is above the target on both volume and value cumulatively. The year to date position shows that the PHA is achieving its target on volume but is slightly below on value due to one significant invoice relating to R&D missing the 30-day target in June 2026. Prompt payment targets will continue to be monitored closely over the 2026/27 financial year.

Table 4: Prompt Payment Performance	Aug 2026	Aug 2026	Cumulative position as at Aug 2026	Cumulative position as at Aug 2026
	Value	Volume	Value	Volume
Total bills paid (relating to Prompt Payment target)	£7,369,516	305	£23,680,478	1,630
Total bills paid on time (within 30 days or under other agreed terms)	£7,093,265	299	£22,561,245	1,572
Percentage of bills paid on time	96.3%	98.0%	95.3%	96.4%

The 10-day prompt payment performance remains above the current DoH target for 2026/27 of 70%, at 85.5% on volume for the year to date.

Section F: Capital position

The PHA has a capital allocation (CRL) of £13.505m at 31 August 2026. This mainly relates to projects managed through the Research & Development (R&D) team with £5.218m to be allocated to Trusts in-year.

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

Table 5: PHA Summary capital position – 31 August 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	1,293	3,859	-
R&D - Capital Receipts	(564)	(101)	(564)	-
Subtotal HSC R&D	8,148	1,192	8,148	-
Other:				
Congenital Heart Disease Network	627	-	627	-
iReach Project	1,589	-	1,589	-
R&D - NICOLA	691	10	691	-
VMS - Add PPV and hepB (Small Projects)	47	12	47	-
Planning Laptops	-	-	-	-
Device Refresh	-	-	-	-
R&D VPAG	1,281	15	1,281	-
R&D VPAG Trusts	626	-	626	-
R&D VPAG Other Bodies	496	47	496	-
Subtotal Other	5,358	84	5,358	-
Total PHA Capital position	13,505	1,276	13,505	-

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 August 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
PHA 2		£57,760
Assumed allocations to come from DoH (currently included in budget):		
	SBNI CCE	£110,000
	Clinical Excellence Award	£60,931
	Joint Partnership Lead - J McGinty	£40,000
	Accommodation funding for LHS from SPPG	£250,000
	BSO Re-alignment exercise	£526,083
	Vaccinations - Shingles, Flu etc	£3,196,291
	Farm Families	£187,846
	DoJ funding - Domestic Abuse Enquiry	£59,000
	Ringfenced funding	
	Fresh Start - Tackling Paramilitarism	£408,000
	Sessional Vaccinators	£289,000
	Assumed Funding from NIMDTA	£498,126
Total Funding for 2026-27		£143,961,784

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Complaints, Compliments and Claims Quarterly Report

Reference PHA/04/10/26

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.

3 Key Issues

During the first two quarters of 2026/27, the PHA received three formal complaints, three compliment and one claim.

4 Next Steps

The next Report will be brought to the Board in February 2027.

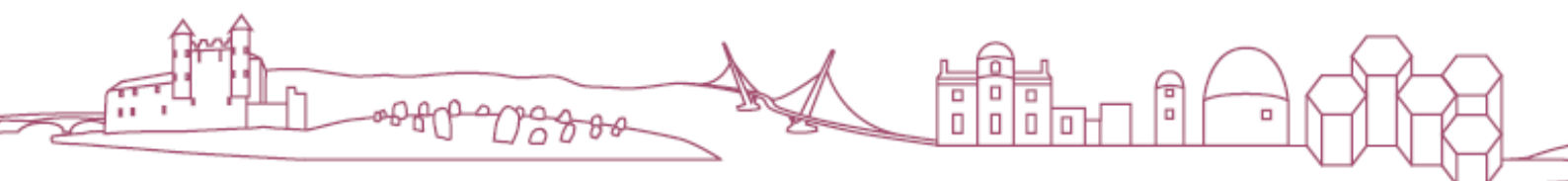


2026/2027

Complaints, Compliments and Claims Quarterly Report

Internal Qtr 2 Report
Position as at 30 September 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.

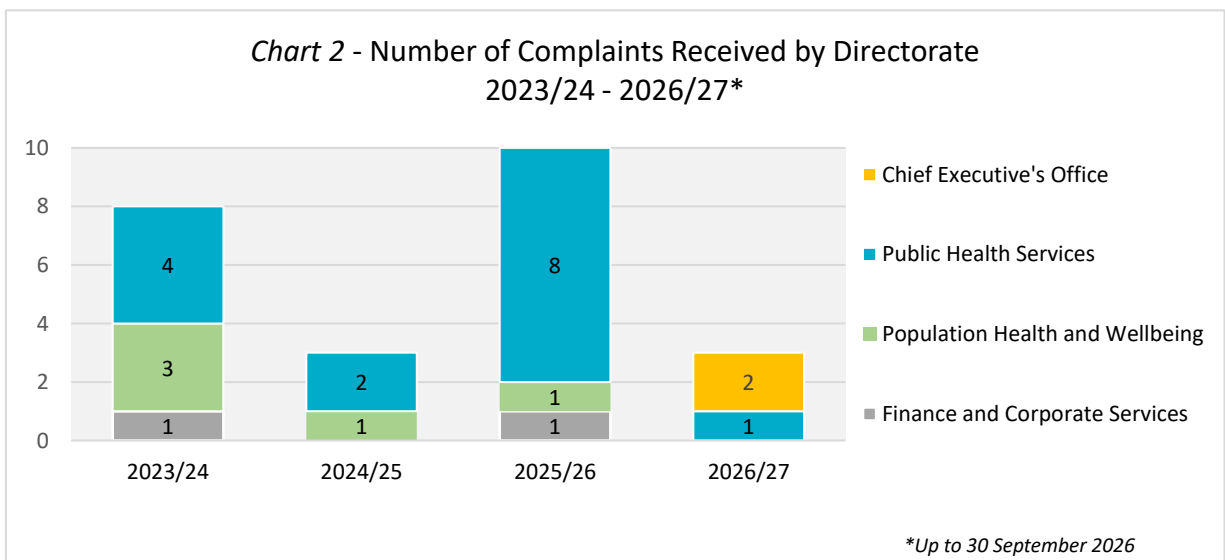
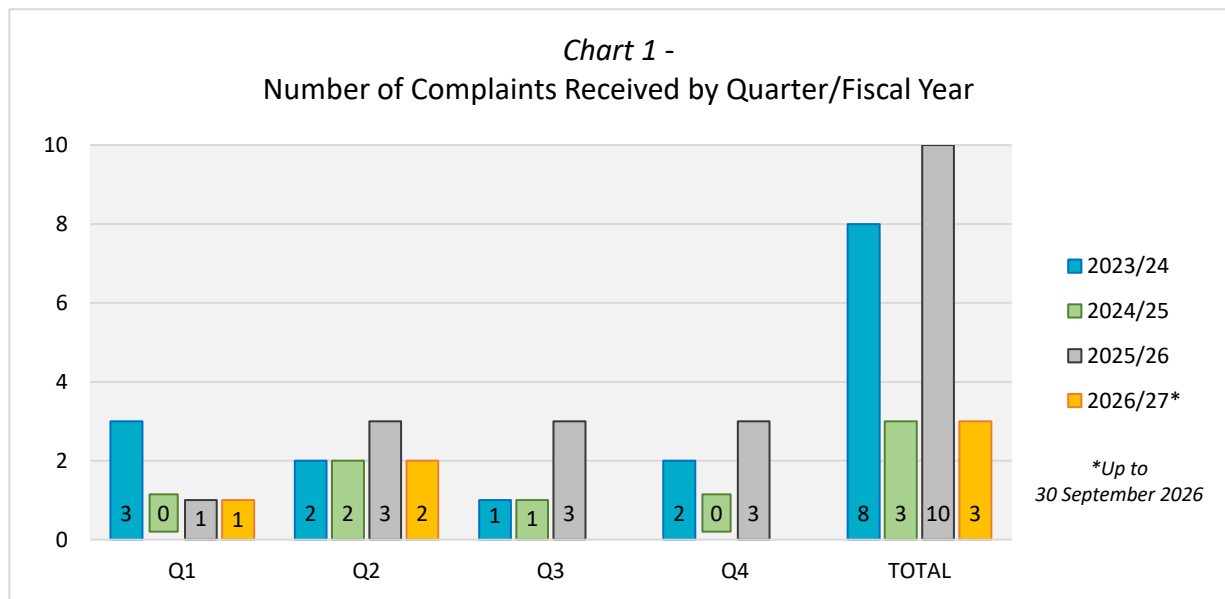
Stage Two Complaints

- 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 September 2026, three complaints were 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.



1.3 2026/27 Closed Complaints

Two complaints were closed within the Agency during quarter two 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	-	-
Q2 2026/27	2	1	1

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	-	-	-	-	-
Q2 2026/27	1	1	0	0	1

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	-	-	-	-	-
Q2 2026/27	1	1	0	0	1

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	-	-	-	-
Q2 2026/27	1 (100%)	2	2	2

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	-	-	-	-
Q2 2026/27	0 (0%)	53	53	53

Table 6 Synopsis of Closed Complaints 2026/27

PHA Ref	Responsible Directorate	Synopsis of Complaint and Response
S1/4/2627	Chief Executive's Office	Complaint - Concerns in relation to the response options contained within an equality monitoring form used by a PHA commissioned service Outcome and Response - Not Upheld, complainant advised that, while the PHA may provide funding and oversight arrangements for a given service, responsibility for the day-to-day operations; including the design and administration of forms and processes, rested with the service provider.
S2/3/2627	Public Health Services	Complaint - Concerns regarding the perceived impartiality of a staff member acting in their professional capacity on behalf of the Agency Outcome and Response - Not Upheld, following a Stage Two review the complainant was advised that the Agency was satisfied that the staff member acted appropriately and in accordance with their professional responsibilities.

1.4 2026/27 Open Complaints

As at 30 September 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 September 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 September 2026, the PHA Complaints Office was notified of three compliments.

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>'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.'</i>
02/2627	Public Health Services	Member of the Public	<i>'I just wanted to say that I felt your team was extremely supportive throughout the entire process. Any queries or concerns I had were dealt with promptly, and whenever I requested that service users or their next of kin be contacted again for reassurance or further information, this was always done without issue. Communication throughout was clear, timely and professional, which made managing the situation much easier from our perspective.'</i>
03/2627	Public Health Services	Member of the Public	<i>"I wanted to send some feedback on the Weaning made easy: moving from milk to family meals booklet. I think it is a great resource. It is clear, practical and very helpful for parents navigating weaning, and I have found it useful myself.'</i>

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 September 2026 period.

3.3 Open Claims

One claim in relation to the PHA has been opened during the 1 April 2026 to 30 September 2026 period. Further detail in relation to this claim is set out at table 8.

Table 8 Synopsis of Open Claims 2026/27

Date Opened	Type of Potential Liability	Claim Synopsis
25 Sept 2026	Employment Law	A claim relating to a recruitment process has been lodged with the Office of the Industrial Tribunal and Fair Employment Tribunal. A formal response is currently being prepared, with submission anticipated within the next 4 to 6 weeks.

PHA Complaints Office
complaints.pha@hscni.net

END

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper PHA Mid-Year Assurance Statement

Reference PHA/05/10/26

Prepared by Joanne Martin

Lead Director Leah Scott

Recommendation

For **Approval** ☒

For **Noting** ☐

1 Purpose

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

2 Background Information

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

The Statement was approved by the Agency Management Team on 5 October and by the Governance and Audit Committee on 16 October.

3 Key Issues

The Mid-Year Assurance Statement provides assurance on the systems of internal control in line with Departmental guidance. It includes details of Internal Audit assignments for 2026/27 completed to date.

4 Next Steps

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

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

This statement concerns the condition of the system of internal governance in Public Health Agency as at **30 September 2026**.

The scope of my responsibilities as Accounting Officer for the Public Health Agency, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 18 June 2026. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Audit Committee, the Remuneration and Terms of Service Committee, and the Planning, Performance and Resources Committee have continued to meet and to discharge their assigned business.

The inaugural meeting of the newly formed Human Resource and Organisational Development Committee took place during the period to complement the work of the Board. Minutes of Committee meetings, together with Board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

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

3. Risk Register

I confirm that the Corporate Risk Register has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Corporate Risk Registers are reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). Directorate Risk Registers are also reviewed by AMT and the GAC on a rotational basis. The Corporate Risk Register is brought to the PHA Board on a quarterly basis, most recently on 27 August 2026.

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

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set by out in the organisation's business plan 2026/27, as approved by the Department. The latest Performance Report to the Board as at 30 June, advised that of the **132** key performance indicators (KPIs) for the 43 actions agreed, **6** KPIs actions have been categorised as red (significantly behind target/will not be completed), **37** KPIs have been categorised as amber (will be completed, but with slight delay), **79** KPIs have been categorised as green (on target to be achieved) and, 10 KPIs have been categorised as blue (KPI achieved/action completed).

In relation to the 6 KPIs rated as red across 4 actions, the PHA is continuing to progress work in these areas.

Work to implement the Blood Borne Virus (BBV) Strategy and provide a holistic BBV care model continues with work on track to adopt the WHO bloodborne virus elimination targets, ongoing engagement with prison healthcare and the community and voluntary sector continues. The KPI relating to BBV positive prisoners reporting on release from

prison that they know how to access treatment has been categorised as red and will not be reported on within the 2026/27 period.

Work continues to improve the safety, quality and consistency of maternity care across the region. Two KPIs of this action have been categorised as red. While work on the Regional Maternity Improvement Action Plan continues, it did not meet the original June 2026 timescale due to delays in discussions on terms of reference. Work is expected to continue with progress expected in Quarter 3. There has been notable progress on implementing the Saving Babies' Lives Care Bundles, but compliance with core elements of Saving Babies' Lives v3 including commissioning of essential services have been impacted by system wide savings. Business cases are prepared for all aspects and further progress is dependent on funding becoming available.

The review of the delivery model for the Youth Engagement Services for substance use is underway but the joint procurement process between PHA and the Education Authority has been delayed.

Implementation of Advance Care Planning (ACP) policy for adults has been delayed due to resource constraints and ongoing engagement with DoH colleagues regarding savings requirements and 2 KPIs are categorised as red noting that neither the governance and accountability structures or the public messaging required to support implementation of ACP policy can be progressed with resource.

5. Finance

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

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with FD(DoF)11/20 Better Business Cases NI and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;
- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

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

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

7. External Audit Reports

I confirm partial implementation of the external auditor's accepted Priority 2 recommendation in relation to the management of vaccine stock levels. The Agency continues to implement the agreed recommendation through ongoing review of vaccine uptake trends, close monitoring of stock levels and refinement of ordering arrangements to minimise losses while ensuring continuity of supply.

8. Internal Audit

As at 30 September 2026 the following internal audit reports planned for 2026/27 have been finalised.

SYSTEMS REVIEWED	LEVEL OF ASSURANCE RECEIVED*
Management of Duty Room	Satisfactory
Information Governance	Satisfactory

****Internal Audit's definition of levels of assurance:***

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

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

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

There were no priority one findings issued in the 26/27 reports which represent 40% of the current year audit programme. There are 4 significant and 13 key Priority 2 recommendations outstanding which continue to be progressed.

There are 2 outstanding Priority 1 recommendations arising from the 2025/26 internal audit report for population screening which received limited assurance. The report identified opportunities to strengthen governance arrangements, quality assurance operating models and clarity of roles and responsibilities across screening programmes. A comprehensive action plan has been developed and is monitored monthly. Both Priority 1 recommendations remain on track for implementation by 31 March 2027. Management is satisfied that appropriate mitigating controls are in place and that satisfactory progress is being made towards implementation of all recommendations.

9. RQIA and Other Reports

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

NIAO Audit Committee Checklist

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

10. Board Governance Self-Assessment Tool

I confirm completion of the Board Governance Self-Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

11. Internal Control Divergences

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

set by other parts of government. Any significant control divergences are reported below.

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

Management of Vaccine Programme

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

Following the internal audit, the team has strengthened vaccine stock management through the appointment of a Band 6 Vaccine Logistics Coordinator and the introduction of enhanced monitoring tools. Vaccine stock is now managed through operational dashboards showing vaccines ordered and administered, with GP practices receiving information on vaccine waste and ordering patterns. Practices also have access to their own dashboards and, for the 2026/27 flu programme, must demonstrate stock usage and declare any wasted vaccine before requesting additional supplies. These changes have been communicated through GP training sessions.

Further improvements include aligning GP payments with vaccinations recorded on VMS to improve data quality, monitoring and waste reduction. The PHA has also strengthened controls over regional vaccine distribution by checking deliveries against practice quotas and introducing spot checks of signed delivery documentation. In addition, a new Memorandum of Understanding has been developed between SPPG, DoH, the Regional Pharmaceutical Procurement Service and PHA to clearly define roles and responsibilities for the strategic and operational delivery of vaccination programmes.

As a result of the improvements, the internal audit recommendations have been fully implemented and outstanding issues have been resolved.

Cervical screening

Following publication of the Royal College of Pathologists (RCPATH) review in September 2023, which identified significant performance and oversight failures within the Southern Trust cervical cytology laboratory between 2008 and 2021, the PHA worked closely with the Southern Trust to implement a comprehensive review of affected screening samples. The review, completed in 2024, found that the vast majority of results remained unchanged and independent external validation confirmed the robustness of the review methodology and findings.

Significant regional improvements have since been implemented. Primary HPV screening was introduced across Northern Ireland in December 2023 and laboratory services were consolidated into a single regional service within Belfast Trust from November 2024. Business continuity arrangements are now established with Gateshead Laboratory and a new regional cellular pathology equipment contract was awarded in February 2026. As the contract has been secured and the replacement programme is underway the PHA consider the matter closed from a PHA assurance perspective

The PHA has also strengthened its quality assurance arrangements following an independent peer evaluation by NHS England experts. Most recommendations have been implemented, including enhanced audit arrangements for invasive cervical cancers and the appointment of an independent external Professional and Clinical Advisor. Remaining actions are on track for completion by December 2026.

In response to recommendations arising from published reviews and Serious Adverse Incident investigations, the PHA led regional work to standardise the cervical screening audit and patient disclosure processes. Revised arrangements have now been fully implemented and embedded within routine practice.

The independent review led by Professor Sir Frank Atherton, published in May 2026, concluded that a statutory public inquiry was not required. The PHA has completed its consideration of the review findings and concluded all actions identified as requiring implementation by the Agency. Any wider system actions will be progressed through

normal governance arrangements with the Department of Health and partner organisations.

Substantial progress has been made in addressing the issues identified by the RCPATH review. Key service, quality assurance and governance improvements have been implemented, with remaining actions being progressed through established programmes of work. No significant unresolved assurance concerns have been identified for the PHA, although oversight of the final implementation of outstanding quality assurance recommendations and laboratory equipment replacement arrangements will continue through routine governance processes.

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

Trust Commissioned Services

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

The report highlighted the need to standardise and strengthen the approach to performance management with HSC Trusts and the need to develop a framework of accountability to ensure robust monitoring. The establishment of a formal review process by PHA to ensure services, currently commissioned, are sufficiently aligned to population needs was also identified. The report contains a priority one recommendation which relates to a funding stream from PHA to HSC Trust which no longer falls within the PHA remit. This funding has now been transferred to SPPG who will monitor future performance of the initiative. PHA has established a project team to review Contract Management Processes and consider the audit recommendations. The work of this group, audit requirements and legislative changes connected with the Procurement Act 2023 culminated in the development of a Contract Management

Transformation paper. This paper and the 10 interconnected recommendations were approved by AMT in August 2026. Work is underway to establish a project board comprised of senior leaders across the agency to implement the recommendations over a 24-month period. This work will improve the PHA's contract management processes and systems; strengthen governance, and improve performance and outcomes monitoring, within the context of evolving internal and external operating environments. During 2025/26 significant progress has been made to improve the performance management processes and accountability arrangements. Two of the four outstanding audit recommendations have now been fully implemented and it is anticipated that the remaining two will be fully implemented by the middle of 2026/27.

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

Financial Sustainability and Delivery of a Balanced Financial Position

As at 30 September 2026, the PHA has identified a significant financial risk arising from an unresolved funding gap of £1.682m within its approved Financial Plan for 2026/27. The deficit has arisen following the Department of Health's indicative allocation, which incorporated a 6% reduction in baseline funding, while the Agency has only been able to identify and implement savings equivalent to 4% of baseline expenditure without Departmental approval for further programme reductions.

The Agency has undertaken a comprehensive review of expenditure and identified all reasonable savings opportunities available within its control. Robust financial management arrangements remain in place, and expenditure continues to be closely monitored through established governance processes.

The Agency continues to actively manage the position and engage with the Department of Health regarding potential solutions. However, achievement of an in-year breakeven position remains dependent on the receipt of the necessary approvals and directions relating to proposed programme expenditure reductions.

This position has been further complicated by the continuing uncertainty surrounding the wider Northern Ireland public expenditure environment and the absence of an agreed Northern Ireland budget settlement, requiring organisations to plan on the basis of indicative allocations and constrained funding assumptions. While robust financial controls remain in place, the residual deficit represents a material financial risk which will continue to be actively monitored and managed through the Agency's governance and risk management arrangements.

This issue has been reflected within the Corporate Risk Register and is subject to regular review by the Agency Management Team, Governance and Audit Committee and Board.

12. Mid-Year Assurance Report from Chief Internal Auditor

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

13. Annual Assurance of Fitness of Accounting Officer

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

Signed:

Date:

CHIEF EXECUTIVE & ACCOUNTING OFFICER

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper PHA Assurance Framework

Reference PHA/06/10/26

Prepared by IG Team

Lead Director Leah Scott

Recommendation

For **Approval** ☒

For **Noting** ☐

1 Purpose

The purpose of this paper is to bring the updated PHA Assurance Framework to the Board for approval.

2 Background Information

Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements.

The PHA's Assurance Framework is designed to meet these duties. It provides the systematic assurances required by the PHA Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary in discharging our functions and duties.

3 Key Issues

As per the reporting arrangements documented within the Assurance Framework it is required to review the Framework regularly. This new iteration of the Framework has been titled Assurance Framework 2026/27

A review was carried in each Directorate and Directorates were asked to:

- (1) Update the text were required, and

- (2) Update the template, and record any gaps in controls/assurances along with actions to remove those gaps.

Changes to the document were minimal following this review, consisting mainly of formatting changes. All suggested changes are highlighted in green throughout.

The updated Assurance Framework was approved by the Agency Management Team at its meeting on 12 October 2026 and by the Governance and Audit Committee on 16 October 2026.

4 Next Steps

The next review of the Assurance Framework is due to take place during 2026/27.

Assurance Framework

~~2025-2026~~

2026-2027

Review as at **~~October 2025~~**
October 2026

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INTRODUCTION

The Public Health Agency (PHA) has a duty to carry out its responsibilities within a system of effective control and in line with the objectives set by the Minister for the Department of Health (DoH). It must also demonstrate value for money, maximising resources to support the highest standards of service.

A key element of a system of effective control is the management of risk. It is vital the PHA discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible to meet corporate objectives and to continuously improve quality and outcomes. This means that equal priority needs to be given to the obligations of governance across all aspects of the organisation whether financial, organisational or clinical and social care and for governance to be an integral part of the organisation's culture. Good governance depends on having clear objectives, sound practices, a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements.

In order to meet these duties, the PHA has prepared this Assurance Framework. The framework will provide the systematic assurances required by the PHA Board on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary in discharging our functions and duties.

BACKGROUND

In April 2009, DHSSPS issued 'An Assurance Framework: *A Practical Guide for Boards of DHSSPS Arm's Length bodies*'. The Framework guidance is intended to help the boards of HSC organisations improve the effectiveness of their systems of internal control, by showing how the evidence for adequate control can be marshalled, tested and strengthened within an Assurance Framework.

The HSC Paper Performance and Assurance Roles and Responsibilities (MIPB 74/09) issued in April 2009, sets out performance and assurance roles and responsibilities in relation to four key HSC domains and identifies the key functions and associated roles and responsibilities of DoH, HSCB (now SPPG), PHA, BSO, Trusts and other Arm's Length Bodies.

In September 2011, the then DHSSPS produced a Framework Document to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. The Framework Document outlines the four performance and assurance dimensions previously introduced in the MIPB 74/09 paper.

For ease of reference, please see a Glossary of terms at Appendix A

STRATEGIC CONTEXT

The Programme for Government (PfG) Framework sets out the major outcomes which the Northern Ireland Executive aim to achieve for Northern Ireland society. By setting clear priorities, the PfG Framework informs the targeting of funds. PHA reflects these priorities and strategic outcomes in their own strategic directions and sets them out in PHA's Corporate Plan.

The PHA is governed by Statutory Instruments: HPSS (NI) Order 1972 (SI 1972/1265 NI14), the HPSS (NI) Order 1991 (SI 1991/194 NI1), the Audit and Accountability (NI) Order 2003 and the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The primary functions of the PHA can be summarised under 3 broad headings:¹

- Improving health and social well-being and reducing health inequalities;
- Health protection;
- Professional input to commissioning of health and social care services and providing professional leadership.

In carrying out these functions the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being. The PHA also has a range of statutory duties in the area of Public Health and PPI under the duty to Involve and Consult. It is also responsible for the commissioning and quality assurance of existing and new screening programmes. In discharging these duties the Agency shall maintain the highest standards of decision-making. The detail of these duties is set out in various legislation, regulations or other guidance documents.

The Agency's Business Plan 2025/2026 sets out the key priorities that will be taken forward by the PHA that will help to improve health and social wellbeing and protect the health of the community. The priorities and targets set have been shaped by the Departmental priorities and the longer-term goals that have been set out in the PHA Corporate Plan 2025-2030. The Business Plan is focused around the 5 key outcomes as set out in the Corporate Plan 2025-2030. These are:

- That our population is protected from threats to health arising from infectious diseases and environmental hazards and that we reduce death and ill health through effective screening.
- That all children and families in Northern Ireland have the healthiest start in life.
- That all people in Northern Ireland can live longer, healthier and independent

¹ DHSSPS Framework Document September 2011

lives.

- That people live healthier, independent lives for longer.
- That we are an exceptional organisation, working effectively to improve health and wellbeing for everyone.

- ~~All children and young people have the best start in life~~
- ~~All older adults are enabled to live healthier and fulfilling lives~~
- ~~All individuals and communities are equipped and enabled to live long healthy lives~~
- ~~All health and wellbeing services should be safe and high quality~~
- ~~Our organisation works effectively~~

PHA ASSURANCE FRAMEWORK

The PHA Assurance Framework sets out how PHA can be assured that the objectives of the Agency can be achieved. The layout of the Framework is based on the four performance and assurance dimensions also known as the 'Four Dimensions of Governance' as set out in the Department of Health Social Services and Public Safety ('DHSSPS') Framework Document September 2011.

The Four Dimensions are:

1. **Corporate Control** – the arrangements by which the PHA directs and controls its functions and relates to stakeholders;
2. **Safety and Quality** – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and client's needs, including appropriate involvement;
3. **Finance** – the arrangements for ensuring the financial stability of the PHA, for ensuring value for money and for ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework; and
4. **Operational Performance and Service Improvement** – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

The Framework Document states that "each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance."

The PHA Assurance Framework must also link with its corporate objectives and risks.

An effective Assurance Framework provides a clear, concise structure for reporting key information to boards, and should be read alongside the corporate risk register to provide structured assurance about how risks are managed effectively to deliver agreed objectives.

The following tables on pages 9 - 13 form the basis of the Assurance Framework and have been structured according to the DOH performance and assurance dimensions, with a link to the relevant corporate objectives and primary risks.

This Assurance Framework provides the organisation with a simple but comprehensive method for effectively managing the principal risks to meet its objectives. It also provides a structure for acquiring and examining the evidence to support the Governance Statement and the Mid-Year Assurance Statement.

LINKS TO OTHER PHA POLICIES AND DOCUMENTS

The following policies and documents should be read in conjunction with the PHA Assurance Framework:

- [PHA Risk Management Strategy and Policy](#)
- [PHA Corporate Risk Register](#)
- [PHA Corporate Plan 2025-2030](#)
- [PHA Annual Business Plan 2025/26 2026/27](#)
- [PHA Corporate Governance Framework](#)
- PHA Board Performance Framework

REVIEW AND APPROVAL

The Assurance Framework will be reviewed on an annual basis. It will be brought to the Governance and Audit Committee for approval annually, and the PHA board, for approval annually.

Dimension 1 – Corporate Control

The dimension of ‘corporate control’ encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the PHA is fulfilling its essential obligations as a public body. For that reason, most of the requirements reflect those in place across the wider public sector; however, there are a number that have been instituted specifically for the field of health and social care, notably the statutory duty of care created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, and the statutory duty to Involve and Consult with the recipients of health and social care created by sections 19 and 20 of the HSC (Reform) Act (NI) 2009.

The staple public sector requirements include the existence of appropriate board roles, structures and capacity; compliance with prescribed standards of public administration, national or regional policy on procurement and pay, operation of a professional internal audit service and corporate and business planning approvals. The accounting officer letter of appointment spells out the principles underlying many of these obligations, while the letters appointing chairs and non- executive members of the board also gives due emphasis to this aspect of the appointees’ duties.

The table below highlights the corporate control requirements for the PHA along with how the PHA meets each obligation by way of providing assurances to the board and its Committees.

Dimension 1 – PHA Corporate Control Arrangements

Link to Corporate Objectives:

Corporate Objective 5 – Our organisation works effectively

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Governance Statement signed by the Chief Executive	Chief Executive	AMT GAC Board	Approval Approval Approval	Annually Annually Annually	All risks in the Corporate Risk Register		
Mid-Year Assurance Statement signed by the Chief Executive	Chief Executive	AMT GAC Board	Approval Approval Approval	Annually Annually Annually	All risks in the Corporate Risk Register		
PHA Annual Report	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Annually Annually Annually			
Corporate Plan	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	4-5-yearly 4-5-yearly 4-5-yearly			
Annual Business Plan	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Annually Annually Annually			
Corporate Risk Register (supported by Directorate Risk Registers)	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Quarterly Quarterly Quarterly			
Assurance Framework	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Annually Annually Annually			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Board Performance Framework	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Annually Annually Annually			
ALB Self-Assessment	Chair	Board	Approval	Annually			
Sealing of Documents	Chief Executive	Board	Approval	As required			
Review of Standing Orders and Standing Financial Instructions	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Annually Annually Annually		Completed Oct 24 presented AMT and GAC approved subject to clarification of PHA statutory roles & responsibilities.	Continues to be an issue in the 2025 review: Clarification required from DoH regarding PHA commissioning and issuing of revised framework to reflect same.
Partnership Agreement	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	3-yearly 3-yearly 3-yearly			
Register of Board Members Interests	Director of Finance and Corporate Services	Board	Noting	Annually			
Gifts and Hospitality Register	Director of Finance and Corporate Services	AMT GAC	Noting Noting	Annually Annually			
Minutes of Governance and Audit Committee	Committee Chair	GAC Board	Approval Noting	Quarterly Quarterly			
Governance and Audit Committee Annual Report	Director of Finance and Corporate Services	GAC Board	Approval Noting	Annually Annually			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Internal Audit Plan	Head of Internal Audit	GAC	Approval	Annually			
Internal Audit Reports	Head of Internal Audit	GAC	Noting	Annually			
Mid-Year and End-Year Head of Internal Audit Report	Head of Internal Audit	GAC	Noting	Annually			
Governance and Audit Committee Self-Assessment Checklist	Committee Chair	GAC	Approval	Annually			
Minutes of Planning, Performance and Resources Committee	Committee Chair	PPR Board	Approval Noting	Quarterly Quarterly			
Minutes of Remuneration and Terms of Service Committee	Chair	RTSC Board	Approval Noting	Biannually Biannually			
Remuneration of Executive Directors	Chair	RTSC Board	Approval Approval	Annually Annually			
Report on Progress in respect of Equality and Disability Duties under Section 75 of the Northern Ireland Act 1998 and Disability Section 49a of the Disability Discrimination Order (DDO) 2006	Director of Finance and Corporate Services	AMT Board	Approval Approval	Annually Annually			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Equality Scheme and subsequent review	Director of Finance and Corporate Services	AMT Board	Approval Approval	5-yearly 5-yearly			
Equality and Disability Action Plan	Director of Finance and Corporate Services	AMT Board	Approval Approval	5-yearly 5-yearly			
Article 55 Review (report to Equality Commission on staffing composition)	Director of Finance and Corporate Services	AMT HR/OD Cttee Board	Approval Approval Approval	3-yearly 3-yearly 3-yearly		Currently in progress with an expectation that the analysis and report will be available by end of December 2026	
Rural Needs Annual Monitoring Report	Director of Finance and Corporate Services	AMT	Approval	Annually			
Information Governance Strategy 2023-2026	Director of Finance and Corporate Services	AMT IGSG GAC Board	Approval Approval Approval Approval	3-yearly 3-yearly 3-yearly 3-yearly	Risk 39 – Cyber Security		
Information Governance Action Plan	Director of Finance and Corporate Services	AMT IGSG GAC	Noting Noting Approval	3 per year 3 per year 3 per year	Risk 39 – Cyber Security		
PPI Update Report	Director of Nursing and AHPs	AMT Board	Noting Noting	Annually Annually			
Approval of new/revised PHA strategies and policies	Relevant Director	AMT Committee Board	Approval Approval Approval	As required As required As required			
Business Continuity Plan (Annual Review)	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Annually Annually Annually			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Joint Report on Emergency Preparedness	Director of Public Health	AMT GAC Board	Approval Approval Approval	Annually Annually Annually	Risk 75 – Pandemic preparedness	Drafted but delayed due to Pegasus. DoH advised.	Planned for presentation to AMT Nov 25
Complaints, Compliments and Claims Report	Chief Executive	AMT GAC Board	Approval Approval Approval	Quarterly Quarterly Quarterly			
PHA Health and Safety, Fire Safety and Security Annual report	Director of Finance and Corporate Services	AMT Board	Approval Noting	Annually Annually			

Dimension 2 – Safety and Quality

The second dimension covers the arrangements whereby the PHA ensures that health and social care services, are safe and effective and meet people's needs. This covers a broad field and applies to all programmes of care and to infrastructure.

In addition to the numerous operational/professional requirements that concern or touch on safety and quality, there are more general requirements with which compliance is demanded. In the latter category, those issued by DoH include the Quality Standards², Care Standards, and applicable Controls Assurance standards. The most notable, being the statutory duty of quality created under the HPSS (Quality, Improvement and Regulation) (NI) Order 2003.

The table below highlights the safety and quality functions required by the PHA. It also shows how the PHA meets each obligation by way of providing assurances to the board and its Committees.

² The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DHSSPS, March 2006)

Dimension 2 - Safety and Quality

Link to Corporate Objectives:

Corporate Objective 1 – All children and young people have the best start in life

Corporate Objective 2 – All older adults are enabled to live healthier and fulfilling lives

Corporate Objective 3 – all individuals and communities are equipped and enabled to live long healthy lives

Corporate Objective 4 – All health and wellbeing services should be high quality

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Reports on Safety/Quality issues • Serious Adverse Incidents • Annual Safety and Quality assurance report • Quality Improvement Plans • 10,000 Voices • Care Opinion • Implementation of RQIA and other independent review recommendations relevant to PHA • Annual Quality report • Professional governance report • Annual joint Learning report	Director of Nursing and AHPs	AMT GAC Board	Noting Noting Noting	As required As required As required	Reports on Safety/Quality issues • Serious Adverse Incidents • Quality Improvement Plans • 10,000 Voices • Care Opinion • Implementation of RQIA and other independent review recommendations relevant to PHA		

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Family Nurse Partnership Annual Report	Director of Nursing and AHPs	AMT Board	Approval Approval	Annually Annually			
~~Annual Quality Report~~	~~Director of Nursing and AHPs~~	~~AMT Board~~	~~Approval Approval~~	~~Annually Annually~~			
Director of Public Health Annual Report	Director of Public Health	AMT Board	Noting Noting	Annually Annually		Paused during time when PHA had large numbers of consultant vacancies	DPH to consider how this is resumed and what format
Population Screening Annual Reports	Director of Public Health	AMT Board	Approval Noting	Annually Annually	Risk 59 – Quality Assurance and Commissioning of Screening		
Health Protection Annual Reports	Director of Public Health	AMT Board	Noting Noting	Annually Annually		Not reported for some years	Proposal to replace with the Annual report from Public Health Planning Teams
Research and Development Annual Report	Director of Public Health	AMT Board	Noting Noting	Annually Annually			
GMC Revalidation / Appraisal – Assurance of Annual Appraisal Cycle	Director of Public Health	AMT Board	Noting Noting	Annually Annually		Not reported for some years	DPH to oversee resumption
Confirmation of Progress against NIMDTA/GMC Requirements for Doctors in Training	Director of Public Health	AMT Board	Noting Noting	Annually Annually			

Dimension 3 – Finance

Appropriate financial accountability mechanisms are necessary to:

- Ensure that the optimum resources ~~are secured from the Executive~~ for Health and Social Care **are secured from the Executive**
- Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money
- Deliver and maintain financial stability
- Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost
- Facilitate the development of innovative and effective models of care

The table below highlights the PHA finance requirements. It also identifies how the PHA meets each obligation by way of providing assurances to the board and its Committees.

Dimension 3 - Finance

Link to Corporate Objectives:

Corporate Objective 5 – Our organisation works effectively

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Finance Report	Director of Finance and Corporate Services	AMT Board	Noting Noting	Monthly Monthly			
PHA Financial Plan	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Annually Annually Annually	Risk 73 – Financial Planning context 2025/26		
Annual Report and Accounts <i>GAC and PHA board full accounts and supporting financial excerpt from Annual Report.</i> <i>AMT summary financial statements</i>	Director of Finance and Corporate Services	AMT GAC Board	Approval Approval Approval	Annually Annually Annually		Not formally presented to AMT prior to the board due to time constraints	Financial Report shared in advance and full accounts shared at Board and with GAC members and Chief Executive when draft complete. Issues discussed as necessary.
External Audit Report to those Charged with Governance	External Audit	AMT GAC Board	Review Review Review	Annually Annually Annually		Not formally presented to AMT prior to the board due to time constraints	Discussed with AMT officers for management responses.
Fraud Prevention and Detection Report	Director of Finance and Corporate Services	GAC	Noting	Quarterly			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Use of External Management Consultants	Director of Finance and Corporate Services	AMT	Noting	Annually			
PHA capital expenditure in excess of £50,000 or £1.5m for R&D capital expenditure. Note – May be required to be submitted to DoH/DoF dependant on delegated limits.	Director of Finance and Corporate Services	AMT Board	Approval Approval	As required As required			
Disposal of PHA assets in excess of £50,000	Director of Finance and Corporate Services	AMT Board	Approval Approval	As required As required			

Dimension 4 – Operational Performance and Service Improvement

Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and Ministerial objectives and targets.

The table below highlights the PHA requirements identifying how the PHA meets each obligation by way of providing assurances to the board and its Committees.

Dimension 4 – Operational Performance and Service Improvement

Link to Corporate Objectives:

Corporate Objective 1 – All children and young people have the best start in life

Corporate Objective 2 – All older adults are enabled to live healthier and fulfilling lives

Corporate Objective 3 – all individuals and communities are equipped and enabled to live long healthy lives

Corporate Objective 4 – All health and wellbeing services should be high quality

Corporate Objective 5 – Our organisation works effectively

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Annual Business Plan Performance Report (including Commissioning Direction targets and corporate objectives)	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Quarterly Quarterly Quarterly			
Commissioning Plan	Chief Executive	AMT Board	Approval Approval	Annually Annually		Not been compiled – Commissioning Plan from 2019/20 remains the extant Plan	Ongoing work to redefine roles of commissioning in HSC lead by DOH/PHA/SPPG
PEMS Report	Director of Finance and Corporate Services	AMT Board	Approval Noting	Annually Annually		Not reported in a number of years	Replaced by Contract performance reports and PHPT annual reports
Procurement Plan and Contract Performance report	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Annually Annually Annually			
Verbal update to Board on Accountability	Chief Executive	Board	Noting	Biannually			

Principal Area / Function / Reporting Arrangement	Lead Director	Existing Controls / Assurances			Link to Corporate Risk Register	Gaps in Controls / Assurances	Actions to Remove Gaps
		Level	Purpose	Frequency			
Review meetings between PHA Chief Executive and Trust Chief Executives.							
PHPT 3 year Strategic Plans	Director of Finance and Corporate Services	AMT PPR Board	Approval Approval Approval	Every 3 years			
PHPT End of Year Reports	Director of Finance and Corporate Services	AMT PPR	Approval Approval	Annually Approval			
PHPT Annual Action Plans	Director of Finance and Corporate Services	AMT PPR	Approval Noting	Annually Annually			

Glossary

- **(AHP)** Allied Health Professionals
- **(AMT)** The Agency Management Team
- **(board)** PHA Board
- **(DoF)** Department of Finance
- **(DoH)** Department of Health
- **(DHSSPS)** Department of Health, Social Services and Public Safety
- **(GAC)** Governance and Audit Committee
- **(GMC)** General Medical Committee
- **(HPSS)** the Health and Personal Social Services (Northern Ireland) Order
- **(HSC)** Health & Social Care
- **(IGSC)** Information Governance Steering Group
- **(Minister)** Minister for Health, Social Services and Public Safety
- **(NIMDTA)** Northern Ireland Medical and Training Agency
- **(PEMs)** Programme Expenditure Monitoring System
- **(PfG)** Programme for Government
- **(PHA)** Public Health Agency
- **(PPI)** Personal and Public Involvement
- **(PPR)** Planning, Performance and Resources
- **(Reform Act)** the Health & Social Care (Reform) Act (Northern Ireland) 2009
- **(R&D)** Research & Development
- **(RQIA)** The Regulation and Quality Improvement Authority
- **(RTSC)** Remuneration and Terms of Service Committee
- **(SPPG)** Strategic Planning and Performance

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Annual Quality Report

Reference PHA/07/10/26

Prepared by Shannon Black and Grainne Cushley

Lead Director Emily Roberts

Recommendation

For **Approval** ☒

For **Noting** ☐

1 Purpose

The purpose of this paper is to approve the 2025/26 Annual Quality Report.

2 Background Information

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

This is the PHAs thirteenth Annual Quality Report. The aim of the report is to share information and demonstrate improvements both to those who use health and social care services and those who deliver them.

The DoH issued guidance on the content of the Annual Report and the expected timescales for completion. The DOH has stated they no longer need to review the publication before formal publication on the 12th November 2026, 'World Quality Day' in conjunction with all HSC Trust and ALB Annual Quality reports.

3 Key Issues

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

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

4 Next Steps

Following approval by the PHA Board, the Annual Quality Report will be sent to the Department of Health for publication on World Quality Day on the 12th November 2026.



ANNUAL QUALITY REPORT 2025/26



Transforming
the Culture



Strengthening
the Workforce



Measuring
Improvement



Raising the
Standards



Integrating
the Care



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

I am pleased to present our thirteenth Annual Quality Report, covering the period from 1 April 2025 to 31 March 2026.

This report highlights the significant work undertaken across the Agency to improve the quality, safety and effectiveness of health and social care services for the population of Northern Ireland. It demonstrates our continued commitment to supporting improvement, reducing harm and delivering better outcomes through partnership working, innovation and evidence-based practice.

Throughout the year, PHA has worked closely with the Department of Health, Strategic Planning and Performance Group, Health and Social Care Trusts, local government, community and voluntary organisations, and service users to drive improvements across a wide range of programmes. The achievements outlined in this report reflect the dedication of our staff and partners in addressing both current challenges and future priorities.

We continue to operate within a complex and demanding environment, characterised by increasing demand, workforce pressures and financial constraints. Despite these challenges, our focus remains on delivering high quality services, supporting learning and improvement, and placing the needs of patients, service users and communities at the centre of everything we do.

I would like to thank all staff, partners, carers, volunteers and service users who have contributed to the achievements described within this report. Their commitment and collaboration have been instrumental in helping us improve health and wellbeing outcomes across Northern Ireland.

As we look ahead, we remain committed to working together to improve quality, strengthen services and support better outcomes for the people we serve.

Thank you

Aidan Dawson
Chief Executive
Public Health Agency



Transforming the culture

INTRODUCTION

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

PHA continue to work in partnership with SPPG, DoH policy leads and HSC Trusts the redesign the current SAI Procedure. The project will seek to address the recommendations from the Inquiry into Hyponatraemia-related Deaths and the Independent

Neurology Inquiry alongside recommendations from the RQIA Review of Systems and Processes for Learning from SAls.

The recommendations from these reports have provided a strong evidence base to support the development and introduction of a new framework which will support the identification, review, capture and embedding of learning from healthcare incidents or events.



1. Serious Adverse Incidents: Monitoring, Learning and Improving Together

The PHA and the Strategic Planning and Performance Group (SPPG) continue to work collaboratively to monitor, review and learn from Serious Adverse Incidents (SAIs) across Health and Social Care services in Northern Ireland. Through the analysis of SAI data and the dissemination of learning identified through reviews, both organisations support a culture of openness, learning and continuous improvement. This work helps identify emerging risks, strengthen systems and improve the safety and quality of care for patients and service users.

What We Did

During 1 April 2025 to 31 March 2026, 479 SAI notifications were reported across HSC organisations. Learning was shared on recognition and management of deteriorating patients, delayed diagnosis and treatment, medication safety, medical device issues, communication and documentation failures, and escalation of care. This learning was promoted through publications, presentations, networks and quality improvement forums to support safer practice across the system.

Table 1. SAIs by Reporting Organisation

Category	Number
BHSCT	107
NHSCT	90
NIAS	45
PCARE	6
SEHSCT	94
SHSCT	66
WHSCT	71
TOTAL	479

Table 2. SAIs by Level of Review

Category	Number
Level 1	427
Level 2	47
Level 3	5
TOTAL	479

Table 3. SAIs by Programme of Care

Category	Number
Acute Services	228
Maternity and Child Health	50
Family and Childcare (inc CAMHS)	23
Older People	33
Mental Health	119
Learning Disability	16
Physical Disability and Sensory Impairment	1
Primary Health and Adult Community	6
Corporate Business/Other	2
Health Promotion and Disease Prevention	1
TOTAL	479



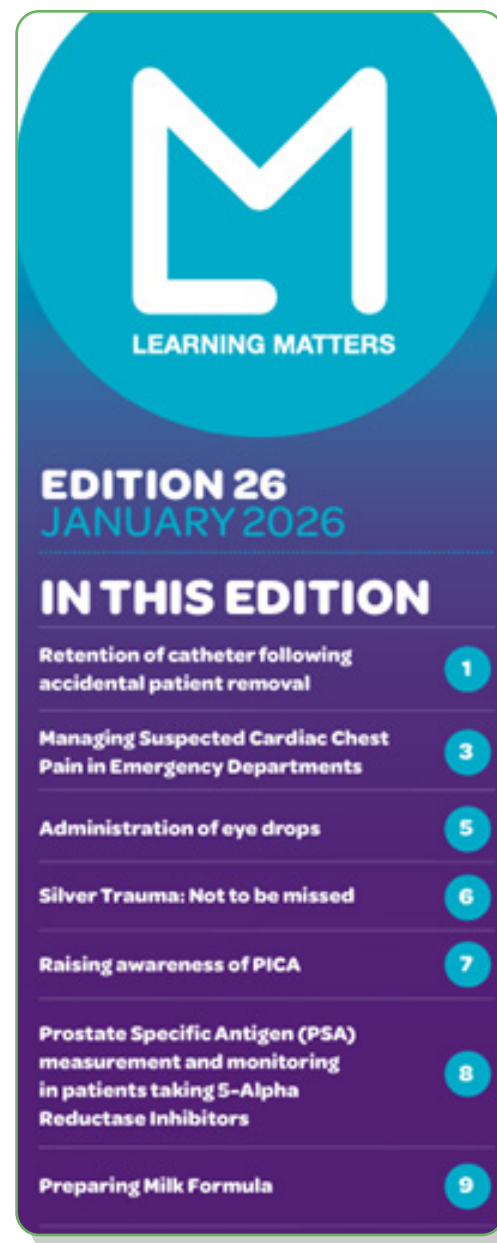


Outcomes

- ▶ Learning from SAIs was shared widely through newsletters, presentations, networks and quality improvement forums.
- ▶ Staff were provided with accessible case-based examples to support safer practice.
- ▶ Learning identified in one organisation was shared across the wider HSC system.
- ▶ Awareness of evidence-based guidance and patient safety resources was increased.
- ▶ A culture of openness, reflection and continuous improvement was reinforced.
- ▶ Regional collaboration between PHA, SPPG and HSC organisations was strengthened.

Looking Ahead

PHA and SPPG will continue to review SAI data, identify emerging trends and share learning across the HSC system. Future work will focus on enhancing the accessibility of learning resources, increasing staff engagement with safety learning and strengthening evidence of how shared learning leads to safer outcomes.





2. Strengthening Complaints Handling and Learning Through Implementation of the Model Complaints Handling Procedure



A significant milestone for Health and Social Care (HSC) during 2025/26 was the introduction of the new Model Complaints Handling Procedure (MCHP), published by the Northern Ireland Public Services Ombudsman (NIPSO) on 1 July 2025 and fully implemented across Health and Social Care from 1 January 2026. The MCHP establishes a consistent, accessible and transparent approach to complaints handling, with a strong emphasis on early resolution, learning and service improvement.

The introduction of the MCHP provided an opportunity not only to align local complaints processes with the new statutory requirements, but also to strengthen regional arrangements for the oversight, analysis and use of complaints information to support quality improvement and patient safety. The MCHP reinforces the principle that complaints are a valuable source of insight and should be used proactively to identify opportunities for learning and improvement across the health and social care system.

As a HSC organisation in its own right, the PHA reviewed and strengthened its own complaints handling processes to ensure they reflected the standards, governance requirements and learning-focused approach set out within the MCHP. Alongside this in preparation for implementation, the PHA worked collaboratively with Strategic Planning and Performance Group (SPPG) as leads, HSC Trusts, Primary Care colleagues and other stakeholders to develop a new regional complaints dataset. Introduced from April 2025, the dataset established a consistent approach to the recording and reporting of complaints across all organisations.

Key enhancements included the introduction of standardised complaint categories and sub-categories, improved speciality and programme of care coding, and the collection of additional information relating to complaint outcomes, extensions, links to adverse incidents and referrals to NIPSO.

The dataset has strengthened the quality of information available at both local and regional levels. Complaints can be analysed consistently across organisations, enabling the identification of emerging themes, trends and areas of concern. This has improved the ability to triangulate complaints data with information from other governance and safety processes, supporting a more comprehensive understanding of service quality and patient experience.

The strengthened arrangements reflect a wider commitment across HSC to fostering a culture in which complaints are welcomed, valued and used as a catalyst for improvement. Through improved data quality, enhanced analysis and stronger governance processes, organisations are better positioned to identify learning, understand patient and service user experiences, and inform improvement activity. These developments support the overarching aims of the MCHP and contribute to ongoing efforts to improve safety, quality and person-centred care across the HSC system.

For more information - [Model Complaints Handling Procedures | NIPSO](#)



3. Strengthening the culture of person – centred care

Patient Quote *“Our world shattered into a million pieces, all within a few seconds of hearing the one word – Cancer!”*

The PHA Nurse Consultant Cancer lead a Test of Change project introducing the role of the Macmillan Personalised Care Support Worker (PCSW). The project commenced in January 2025 for 14 months exploring how a dedicated cancer support worker role could strengthen the cancer workforce and improve delivery of personalised care. The PCSW worked alongside Cancer Nurse Specialists and the wider multidisciplinary team to support people living with and beyond cancer.

The role focused on providing proactive person-centred support, undertaking holistic needs assessments, supporting care planning, facilitating health and wellbeing conversations, signposting to community and voluntary sector services, and helping patients navigate the cancer pathway. These actions help address the strategic theme of Living Well, ensuring that people with a cancer diagnosis can access local community support to maximise their wellbeing. This strongly enables several actions within the Northern Ireland Cancer Strategy and aligns to the principles of the RESET and the Neighbourhood model. The PCSW provided practical and emotional support to people living with cancer whilst enabling registered professionals to work at the top of their scope of practice.

Throughout the Test of Change, activity data, patient feedback and staff feedback were collected to evaluate the impact of the role on workforce capacity, patient experience and service delivery. The evaluation examined how the PCSW contributed to service efficiency, addressed unmet needs and strengthened multidisciplinary working across the cancer pathway.

Outcomes:

- ▶ **2,026 patients** were offered a Holistic Needs Assessment across participating Trusts.
- ▶ **570 personalised care plans** were generated, supporting delivery of personalised care.
- ▶ The most common non-clinical concerns identified were **fatigue, anxiety/worry, sleep difficulties, financial concerns and uncertainty about the future**, enabling earlier intervention and support.
- ▶ **65% of interventions (308 patients)** required Level 3 or Level 4 support, demonstrating significant unmet psychosocial and practical needs.
- ▶ Delivery of HNAs by PCSWs released an estimated **570 hours of CNS time** for complex clinical care.



- ▶ Completing HNAs through the PCSW model cost approximately **£13 per hour compared with £24 per hour for CNS delivery**, providing an estimated workforce efficiency benefit of **£6,270**
- ▶ CNSs reported increased capacity for face-to-face clinical care, treatment discussions and key worker responsibilities.
- ▶ Patients reported feeling more supported, informed and in control of their care, with feedback highlighting the value of personalised conversations and ongoing support.

Patient Quote *“HNA – Excellent service.... One of the most important calls I have ever received”*

The evaluation provided sufficient evidence for Macmillan, in line with their strategic vision for personalised care, to commit **£1.6 million of investment** to support regional rollout of the model, funding 2 whole time equivalent PCSWs per HSC Trust.



4. Experience and Involvement: Using People's Voices to Improve Safety and Quality

During 2025/26, the PHA continued to gather and review feedback from service users, carers and families through Patient and Client Experience (PCE), and to monitor Personal and Public Involvement (PPI) activity across Health and Social Care organisations.

These sources provide valuable insight into people's experiences of care and help identify areas of good practice, concerns requiring attention and opportunities for improvement that may not otherwise be recognised.

Care Opinion stories relating to safety and/or quality were reviewed to understand the nature of people's experiences, ranging from positive and neutral feedback through to concerns about clinical and non-clinical care.

Alongside this, regional PPI monitoring provided information on involvement activity across HSC organisations and the outcomes being reported as a result of involving service users, carers and communities in the development and improvement of services.

Taken together, experience and involvement data provide an additional source of intelligence about quality and safety from the perspective of people who use services. This helps ensure that the voices of service users and carers form part of wider learning and improvement across Health and Social Care.





5. Age Friendly Awareness Training

Between 16 and 31 March 2026, PHA commissioned Delivering Options through Tailored Solutions (DOTS) to deliver an Age Friendly Awareness Training Programme across Northern Ireland to increase understanding of ageing, challenge ageism, and strengthen the ability of organisations to provide age-friendly services. Four face-to-face workshops were held in Ballymena, Derry/Londonderry, Lisburn and Omagh, bringing together participants from statutory, community and voluntary, and local business sectors. The programme was aligned with the World Health Organisation (WHO) Age-Friendly Framework and used an interactive learning approach. Participants took part in reflective discussions, organisational self-assessment activities, and experiential exercises focused on communication, accessibility and inclusion. To deepen understanding, the sessions included ageing simulation suits, visual impairment simulation tools, and lived-experience vox pop videos. Supporting resources, including a workshop booklet, presentation materials and a pre-recorded webinar, were provided to all participants. The webinar was also developed as a sustainable learning resource to support ongoing staff development, induction and organisational learning beyond the workshop programme.



Age Friendly

Outcomes:

- ▶ 89 individuals registered for the training programme and 70 attended in person.
- ▶ An additional 101 online webinar views were recorded by 31 March 2026.
- ▶ Total programme engagement reached 171 individuals across in-person and online learning opportunities.
- ▶ Participants reported increased understanding of ageing and age-related challenges.
- ▶ Hands-on simulation activities improved empathy and awareness of barriers experienced by older people.
- ▶ Participants identified practical actions to improve age friendliness within their own services and organisations.
- ▶ Organisations reported increased staff confidence and capacity to deliver inclusive, age-friendly services.
- ▶ Feedback was overwhelmingly positive, highlighting the quality of facilitation, interactive learning methods, networking opportunities and practical relevance of the programme.



6. e-Bug and STEM Ambassador Collaboration

e-Bug is a health education programme for infection prevention and antimicrobial resistance (AMR) and is available for free to teachers and community educators.

The e-Bug platform was actively promoted across the region through a collaborative initiative between PHA and STEM Ambassadors, with the aim of increasing awareness and understanding of antimicrobial resistance (AMR) and infection prevention among school-aged children. As part of this initiative, STEM Ambassadors delivered engaging and interactive e-Bug lessons to pupils in 15 schools, reaching a diverse audience across primary and post-primary education settings.

The lessons were designed to introduce key concepts relating to microbes, the spread of infection, appropriate hygiene practices, and the responsible use of antibiotics. Through practical activities, discussions, and age-appropriate educational resources, pupils gained a greater understanding of how infections can be prevented and why antibiotics should be used responsibly. Educating our children and young people about the threat from AMR and the actions they can take to prevent it is crucial to building a health literate population who can take actions to protect antimicrobials for future use.

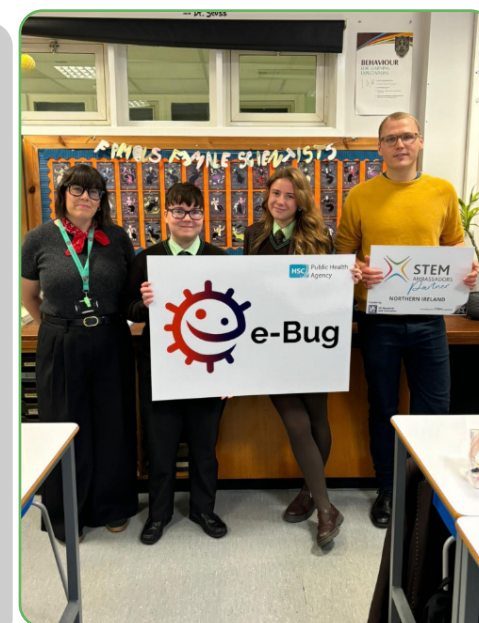
The involvement of STEM Ambassadors brought real-world scientific knowledge and expertise into the classroom, helping to inspire interest in science while reinforcing important public health messages. Their participation also supported teachers in delivering curriculum-linked learning on health, hygiene, and microbiology.

Due to the success of the collaboration, the initiative was submitted into a competitive tender for a National Institute Health Research (NIHR) funded Public Health Interventions Responsive Studies Team (PHIRST) evaluation which has been successfully awarded and will start in August 2026.



Outcomes:

- ▶ AMR and infection prevention principles were taught to approximately **450 primary and post primary pupils**
- ▶ Feedback from STEM ambassadors and participating schools was overwhelmingly positive, and especially where STEM ambassadors from Key Stage 4 delivered lessons to primary school pupils.
- ▶ The initiative successfully raised the profile of the e-Bug platform as a valuable educational resource.
- ▶ The programme strengthened efforts to embed antimicrobial resistance (AMR) awareness within school communities.
- ▶ Early engagement with young people helped build long-term understanding of: Infection prevention, and responsible use of antibiotics



	EYFS	KS1	KS2	KS3	KS4
Introduction to Microbes					
Useful Microbes					
Harmful Microbes					
Hand Hygiene					
Respiratory Hygiene					
Oral Hygiene					
Food Hygiene					
Animal and Farm Hygiene					
Sexually Transmitted Infections					
Vaccinations					
Antibiotics					
Antimicrobial resistance					

Vector Borne Disease – In testing phase





7. Pioneering Clinical Trials Centre increases opportunities for people to take part in research



Research is at the heart of transforming our Health and Social Care system, improving patient outcomes and supporting economic growth; evidence shows that research active hospitals have better patient outcomes.

Following an investment from the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) Investment Programme, the SEHSCT in partnership with HSC Research & Development Division launched a new Clinical Trial Centre at the Ulster Hospital site.

Equipped with 23 rooms, the Ulster Hospital Clinical Trials Centre includes consultation examination rooms, a meeting room, a dedicated drug dispensary, a central observation unit for drug monitoring (including overnight stays), an infusion suite and an onsite laboratory testing area linked to the hospital's core laboratory.

Through taking part in clinical trials research participants often receive cutting-edge medications at no cost to the NHS, while helping accelerate the development of new therapies and medical technologies that improve outcomes for future generations.

The research taking place at the new Centre will benefit patients directly, targeting the conditions that affect them most and attracting research that will provide them with faster access to life-changing treatments.

Outcomes:

- ▶ A new 23 room Clinical Trial Centre was launched at the Ulster Hospital site.
- ▶ The facility will significantly broaden the scope and scale of research available to patients in the South Eastern Trust and beyond.
- ▶ Among the first to benefit from the new Centre is cardiology research patient, Moya Gibson from Groomsport, who is taking part in the VICTORION-1-PREVENT study. Moya has been identified as being at very high risk for future heart disease. Traditional risk factors such as high blood pressure and cholesterol can be easily identified and treated. Her condition causes her to have episodes of dizziness.
- ▶ VICTORION-1-PREVENT is a pivotal Phase III global clinical trial that assesses the effectiveness of the investigational drug, Inclisiran. This is a brand-new type of drug for cholesterol reduction and it may help prevent cardiovascular events in adults at high risk for heart disease. The study involves around 14,000 participants across 45 countries, aiming to better understand how the drug may help reduce "bad" LDL cholesterol levels and prevent heart attacks or strokes.
- ▶ Clinical research within Health and Social Care offers significant benefits, giving patients early access to medical breakthroughs, innovative treatments and improved care



Opening the new centre is L/R: Roisin Coulter (Chief Executive, South Eastern Trust), Health Minister, Mike Nesbitt, MLA, Professor Patrick Donnelly (Clinical Research Director and Consultant Cardiologist, South Eastern Trust), Dr Rhonda Campbell (Assistant Director of Health and Social Care Research & Development (HSC R&D)) & Professor Ian Young, (Chief Scientific Officer, Department of Health)



Aaron McGibbon (Research & Development Governance Co-Ordinator, South Eastern Trust) and Stephanie Kelly (Research Manager, South Eastern Trust) with Health Minister, Mike Nesbitt MLA



8. Roadshows for World Antimicrobial resistance Awareness Week

The health protection team, with support from colleagues across PHA and other partner organisations, went on a roadshow across the region to increase public awareness and understanding of antimicrobial resistance (AMR), infection prevention, and the responsible use of antibiotics. The roadshow visited five different venues, with one event taking place in each Health and Social Care Trust area, ensuring broad geographical coverage and providing opportunities to engage with a diverse range of communities.

The events were designed to raise the profile of AMR as a significant public health issue and to encourage individuals to take simple but effective actions to help prevent the spread of infection. Educational resources and engagement activities were used to communicate key messages about hand hygiene, respiratory etiquette, and the importance of using antibiotics only when prescribed by a healthcare professional.

Members of the public were able to speak directly with healthcare professionals and public health representatives, providing an opportunity to ask questions and gain a better understanding of how antimicrobial resistance develops and why it poses a growing threat to healthcare systems worldwide. Resources were also distributed to signpost individuals to reliable sources of information and to support ongoing learning beyond the events.

A key feature of the roadshow was an interactive AMR quiz, which encouraged participants to test their knowledge and challenge common misconceptions about antibiotics and antimicrobial resistance. The quiz provided an engaging and accessible way to

learn, prompting discussion around topics such as the differences between bacterial and viral infections, and the actions individuals can take to prevent the spread of infection. The quiz proved popular with attendees of all ages and helped reinforce key educational messages in a memorable way.





Outcomes:

- ▶ The roadshow was delivered across all five Trust areas, helping to ensure equitable access to public health information.
- ▶ The initiative facilitated engagement with a wide range of audiences, including:
 - Families
 - Older adults
 - Students
 - Community groups
- ▶ The roadshow successfully increased awareness of antimicrobial resistance (AMR).
- ▶ Key infection prevention messages were reinforced through the initiative.
- ▶ The programme contributed to wider regional and national efforts to tackle antimicrobial resistance.
- ▶ By bringing public health messages directly into community settings, the roadshow:
 - Increased understanding of AMR and infection prevention
 - Encouraged positive behaviour change
 - Strengthened community awareness of this important public health challenge





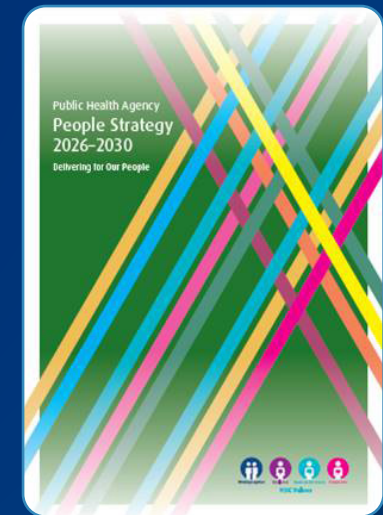
Strengthening the Workforce

INTRODUCTION

The Public Health Agency has approximately 417 staff working collaboratively to deliver a vast Public Health Agenda. To underpin this, a new four year People Strategy has been developed which outlines a clear ambition:

“To create a compassionate and inclusive workplace which builds on then dedication, expertise and commitment already demonstrated by our staff. By continuing to nurture compassionate relationships, proactive support, and understanding of diverse needs, we aim to empower our people through openness, collaboration, and excellence to improve health and wellbeing foreveryone in Northern Ireland.”

The PHA will work to implement the People Strategy, its goals and objectives over the coming years, building a workplace culture that attracts, retains, and develops talented individuals, enabling us to meet current and future public health needs with compassion and excellence.
[link to people strategy]





9. Strengthening cancer workforce communication capability through the development of a tiered communication skills training framework.

Effective communication is central to safe, person-centred, high-quality care, yet communication quality is inconsistent. In an endeavour to improve communication in cancer services, the NI Cancer Strategy (DoH, 2022), set out, in Action 53 that:

All healthcare professionals who are expected to carry out sensitive communication must complete an advanced communication skills training (ACST) programme. (p.106)

Since 2024, PHA Regional Advanced Communication Skills Training Programme Lead has been instrumental in enabling the a response with 500 professionals completing ACST over 27 months.

While investment in Advanced Communication Skills Training has strengthened specialist capability, stakeholders consistently report that:

- ▶ ACST is reaching a small percentage of professionals and it alone cannot meet the needs of the wider workforce.
- ▶ Sensitive cancer-related conversations occur across all settings, not only within cancer MDTs.
- ▶ All Health and Social Care staff require communication skills training, but not the same training.
- ▶ A tiered, scalable, evidence-based model is required to build required skills across the workforce, ensure consistency and reach to staff within statutory, independent and voluntary services.

A regional stakeholder workshop, bringing together 49 stakeholders including people with lived experience, healthcare professionals, university educators, policymakers and workforce development leaders took place in November 2025 to explore how communication skills could be strengthened across the cancer workforce and wider Health and Social Care system.

Outcomes:

Stakeholders strongly supported the development of a tiered communication skills framework (the Framework) comprising Foundation, Intermediate and Advanced levels aligned with agreed core principles, defined critical skills and experiential learning methods to maximise skill development over awareness raising or knowledge growth. The Framework was viewed as a practical and scalable approach to ensuring communication training is aligned to workforce needs while maintaining consistency but flexibility across organisations and professions. The development and implementation of the framework will be rolled out during 2026.



9. Advancing Advance Care Planning: Three Levels of ACP Education Now Available for Staff

For Now and For the Future Advance Care Planning (ACP) for Adults in Northern Ireland is underpinned by education and training. ACP is a key component of person-centred care, enabling individuals to express their wishes, values and preferences for future care and treatment.

At the launch of the policy, a three-tiered ACP Capabilities Framework was developed to support and strengthen staff knowledge, confidence and capability in undertaking ACP conversations. PHA has worked alongside colleagues from the Clinical Education Centre (CEC) to ensure that three levels of ACP training are available to staff across health and social care services.

The programme offers a progressive learning pathway that supports staff according to their role and level of involvement in ACP discussions:

- ▶ **Level 1: ACP Awareness and ReSPECT** is available to all staff and members of the public. It provides foundational knowledge on the principles of ACP, the benefits for patients and families, and the role everyone can play in supporting person-centred conversations.
- ▶ **Level 2: ACP Conversations** is designed for staff and community leads involved in supporting, encouraging and providing care to a person who may have, or require, a ReSPECT Plan. It equips participants with the skills and confidence to initiate and engage in meaningful ACP discussions.

- ▶ **Level 3: ACP Facilitation and Leadership** supports experienced practitioners who have a significant role in leading, facilitating, documenting and sharing ReSPECT conversations. These practitioners will also mentor colleagues and champion ACP within their teams and organisations.

The availability of these three levels of training supports the implementation of regional ACP standards, promotes a consistent approach to ACP practice, and ensures that patients, families and carers are offered opportunities to discuss and record what matters most to them. As awareness of the programme increases, it is anticipated that training uptake across all levels will continue to grow over the coming months, further strengthening workforce capability and confidence in Advance Care Planning.

Outcomes:

- ▶ Three levels of ACP education are now available through a structured learning pathway. Levels 1 and 3 are available via eLearning, while Level 2 is delivered through the Clinical Education Centre.
- ▶ Supports regional standardisation by ensuring staff can access training appropriate to their role, experience and responsibilities.
- ▶ Increases opportunities for staff to develop confidence and competence in ACP conversations.
- ▶ Supports earlier and more meaningful person-centred conversations about future care preferences.



- ▶ Promotes consistency in ACP practice across services and care settings.
- ▶ Enhances person-centred care by ensuring patients' values, wishes and preferences are recognised and respected.
- ▶ Builds organisational capacity through the development of ACP champions and leaders.
- ▶ Contributes to improved communication between patients, families and healthcare professionals.
- ▶ Supports implementation of regional and organisational ACP priorities.
- ▶ Training uptake is expected to continue to increase over the coming months as awareness of the programme grows and organisations embed ACP training within workforce.

CEC attendance figures

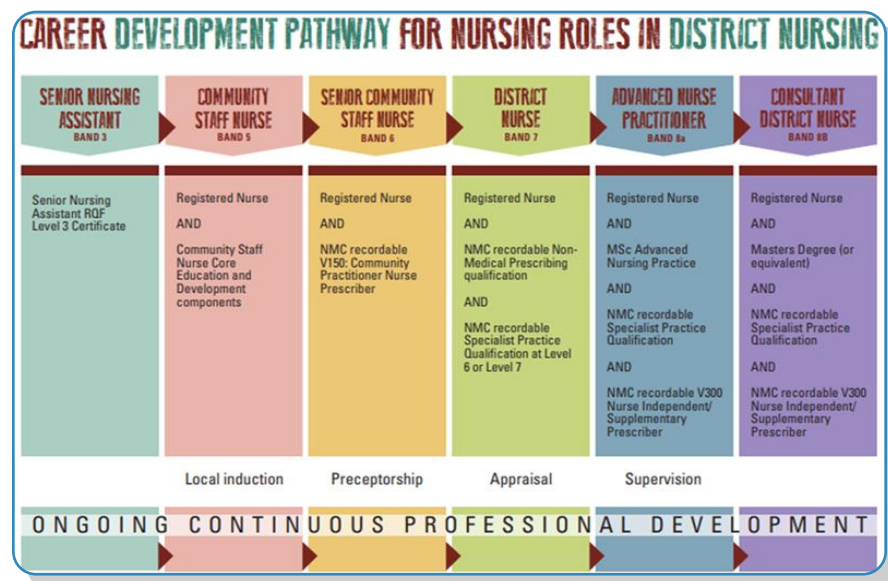
Application status	Number of Applications
Attended	1,045
Did Not Attend	100
Late Cancellation	84
Did Not Complete	110
Yet To Run	84
Total	1,423



10. Exploring the Role of the Advanced Nurse Practitioner within District Nursing (DN) in Northern Ireland (2026)

The Nursing and Midwifery Task Group Report (DoH 2020) highlighted that significant transformation of nursing and midwifery services was essential to the stability and sustainability of the Northern Ireland HSC system. Similar to many other countries NI is experiencing an increasing demand for healthcare services with more older individuals with co-morbidities and polypharmacy often requiring more complex care.

The District Nursing Career Pathway (2022) below was a key outcome in realising this vision in relation to the funding and recruitment of Advanced Nurse Practitioners (ANP) within the District Nursing Service in NI.



Each HSC Trust was funded for one ANP within District Nursing at that time, this was progressed and from 2024-2026 a focus was placed on the development of these ANP roles by all Trusts lead & monitored by the PHA.

Outcomes:

- ▶ The ANPs within DN are a critical asset to the delivery of integrated, person-centred, high-quality care in the community. With autonomous practice, leadership and cross-boundary collaboration they improve patient experiences through timely assessment and treatment.
- ▶ The ANPs within DN improve clinical outcomes with reduced admissions to hospital, a reduction in the need for GP home visits, and contribute overall to the transformation and modernisation of community services.
- ▶ As the NI Neighbourhood Model develops further and the demand for complex community care increases, the ANP (DN) role will continue to be central to person-centred patient care; prevention of ill-health and promotion of well-being within communities, new innovative treatments/practice, workforce development and the provision of sustainable health and social care within the community.
- ▶ The PHA are now progressing Key Performance Indicators for this role to ensure regional standardisation and reporting.



11. High Consequence Infectious Disease PPE Training Event

PHA organised and hosted a 3-day High Consequence Infectious Disease (HCID) Train the Trainer (TTT) programme, delivered by 5 specialist HCID trainers from Sheffield. The event trained 60 clinical staff and educators from across Northern Ireland, including representatives from all Health and Social Care Trusts and the Northern Ireland Ambulance Service (NIAS).

The HCID Network has extensive experience in delivering TTT programmes in line with the National Infection Prevention and Control Manual (NIPCM) for England. National guidance states that all clinical medical and nursing staff who may be required to wear Personal Protective Equipment (PPE) when assessing or caring for suspected or confirmed HCID cases must be trained, practised and competent in the use of the HCID assessment ensemble.

The programme was designed to standardise training delivery and ensure consistency in both educator and learner outcomes. Through this approach, local trainers, educators and healthcare workers identified by the Northern Ireland team are now equipped to cascade HCID PPE training across relevant healthcare settings within their organisations.

To support implementation and ongoing development, the HCID Network has committed to providing quarterly virtual meetings with trainers over the next 12 months and will continue to offer additional support as required.

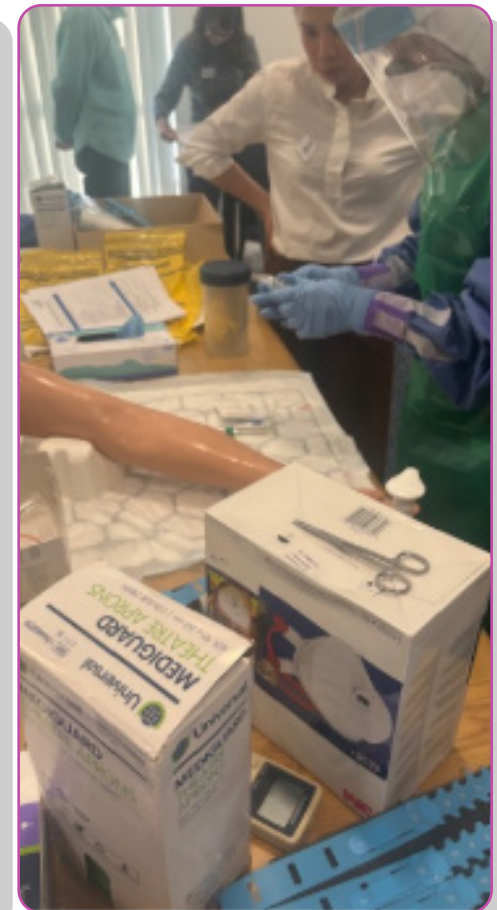
This training has strengthened Northern Ireland's preparedness and response capability, ensuring that healthcare staff across the region are trained and competent in the appropriate infection prevention and control measures, including the correct use of PPE, should a suspected or confirmed HCID case arise.





Outcomes:

- ▶ Trainers made the content engaging, encouraged participation and fostered discussion throughout the programme.
- ▶ The hands-on practical sessions were identified as one of the most valuable aspects of the training.
- ▶ Participants found the donning and doffing PPE exercises particularly beneficial in building confidence and competence.
- ▶ Waste management discussions were highlighted as an important and useful component of the programme.
- ▶ Attendees valued the opportunity to learn from trainers with first-hand HCID experience and expertise.
- ▶ Increased knowledge and understanding of HCID preparedness and response requirements.
- ▶ Improved confidence and competence in the correct use of HCID PPE.
- ▶ Established a network of trained educators able to cascade training across Northern Ireland organisations.
- ▶ Enhanced regional preparedness and resilience in the event of a suspected or confirmed HCID case.
- ▶ Ongoing collaboration with the HCID Network will help maintain competencies and strengthen HCID response arrangements across Northern Ireland.





12. Pressure Ulcer Prevention and System Learning in Action

The Regional Adult Inpatient Pressure Ulcer Prevention Group continued to provide strategic leadership for pressure ulcer prevention across Northern Ireland. Coordinated by the PHA, the multidisciplinary group brings together representatives from all Health and Social Care Trusts and regional partners to strengthen system learning, support evidence-informed practice and reduce unwarranted variation.

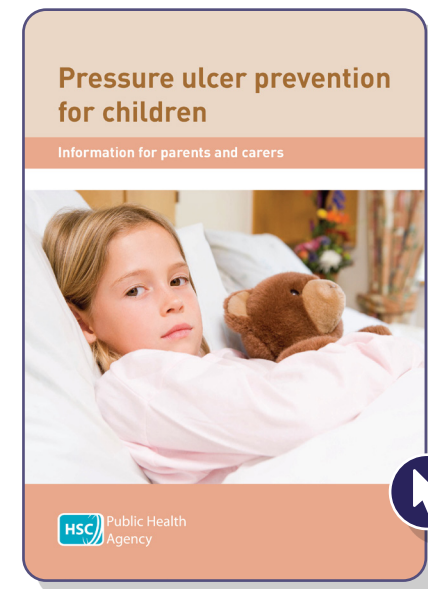
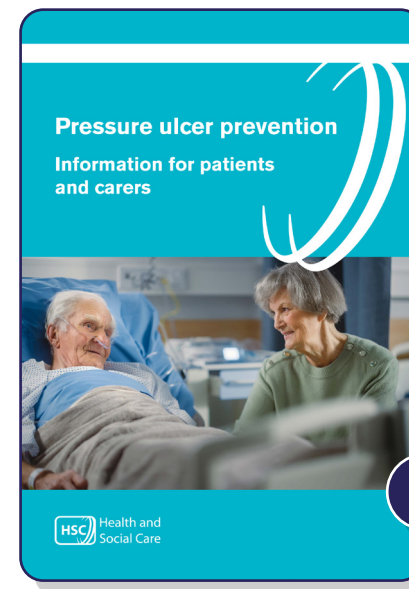
Key areas of work included:

- ▶ sharing learning from incidents, emerging evidence and regional practice to inform continuous improvement;
- ▶ reviewing and updating regional pressure ulcer prevention guidance and resources
- ▶ strengthening collaboration through regional networks; and
- ▶ using data and quality improvement principles to inform regional priorities.

A key focus was improving accessible information for patients and carers. The Group also continued to oversee the review and development of regional resources for children, contracture prevention and palliative care ensuring these reflect current evidence and support consistent practice across Northern Ireland.

Outcomes:

- ▶ Updated regional **Pressure ulcer prevention Information leaflet for patients and carers.**
- ▶ Updated regional **Pressure Ulcer Prevention for Children**
- ▶ New **Accessible Information/ Easy Read Pressure Ulcer Prevention leaflet.**
- ▶ Review and development of **Prevention of Contractures guidance.**
- ▶ Review and development of the **SCALE (Palliative Care Advice Leaflet)**





13. Making Pressure Ulcer Prevention Information More Accessible

During 2025/26, the PHA worked with Trust Tissue Viability Nurses, TILLI Translates and regional partners to improve the accessibility of information available to patients and carers on pressure ulcer prevention.

The existing regional Pressure Ulcer Prevention Information Leaflet was reviewed and updated, alongside the development of a new Easy Read version.

The work recognised that written health information does not work equally well for everyone. Providing information in a clearer and more accessible format helps widen access to important prevention messages and supports patients, carers and families to understand what they can do to reduce the risk of pressure ulcers.

The Easy Read resource was developed collaboratively and approved through the relevant regional group, helping ensure a consistent approach across Northern Ireland.

The leaflet also signposts users, through a QR code, to an existing Easy Read video developed by Trust colleagues, a service user and Queen's University Belfast. This provides another way for people to access the same key information in a format that may better suit their individual needs.

The work demonstrates how collaboration across organisations, professions and service users can help make patient safety information more inclusive and easier to use.



Video link: how to look after your skin.



Measuring Improvement

INTRODUCTION

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



15. Adult In-patient Falls Prevention

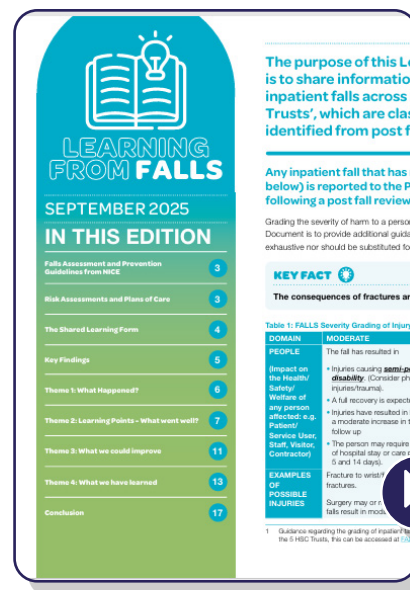
Aligned with the **PHA Corporate Plan 2025-2030**, the Regional Adult Inpatient Falls Prevention Group continued to provide strategic leadership for falls prevention across Northern Ireland. The multidisciplinary group, representing all Health and Social Care Trust and regional partners, worked collaboratively to improve patient safety, strengthen system learning and support evidence informed practice.

Key areas of work included:

- ▶ reviewing and updating regional falls prevention guidance;
- ▶ sharing learning from incidents and improvement activity across organisations;
- ▶ promoting evidence-based practice;
- ▶ supporting quality improvement approaches; and
- ▶ strengthening collaboration across regional networks.

To further support system wide learning, the PHA brought together colleagues from the Regional Adult Inpatient Falls Prevention Group, Safer Mobility, the Safety Executive Northern Ireland, Mental Health and Learning Disability Services, and the Nursing, Midwifery Quality Assurance Network (NMQAN) for a regional workshop focused on learning from falls data across Northern Ireland. The workshop enabled multidisciplinary discussion, shared good practice and identified priorities for improvement.

The Regional Adult Inpatient Falls Prevention Group also reviewed existing Trust guidance on bedrails and agreed that a consistent regional approach was required. This work has informed the development of new regional bed rails guidance to promote safer, evidence-based practice and reduce unwarranted variation across organisations.





Outcomes:

- ▶ Strengthened regional collaboration through multidisciplinary partnerships and shared learning.
- ▶ Delivered a regional workshop bringing together clinical, safety and quality improvement expertise to identify priorities from falls data.
- ▶ Developed a Regional Adult Inpatient Falls Prevention Action Plan to support improvement priorities across Northern Ireland.
- ▶ Completed **Regional Learning from Falls** analysis resource to support dissemination of learning across Health and Social Care organisations.
- ▶ Developed **Regional Guidance on the Safe Use of Bed Rails**, promoting a consistent evidence-based approach across Northern Ireland.
- ▶ Refreshed **Falls Prevention Advice Leaflet for Patients and Visitors** leaflet to maintain readability and accessibility.



16. Better information, better decisions: improving data and communications quality in Health Protection

HPZone is the case management system where every gastrointestinal infection notified in NI is recorded. Most surveillance, reporting and outbreak decisions rely on this information, so complete and accurate records are essential.

We have established a rolling programme of data quality improvement, with regular reviews of HPZone records to ensure critical exposure information such as food, travel, contact and clinical details are recorded consistently.

Missing information is identified and completed where possible, improving the quality of datasets used for surveillance and public health decision-making. Alongside this, we are developing standard operating procedures (SOPs) and a core minimum dataset to support consistent data collection and recording. We are also working with the system supplier (InFact) to introduce improvements such as prompts, additional fields and mandatory data entry requirements.

Alongside, we have reviewed the quality of information issued from the Health Protection duty room, particularly for STEC investigations. Standard letters and templates are being revised using Plain English and [GOV.UK](#) style principles to improve clarity, consistency and accessibility for cases and families. The introduction of GOV.Notify email and SMS messaging is helping deliver information more quickly and consistently, particularly for exclusion advice and case updates. Future developments include exploring digital self-completed questionnaires for selected infections, reducing administrative burden while improving the completeness and timeliness of information collected.

Outcomes:

- ▶ Regular review of HPZone records to improve completeness and accuracy of key surveillance data.
- ▶ Development of a core minimum dataset and improved SOPs to support consistent data collection.
- ▶ New and improved standard operating procedures (SOPs) so key fields are recorded correctly first time and not missed in future.
- ▶ System improvement requests submitted to InFact, including prompts and mandatory fields for key information.
- ▶ Review and standardisation of STEC correspondence using Plain English and [GOV.UK](#) style principles.
- ▶ Introduction of [GOV.Notify](#) email and SMS messaging to improve the speed and consistency of communications.
- ▶ Improved quality assurance of information provided to cases, parents and professionals.
- ▶ Exploration of digital self-completed questionnaires to support future service improvement.
- ▶ Active duty room presence and targeted staff training to embed good data practice day to day.
- ▶ Better, more complete and more reliable data, supporting stronger public health decisions, outbreak detection and case management (status: Green, in progress; scheduled look backs also help complete the annual report)



17. Digitalising the Palliative Care Nursing Quality Indicator (NQI) within District Nursing in Northern Ireland

As patients' conditions deteriorate the need for them to be assessed holistically and their care planned; delivered and evaluated with skill and compassion is essential. This requires significant co-ordination and District Nurses have been recognised, as best placed to be the Palliative Care Keyworkers (PCKW) for patients in their homes. There is a requirement to ensure that this pivotal work is quality assured and subsequently a District Nursing Palliative Care Nursing Quality Indicator (NQI) was introduced in January 2023.

Aim of Project

To ensure that the effectiveness, safety and standard of that, often complex care is provided for each patient, regardless of what life-limiting condition they have or where they live in Northern Ireland.

Objectives

To collaboratively update the key elements of the Palliative Care Nursing Quality Indicator to enable digitalisation and reporting within the District Nursing Service and to the DoH.

To review the current quality indicator with the Nursing & Midwifery Quality Assurance Network (NMQAN) and Encompass to ensure digital reliability and validity.

To establish a regional implementation plan which embeds digital technology, continuous quality improvement methodology and data-driven learning to improve palliative care outcomes for patients in their own homes.

Design/Methods

Using Encompass, the following information which relates to this NQI was collated from Palliative Care Flowsheets from those patients who had died on the caseload:

1. Was the Palliative Care Key Worker Identified?
2. Was the role of the Palliative Care Key Worker explained to the patient and family/carers?

"The District Nurses were so responsive, ensuring my aunt was pain-free and comfortable."

"Their professionalism was exceptional; their caring manner was exemplary and their concern for both Tom and myself was outstanding."

"At my worst she was one of the people that I didn't mind seeing. She was always reassuring, kind, and caring."

"We had no idea of the work these nurses do every day in caring for palliative patients in their homes, how they must carry the grief of their patients' families as they travel from house to house and probably take it home at the end of the day, yet they keep turning up to do it and thank God for them."

"Our family witnessed a team of nurses beyond compare, each and every member of the team that we encountered were dedicated, compassionate, professional and nothing was too much for them."

3. Was the patients' diagnosis recorded?
4. Was the End of Life Operational System (ELCOS) phase recorded?
5. Were Anticipatory Medications prescribed?
6. Was the Preferred Place of Care recorded?



Outcomes:

- ▶ The target compliance for each element is 95% and improvement was noted in five of the six key elements from Jan-July 2026 however there is further quality improvement ongoing within all HSC Trusts and this is monitored monthly by PHA & DoH.
- ▶ Audit bias was minimised through the inclusion of all patients encompass records enabling a comprehensive assessment of compliance (N=1288).
- ▶ HSC Trusts now noting high level of confidence in the data submitted as encompass build has been refined
- ▶ Timely quality improvement progressed within HSC Trusts depending on compliance levels supporting safe, effective and quality outcomes for patients.
- ▶ Regional poster presentation accepted by the AIHPC for Conference in Sept 2026



18. Early Intervention Support Service (EISS)

The EISS provides personalised, evidence-based support for families with children and young people aged 0 – 18 years to offset emerging vulnerabilities for up to 12 weeks. It offers a regional integrated pathway for early intervention focussed family support and improves outcomes for Tier 2 families.

How much did we do?

- ▶ 1000 referrals received
- ▶ 655 families offered support with 545 accepting the service
- ▶ 96 families to make their decision
- ▶ 14 families declined service
- ▶ 8 inappropriate referrals
- ▶ 258 families on waiting list up to 8 weeks
- ▶ 79 referrals received where there was no capacity to provide service

How well did we do it?

- ▶ 99% families received contact within first 10 working days from referral
- ▶ 8 weeks average length of intervention
- ▶ 754 families successfully completed the intervention
- ▶ 116 families did not progress with the service
- ▶ 103 families disengaged from the service
- ▶ 87% parents/carers rated the service as excellent, 11% rated the service as very good & 2% rated the service as good
- ▶ 82% children/young people rated the service as excellent, 13% rated the service as very good & 5% rated the service as good or fair.

Parent feedback: *“This has really helped me and my son learn new ways and techniques on how to cope with his behaviour and also helped me along the way with my own emotions. You have been amazing and I couldn’t have asked for anyone better to help us you’ve done amazing from start to finish with us all.”*

Outcomes:

Case Study Summaries (Is anyone better off?)

- ▶ **Northern EISS:** Support for a 7-year-old child focused on anxiety, emotional regulation and bedtime routines, helping the child feel calmer and more secure, with positive changes at home and an excellent service rating from both child and parent.
- ▶ **Belfast EISS:** A 10-year-old child experiencing behavioural difficulties received emotional awareness and parenting support, leading to improved emotional regulation, stronger family relationships and access to appropriate onward support.
- ▶ **Southern EISS:** One-to-one support helped a school-aged child manage emotions linked to bullying, alongside parent and school engagement, strengthening coping skills, reducing family stress and improving communication with school.
- ▶ **South Eastern EISS:** Early, parent-focused support for a 4-year-old child-built confidence in managing emotions, behaviour and communication, with clear progress shown across Family Star outcomes.
- ▶ **Western EISS:** Practical emotional regulation work with a child across home and school settings reduced defiance and improved cooperation, with positive outcomes achieved within EISS timescales.



19. From paper to digital: automating Environmental Health exposure questionnaires

When someone in Northern Ireland gets a gastrointestinal infection such as Salmonella, E. coli or Cryptosporidium, Environmental Health Officers (EHOs) at the 11 local councils interview them about what they ate, where they travelled and who they had been in contact with. These “exposure questionnaires” help us find the source of an infection and prevent outbreaks.

Forms are filled in by hand on paper or typed into a word document, scanned and emailed, then retyped into our systems. This is slow, prone to gaps and errors, and makes it hard to bring the information together quickly when time matters.

We are replacing the paper forms with a digital questionnaire, built using Microsoft and SharePoint tools. Environmental health officers will complete it online and the answers will flow straight into a digital format on a PHA dedicated SharePoint, where it can be entered into our case management system and into surveillance, without any retyping. This gives faster more accurate data that provides consistency and efficiency through the process.

To do this safely we have completed a Data Protection Impact Assessment (required before any new system handling personal data goes live), designing the online form and its links to our systems, and working closely with council EHOs and our information governance and digital teams so the tool fits how officers actually work.

Outcomes:

- ▶ A digital gastro exposure questionnaire designed for Environmental Health Officers across all 11 NI councils, replacing today’s paper and scanned forms.
- ▶ Answers feed directly into SharePoint and surveillance, removing manual retyping and the delays and errors that come with it.
- ▶ Faster, more complete and more consistent case information, improving detection of outbreaks sooner.
- ▶ A Data Protection Impact Assessment has been approved and signed off.
- ▶ Further engagement to start with local councils on a pilot to test the process and streamline the questionnaire.



20. Transforming Caesarean Section Surgical Site Infection Surveillance Through Digital Innovation

Surgical Site Infection (SSI) Health Protection Surveillance at the PHA, in collaboration with colleagues from encompass, HSC Trusts, maternity service leads, surgeons, midwives, Infection Prevention and Control (IPC) staff, transformed the regional C-section SSI surveillance programme from a paper-based process to an infection-only electronic reporting model.

Historically, surveillance required the completion and submission of paper forms for every C-section undertaken across HSC Trust hospitals. This resource-intensive process relied on manual paper-based forms that created a significant administrative burden for frontline staff, and become redundant with the introduction of encompass. Our “lite” surveillance model uses an infection-only electronic webform supported by routinely collected encompass procedure data. Automated extraction of denominator data removes the need for manual recording of every C-section while maintaining the ability to identify, monitor and investigate SSI events.

The transformation strengthened collaboration across stakeholders and aligned surveillance activity with continuous quality improvement by enabling staff to focus on infection prevention, investigation and service improvement rather than administrative data collection. By leveraging digital technology and existing clinical information systems, the programme has modernised surveillance practice, improved data quality and enhanced the ability to monitor trends, benchmark performance and support evidence-based interventions aimed at reducing SSI rates.

A key component of implementation was the delivery of regional training and engagement sessions for midwives, surveillance staff and IPC teams across all HSC Trusts by PHA staff. Ongoing training, stakeholder engagement and data quality assurance will support continued refinement of the electronic surveillance system and ensure the accuracy, completeness and consistency of C-section SSI data regionally across HSC Trusts.

Outcomes:

- ▶ Successfully transitioned from a paper-based surveillance process requiring reporting of all C-sections to an electronic infection-only reporting model.
- ▶ Established stronger collaborative working relationships between PHA Health Protection, the Bugsy Team (encompass), maternity services, IPC teams, surgeons and midwives across HSC Trust hospitals.
- ▶ Reduced the administrative burden associated with manual completion, submission and processing of paper surveillance forms.
- ▶ Improved surveillance efficiency through automated capture of procedure denominator data from encompass.
- ▶ Enhanced data quality by reducing duplication, improving completeness (for some information but not all) and minimising transcription errors.
- ▶ Standardised regional surveillance processes across HSC Trusts, supporting greater consistency in data collection and reporting.



21. Personal and Public Involvement: Regional Monitoring and Impact 2025/26

During 2025/26, the PHA Partnership and Engagement Team continued to collect, analyse and report on Personal and Public Involvement (PPI) activity across all six HSC organisations in Northern Ireland.

Information was collected twice during the year through a consistent regional framework, providing a regional picture of how service users, carers, members of the public and staff are involved in shaping health and social care services.

The monitoring captures involvement activity, participation levels, training delivery, reported outcomes, impact measures, assurance information and implementation of PPI standards and recommendations.

The team combines quantitative analysis, including participation levels, involvement trends and training uptake, with qualitative information on impact, service user and carer feedback, emerging good practice and learning from the Involvement Human Library model.

This intelligence supports regional learning, planning and decision-making and provides assurance to the Department of Health on how involvement is being embedded across HSC organisations.

The PHA has also progressed the digital development of its involvement data infrastructure through regional Power BI dashboards and interfaces, improving the visibility and accessibility of involvement information and supporting more informed use of the data.

- ▶ Reported outcomes associated with involvement included 242 improvements in service user and carer experience, 184 better health outcomes, 177 improvements in communication, 172 quality improvement outcomes, 114 improved relationships between services and stakeholders, 108 more service user and carer-centred services, and 95 increased involvement opportunities.
- ▶ Monitoring also identified reported improvements in service access, health literacy, organisational culture, awareness of rights and entitlements, and patient safety.

Regional PPI Monitoring and Impact 2025/26

Headline figures from Personal and Public Involvement monitoring across HSC organisations in Northern Ireland



812

PPI initiatives



69,973

participants in
involvement activity



90

PPI training
sessions



3,706

training participants



24

Involvement Human
Library sessions

Source: PHA Partnership and Engagement monitoring data, 2025/26



Raising the Standards

INTRODUCTION

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



22. CHROMagar STEC: Local detection of high-risk E. coli in Northern Ireland

Some types of E. coli, known as STEC (Shiga toxin producing E. coli), can cause serious illness, especially in vulnerable people and young children. Knowing exactly which type a patient has helps quickly identify the strain and act proportionately, for example deciding how long a child should stay off school or whether further spread is likely.

The majority of laboratories in Northern Ireland cannot identify these high-risk types locally. Samples are sent to the national reference laboratory in England, which delays answers and, as a precaution, often means people are excluded from school or work for longer than may be necessary.

We are introducing CHROMagar STEC, a specialised specific culture plate that changes colour to flag the high-risk E. coli types (O157, O26 and O145) in all five Trust laboratories. This allows local labs to spot these cases earlier, without waiting for results from England.

To get here we produced a business case, secured agreement on funding, and, working with Trust microbiology leads through the MVSF group, will design a clear risk-based referral system so that only a small number of urgent samples are sent away.

Outcomes:

- ▶ Local testing will be established across all five HSC Trust laboratories, so most high-risk E. coli can be identified in Northern Ireland rather than sent to England. In 2025, 68% of typed cases were types CHROMagar can detect (257 STEC cases were reported in NI that year).
- ▶ Faster diagnostic certainty, supporting earlier, evidence-based decisions on clinical care, school and work exclusions, and outbreak response.
- ▶ A fairer, more consistent service across all Trusts, replacing today's uneven access to local testing.
- ▶ Fewer costly urgent referrals to the UKHSA reference laboratory (~ £406 each), with a regional target of fewer than 30 urgent faecal referrals per year.
- ▶ An "equity dividend": earlier confirmation means children get back to school sooner, and families and employers face less disruption.



23. Development of the 5 National Bereavement Care Pathways in Partnership with SANDS

In partnership with SANDS and HSC Trusts, 3rd Sector Organisations and Professional Bodies we supported the development of five bespoke National Bereavement Care Pathways to improve the quality and consistency of care for families experiencing:

- ▶ Miscarriage, Ectopic Pregnancy or Molar Pregnancy
- ▶ Termination of Pregnancy for Fetal Anomaly (ToPFA)
- ▶ Stillbirth
- ▶ Neonatal Death (NND)
- ▶ Sudden and Unexpected Death in Infancy (SUDI) up to 24 months

Alongside these pathways, we developed three cross-cutting supporting guidance documents focusing on themes relevant across all pathways, including language and communication, staff wellbeing and training, and memory making. National bereavement care standards and a suite of supporting digital resources were also developed to support implementation and practice.

Lived experience was embedded throughout the programme. Six listening events and numerous individual engagement sessions involved over 100 parents. A Parent Advisory Group, chaired by the White Butterfly Foundation, met five times and made a significant contribution to pathway and standards development.

Extensive multidisciplinary engagement included visits to all five HSCTs, engaging around 80 staff working in areas affected by

pregnancy loss and baby death. Over 50 staff participated in pathway development groups, while more than 150 staff received regular programme updates. Collaboration with Queen's University Belfast, Ulster University and Trust bereavement forums supported awareness, education and service improvement.

Strong strategic partnerships were maintained regionally and nationally through engagement with SANDS, the NI Bereavement Network, the Royal College of Midwives, universities, policymakers and government stakeholders. This included contributions to baby loss certificates, maternal death protocols, staff resources and research initiatives.

A comprehensive learning programme reached over 300 staff through pathway-specific education, multidisciplinary study days and bespoke training sessions.

Outcomes:

A suite of accessible digital resources (Padlets) have been developed to provide staff with immediate access to information, guidance and practical support at the point of care. Available on any device, including personal mobile phones, these resources support staff in delivering compassionate, evidence-based bereavement care.



Key Padlets include:

- ▶ **Memory Making:** offering practical ideas and approaches to discuss with families, extending beyond traditional memory boxes and supporting personalised bereavement care.
- ▶ **Reviews, Investigations and Feedback:** providing up-to-date guidance on review processes, investigations and the Perinatal Mortality Review Tool (PMRT).

These resources will increase the availability of consistent information across services and will help improve staff confidence in navigating sensitive and complex discussions with families, including conversations about post-mortem examinations, investigations, and funeral and burial options. By providing easy access to guidance and support “in the moment”, the resources will strengthen staff capability to deliver high-quality bereavement care and support informed decision-making for families.





24. Review of Population Health Needs of Children with Complex Medical Needs Attending Special Schools in Northern Ireland

The PHA was commissioned by the Chief Nursing Officer, in partnership with the Department of Health, Department of Education and Education Authority, to undertake the first regional Review of Population Health Needs of Children with Complex Medical Needs attending Special Schools in Northern Ireland. The review aimed to understand the health and nursing needs of this vulnerable population, examine current models of care delivery, and identify opportunities to improve support for children, families and school staff.

A mixed-methods approach was used, combining analysis of population and workforce data from the Education Authority and Community Children's Nursing (CCN) services across all five HSC Trusts, alongside extensive stakeholder engagement with parents, education staff and healthcare professionals. The review explored current governance arrangements, service models, training provision, workforce capacity and the interface between health and education systems.

The work highlighted the increasing complexity of health needs among children attending Special Schools and examined how services currently respond to ensure safe access to education. The findings have informed a series of strategic recommendations to support future service planning, improve consistency across Northern Ireland, strengthen partnership working between health and education, and ensure that children with complex medical needs continue to receive safe, timely and person-centred care within school settings.

Outcomes:

- ▶ The first population health needs assessment of children with complex medical needs attending special schools in Northern Ireland of its kind
- ▶ It identified children on the Community Children's Nursing caseload requiring complex healthcare interventions to access education.
- ▶ It noted regional variation in healthcare support models, training arrangements and governance structures across Special Schools.
- ▶ It ensured stakeholder input that highlighted the importance of safe, child-centred healthcare support to enable children to attend school and participate fully in education.
- ▶ It gave an opportunity for parents to engage in the review, and their feedback reported high levels of satisfaction with care provision but emphasised the importance of confidence and reassurance.
- ▶ Engagement with education and nursing staff resulted in the identification of increasing complexity of need, workforce pressures, training demands and role ambiguity as key challenges.
- ▶ The review recognised the need for stronger joint working between health and education and more consistent regional approaches to policy, training, governance and service delivery.
- ▶ Key recommendations were developed focusing on workforce development, collaborative care models, improved data collection, cross-departmental policy and funding arrangements, and strengthening the voice of children and young people in future service planning.
- ▶ Recommendations are being taken forward by a joint health and education working group.



25. Rigorous Wastewater Pilot Programme Identifies Most Useful Use-case for Wastewater based surveillance

Between October 2025 and June 2026, we delivered a pilot wastewater pathogen surveillance programme across Northern Ireland. The programme undertook fortnightly surveillance of COVID-19 and influenza and monthly surveillance of poliovirus across six sites, with reporting developed using R and modern analytical methods. The work was undertaken alongside NHS Lothian Molecular Lab and Northern Ireland Water.

A key objective was to evaluate the public health value of wastewater-based surveillance and identify where it could most effectively support decision-making. An FETP fellow undertook a structured review of the programme, including stakeholder engagement with consultants and other users of the surveillance outputs. This provided a practical assessment of the benefits, limitations and cost-effectiveness of different surveillance approaches.

Poliovirus surveillance was considered a valuable early warning system because positive detections would trigger well-established public health responses. The findings informed the implementation of a more sustainable surveillance model based on monthly monitoring at a single site. The evaluation found that more frequent sampling for COVID-19 and influenza would have been preferred and the public health actions to changes in wastewater activity of these pathogens was not as clear compared to Poliovirus.

Alongside informing future surveillance practice, the programme maintained critical relationships and operational capability with laboratories and Northern Ireland Water, ensuring Northern Ireland retains the capacity to rapidly scale up wastewater surveillance during future public health emergencies or pandemics.

Outcomes:

- ▶ Identified poliovirus as the most valuable and cost-effective application of wastewater surveillance in Northern Ireland.
- ▶ Demonstrated the limitations of fortnightly COVID-19 and influenza wastewater monitoring for routine public health use considering available resources.
- ▶ Supported evidence-based decision-making through a formal service evaluation.
- ▶ Developed workforce capability through involvement of an FETP fellow and use of modern analytical methods.
- ▶ Strengthened collaboration between PHA teams, laboratories and Northern Ireland Water.
- ▶ Established and maintained infrastructure, expertise and partnerships required for future pandemic preparedness.
- ▶ Improved understanding of when wastewater surveillance can deliver meaningful public health benefit and support public health action.



26. Routine Enquiry into Domestic Abuse

This particular work is aligned to one of the key priorities of the PHA Corporate Plan which is to “*Work with others to promote the safeguarding, and protection of children and young people*” and delivery against the Domestic and Sexual Abuse Strategy for NI 2024- 2031- to support practitioners to deliver person-centred care.

Routine Enquiry (RE) involves asking all women about domestic abuse, regardless of the presence of any indicators and should be offered in pregnancy and postnatally by healthcare practitioners. It aims to identify women with current or past experience of domestic abuse so they and their children can be offered supportive interventions including information, safety planning and referral.

In the 2024/2025 report, we described the work to review how midwives, family nurses and specialist community public health nurses strengthen their practice in this area.

This work has now concluded and [Routine Enquiry into Domestic Abuse: Guidance for Midwives, Health Visitors, School Nurses and Family Nurses in Northern Ireland | HSC Public Health Agency](#) was launched on 3rd March by the Ministers of Health and Justice. Their comments can be read here: [Guidance published for nurses & midwives to help identify domestic abuse | Department of Health](#).

The guidance was implemented on 1st April, 2026 and was a collaboration between PHA, HSC Trusts, Woman’s Aid, Survivors, DOH, University of Ulster, Clinical Education Centre (CEC).

Next steps include the DOH-led extension of Routine Enquiry in other HSC settings and by additional health professionals. This also aligns to [Ending Violence Against Women and Girls | The Executive Office](#) and [The Katie Simpson Review | Department of Justice](#).

Outcomes:

- ▶ Literature search completed
- ▶ Regional service evaluation completed
- ▶ Regional clinical audit completed
- ▶ Women’s Aid focus groups facilitated and report developed
- ▶ Routine Enquiry Review Report developed
- ▶ Regional Routine Enquiry guidance launched and implemented
- ▶ Awareness training delivered to 149 Trust staff
- ▶ PowerPoint presentation developed to assist with cascade awareness and implementation





27. Updated Regional Nutrition Guidelines for Care Homes

The updated Nutrition Guidelines for Residential and Nursing Homes were developed to reflect the significant changes that have taken place since the previous guidance was published in 2014. Over the past decade, society has evolved, our understanding of nutrition and hydration has advanced, and the evidence base underpinning best practice has strengthened considerably. These developments highlighted the need for revised guidance that supports the delivery of high-quality, person-centred nutrition and hydration care for residents living in care homes.

The PHA led the review and development of the updated guidelines through a collaborative regional partnership. This work brought together dietitians, speech and language therapists, the Regulation and Quality Improvement Authority (RQIA), and care home staff, including managers and catering teams. Their collective expertise ensured that the guidelines are practical, evidence-based, and relevant to everyday care home practice.

The guidelines were officially launched at Somme Care Home on 24 June by the Health Minister. The launch was further strengthened through endorsements from the Commissioner for Older People, the Chief Nursing Officer, and the Chief Allied Health Professions Officer, demonstrating broad commitment across health and social care to improving nutritional care for older people throughout Northern Ireland.

To support implementation and raise awareness of the updated guidance, a regional webinar was held on 25 June, followed

by an ECHO learning session on 2 July. These events provided opportunities to share key messages, outline changes within the guidance, and engage with stakeholders from across the region. Following the launch, each HSC Trust has begun work to embed the guidelines locally, ensuring a consistent

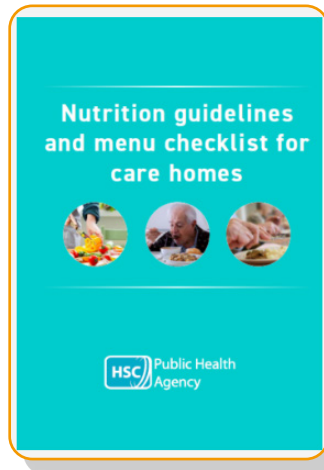
“We all like to eat and enjoy it, and not only enjoy the food but enjoy the service of the people bringing it to us and the opportunity to spend time with other residents” (Tom, care home resident)





Outcomes:

- ▶ Regional evidence-based Nutrition Guidelines for Residential and Nursing Homes were successfully developed in partnership with key stakeholders.
- ▶ The updated guidelines were formally launched and made available to every residential and nursing care home across Northern Ireland, ensuring consistent access to current best practice guidance on nutrition and hydration.
- ▶ The guidelines are available to download from the PHA website: <https://www.publichealth.hscni.net/publications/nutrition-guidelines-and-menu-checklist-care-homes>
- ▶ The guidelines aim not only to improve residents' nutrition and hydration but also to enhance the overall mealtime experience, supporting dignity, choice, enjoyment, wellbeing, and person-centred care.
- ▶ The updated guidance is also being incorporated into the revised Nursing Home Care Standards, which are currently under review, helping to strengthen and embed good nutritional care across the sector.
- ▶ The launch raised awareness of the importance of high-quality, person-centred nutrition and hydration care and secured support from key leaders across the health and social care system.



- ▶ A total of 243 staff from across the care home sector attended a regional webinar to support implementation of the updated guidelines.
- ▶ Webinar evaluation findings demonstrated an improvement in participants' confidence and knowledge. Average confidence in managing nutrition care for residents increased from 4.2 to 4.6 out of 5, while confidence in implementing nutrition guidelines within a care home increased from 3.9 to 4.5 out of 5 following the session.
- ▶ Participants rated the updated guidelines as being a highly useful resource for practice, with an average score of 4.7 out of 5.
- ▶ An ECHO learning session was delivered to further support implementation, providing practical advice and scenario-based learning to help care home staff apply the guidance in real-life situations.
- ▶ The engagement activities provided opportunities for staff to ask questions, share experiences, and increase confidence in implementing the updated recommendations.
- ▶ HSC Trusts have commenced local implementation planning to embed the guidelines within routine practice, supporting a consistent and sustainable approach to nutrition and hydration care across Northern Ireland's care home sector.



"...nutritious meals are far more than just food - they are a cornerstone of dignity, health and quality of life"

Care home executive chef

Please rate the following statements

I feel confident in managing nutrition care for residents

4.2

I feel confident in implementing nutrition guidelines within a care home

3.5

There are challenges in supporting residents' nutrition needs

3.9

Strongly disagree

Strongly agree

Please rate the following statements

I feel confident in managing nutrition care for residents

4.6

I feel confident in implementing nutrition guidelines within a care home

4.5

These guidelines will be a useful resource for me

4.7

Strongly disagree

Strongly agree



Integrating the Care

INTRODUCTION

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

Our success depends on strong partnerships across government, health providers, and communities, underpinned by a culture of collaboration, resilience, and continuous learning.



28. Changing How We Listen: Making Every Voice Count for Children with Complex Disabilities

During 2025/26, the PHA strengthened how children and young people with profound and complex disabilities can be involved in shaping the services and support that affect their lives.

Traditional engagement methods can unintentionally exclude children who communicate in different ways. During 2025/26, PHA committed £78,000 of non-recurrent funding to a further phase of innovative involvement work across seven special schools in Northern Ireland, with delivery commencing in October 2025.

Schools were supported to use individually tailored creative approaches, including art, music and play, to provide children with alternative ways to communicate their experiences, preferences and what matters to them.

Importantly, this was not simply about providing therapeutic activity. The improvement was the creation of a structured and more equitable route for children whose voices may be missed through conventional engagement to contribute to partnership working and future service development.

The work brought together schools, parents and carers, Health professionals and wider partners, supported by clear safeguarding, professional standards and monitoring arrangements.

During the year, governance for the wider Special Schools Partnership Programme was also strengthened, reinforcing cross-sector collaboration, child and parent voice, shared learning and an outcomes-based approach.

This work supports PHA's wider focus on reducing inequalities, strengthening partnership working and ensuring that children with additional and complex needs are meaningfully included in decisions that affect them.

Outcomes:

- ▶ Delivery commenced across seven special schools covering all five HSC Trust areas, creating a regional platform for partnership working between Health, Education, schools and families.
- ▶ The programme set a minimum planned reach of 70 children and young people, with approaches tailored to children with complex communication needs.
- ▶ By 31 March 2026, all participating schools had drawn down their allocated funding for the year, with delivery and agreed reporting requirements continuing.
- ▶ A consistent monitoring framework was established to measure participation, sessions delivered, age and stage, impact for pupils and schools, and expenditure.



- ▶ The programme created a measurable improvement in inclusion by providing a funded and structured route for children who may be unable to participate through conventional verbal engagement methods to communicate what matters to them.
- ▶ Children's communication could be captured through case studies, pictures and video, subject to appropriate consent, helping ensure that non-verbal communication and individual expression could form part of the evidence used to inform future learning.
- ▶ Strengthened governance during 2025/26 embedded child and parent voice, cross-sector collaboration, shared learning and measurable improvement within the wider Special Schools Partnership Programme.
- ▶ An evaluation is being undertaken to assess outcomes, impact and learning from the programme. This will help identify and evidence the benefits of meaningful participation for children and young people with complex communication needs, including improvements in inclusion, service experience, engagement, and the ability of services to capture and respond to the voices of children who may not communicate through conventional verbal methods.





29. Farm Families Health Checks Programme

The **Farm Families Health Checks Programme (FFHCP)** is a regional health improvement initiative that aims to improve the health and social wellbeing of farmers, their families and rural dwellers across Northern Ireland by increasing access to preventative health services, health information and support. The programme was developed in recognition of the importance of providing accessible preventative health services within rural settings and supports early identification of health risks through health screening, personalised advice and signposting to appropriate support services.

The FFHCP is funded by the Department of Agriculture, Environment and Rural Affairs (DAERA) and the PHA, and delivered regionally by the Northern Health and Social Care Trust (NHSCT). A shared leadership model is applied between these organisations in providing the strategic direction of the FFHCP, with PHA leading on the commissioning and contract management processes.

The FFHCP brings health services directly to rural communities through a bespoke mobile health unit and attendance at livestock marts, agricultural shows, agri-food businesses and community events. Trained nurses provide health assessments including blood pressure, cholesterol, body mass index (BMI), diabetes risk and mental wellbeing screening. Participants receive tailored lifestyle advice and, where appropriate, are referred or signposted to relevant health and support services.

Follow-up contact is also undertaken with individuals advised to attend their GP. In 2025/26 the FFHCP also included information sharing on the risks of Bovine Tuberculosis and measures to reduce risk of human infection.

Outcomes:

- ▶ Attended 148 Marts, Agricultural Business events and Community events across Northern Ireland;
- ▶ Completed health assessments on 2420 individuals (1634 males and 796 females);
- ▶ Identified 1449 individuals with high or out of range blood pressure;
- ▶ Identified 1229 individuals at an increased or high risk of diabetes;
- ▶ Identified 200 individuals with high or very high blood pressure;
- ▶ Supported 1109 individuals to try healthier lifestyle changes;

Delighted with ffhc and so glad she attended when she did as highlighted need to see gp, make lifestyle changes and commence medication. Has told many people since about this service.



30. Living Well Community Pharmacy Campaigns

The Living Well community pharmacy service is a partnership between the Public Health Agency (PHA), Community Pharmacy Northern Ireland and the Strategic Planning and Performance Group of the Department of Health (SPPG). The service is offered in over 500 pharmacies across Northern Ireland. It provides information and advice on a range of public health issues, helping address risk factors that contribute to ill health. With footfall in pharmacies averaging 130,000 daily, pharmacists are well placed to provide public health advice, reducing pressure on our healthcare system, particularly in primary care. The campaign schedule aligns with PHA priorities and six campaigns are delivered annually.

Standard materials include a campaign leaflet, posters and a briefing newsletter for pharmacy teams with ideas on activities to engage the public, appropriate signposting, training opportunities for pharmacy staff and useful questions and answers. Additional promotional items are often included as an engagement tool.

In 2025/2026, campaigns were delivered on cancer signs and symptoms, the low risk drinking guidelines, physical activity and deconditioning, staying well in winter, looking after your mental health and childhood immunisation.

Every Living Well campaign is evaluated through an online survey. Survey results are based on estimated figures. Results include quantitative and qualitative data. The summary reports for 2025/2026 are available at <https://bso.hscni.net/living-well>

Outcomes

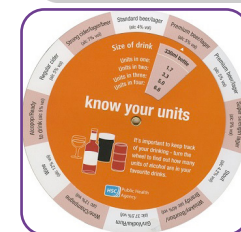
'Be cancer aware' campaign

- ▶ 128 pharmacies referred patients into the community pharmacy Stop Smoking service.
- ▶ The campaign led to early detection of skin cancer, along with investigations for possible prostate cancer, as well as other conditions linked to cancer.



'Know your units' campaign

- ▶ 73 pharmacies used the Alcohol MOT brief intervention tool with over 550 patients.
- ▶ A number of pharmacies reported referrals to the GP and to support groups.



'Move more, feel better' campaign

- ▶ 56 pharmacies referred patients into the community pharmacy Stop Smoking service.
- ▶ 26 pharmacies referred patients to Physical Activity or Walking for Health Coordinators.



'Stay well this winter' campaign

- ▶ 297 pharmacies reported the campaign encouraged people to get or book a winter vaccination.
- ▶ 213 pharmacies reported an increase in flu vaccinations instore.
- ▶ 122 pharmacies reported an increase in COVID-19 vaccinations instore.





- ▶ 142 referrals were made into Pharmacy First services.
- ▶ During the 'Stay well this winter' campaign, 375 pharmacies also took part in a TARGET Antibiotic Checklist Brief Intervention service. Over 8,900 TARGET Antibiotic Checklists were completed with patients.

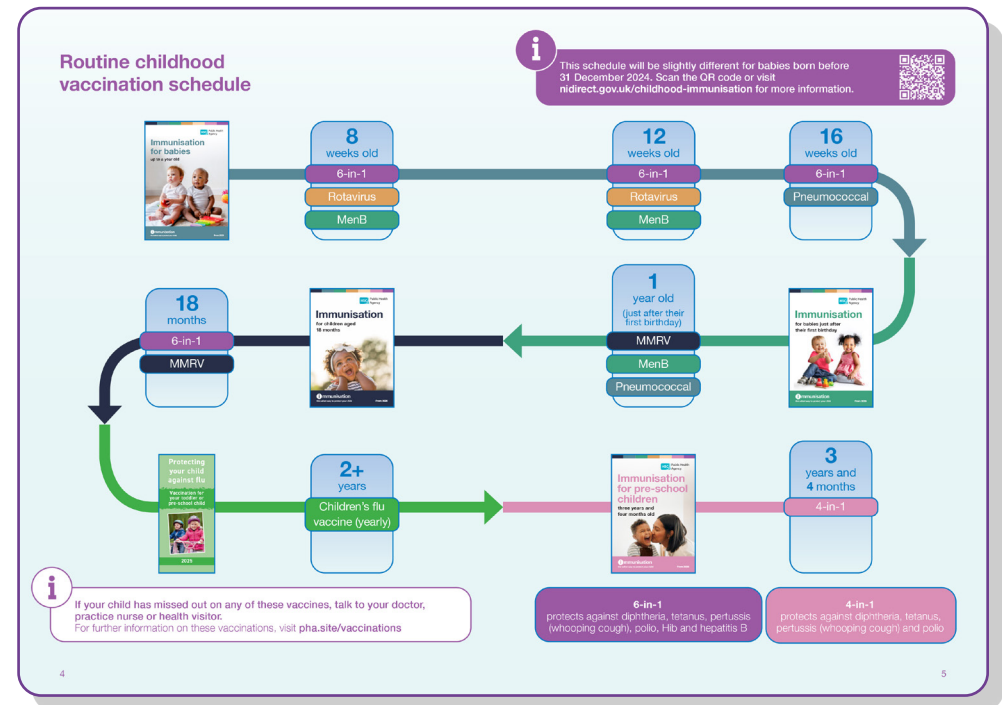
'How are you feeling?' campaign

- ▶ 125 pharmacies signposted people to the Minding your head website.
- ▶ 142 referrals were made into Pharmacy First services.



'Immunise, protect, thrive' campaign

- ▶ 245 pharmacies signposted people to the NI Direct childhood immunisation webpage.
- ▶ 114 referrals were made to GP practices to book both childhood and adult immunisations.
- ▶ 54 pharmacy staff attended a bespoke webinar 'What you need to know: childhood vaccinations schedule changes.'



PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Health Protection Acute Response Activity Report

Reference PHA/08/10/26

Prepared by David Tumilty

Lead Director Dr Joanne McClean

Recommendation

For **Approval** ☐

For **Noting** ☒

1 Purpose

The purpose of this paper is to note the Health Protection Acute Response Activity Report.

2 Background Information

Internal Audit recently completed an audit of the Health Protection Duty Room and recommended that formal activity reports be provided to the Agency Board on a regular basis. Management agreed that these reports would be presented twice yearly, in October and April, to provide assurance on the activity and performance of the Health Protection Acute Response Service.

3 Key Issues

The report provides a high-level overview of Acute Response activity undertaken between April and September 2026, including responses to national incidents, local outbreaks and incidents, duty room activity, multi-agency coordination, and key assurance measures.

The report demonstrates the breadth and scale of activity delivered by the service during the reporting period and provides assurance regarding the effectiveness of surveillance, risk assessment, incident management, and outbreak response arrangements to protect the health of the population.

4 Next Steps

The next report will be brought to the Board in April 2027.



HEALTH PROTECTION ACUTE RESPONSE TEAM

Summary for PHA Board (April - September 2026)

Delivering rapid risk assessment, containment and multi-agency collaboration to protect population health from emerging public health threats.



Early
Detection



Risk
Assessment



Multi-Agency
Collaboration



Protecting
Population Health

1. RESPONSE TO NATIONAL INCIDENTS



HANTAVIRUS

(suspected / confirmed cases)

- UKHSA liaison
- Exposure assessment & contact advice
- Environmental risk mitigation



EBOLA

(HCID preparedness / response)

- HCID protocols activated
- Multi-agency coordination
- Isolation, IPC & clinical oversight



RABIES

(Participation in national rabies lookbacks into falsified rabies vaccine)

- Identification of affected exposed individuals in NI
- Provision of follow up advice and vaccine recommendations
- Participation in national incident team

OUTCOME

National response coordinated and public health risks effectively managed.

2. LOCAL INCIDENT & OUTBREAK RESPONSE



A. SCABIES OUTBREAKS

Educational and Care Home settings

- Mass treatment implemented
- IPC and environmental cleaning
- Family and stakeholder engagement

OUTCOME

Containment achieved with ongoing monitoring



B. E. COLI CLUSTER

- Enhanced surveillance and case finding
- Source investigation to identify source
- Multi-agency collaboration (environmental health, food safety)

OUTCOME

Control measures implemented; no sustained transmission



C. TB outbreaks

- Contact tracing and screening
- Specialist TB coordination
- Community risk assessment in healthcare settings
- TB outbreak management across Nursery school, paediatric care and a rock band.

STATUS

Cases managed within established pathways



D. HCAI OUTBREAK

Carbapenemase-Producing Infection

- Specialist epidemiological support
- National specialist advice and guidance
- Trust IMT support

OUTCOME

Strengthened IPC measures and ongoing surveillance



E. MPOX

Clade 1b Response

- First detection of Clade 1b Mpx in NI
- Coordinated response involving Trusts, IPC and Public Health Teams across all HSCTs
- Communicated key information, raised awareness and promoted vaccination across NI
- IMT coordinated contact tracing and arranged prophylaxis as required

OUTCOME

Rapid containment measures implemented with coordinated multi-agency response and enhanced public health awareness



F. STE C SEPTEMBER 2026

Nursery outbreak management

- Led a multi-agency Incident Management Team response.
- Undertook case finding, contact tracing and outbreak risk assessment.
- Implemented public health control measures, including screening and exclusion.
- Coordinated communications with parents, nursery management and partner agencies.

OUTCOME

Outbreak contained and closed following completion of control measures and evidence review

3. OUR COORDINATED RESPONSE PATHWAY



1. DETECTION

Surveillance systems, alerts and notifications



2. RISK ASSESSMENT

Assess severity, transmission risk and impact



3. ESCALATION & COORDINATION

Multi-agency coordination and resource mobilisation



4. PUBLIC HEALTH ACTIONS

Isolation, treatment, contact tracing, IPC and environmental control



5. MONITORING & REVIEW

Ongoing monitoring, review of measures and incident stand-down



Consistent, evidence-based actions to interrupt transmission and protect population health.

4. DUTY ROOM ACTIVITY



Notification of Infectious Disease (NOID)

eNOIDs from 01.04.26 to 08.10.26 = **252**
Paper NOIDs from 01.04.26 to 08.10.26 = **99**
Total = 351



Enquiries

from 01.04.26 to 08.10.26 = **1,505**



Situations

from 01.04.26 to 08.10.26 = **298**

KEY ASSURANCE



Early detection and escalation

Robust surveillance, timely notification and rapid escalation of incidents.



Alignment with national frameworks

Consistent with UKHSA guidance, NHSP framework and professional standards.



Timely outbreak containment

Effective multi-agency coordination to minimise transmission and protect population health.



OUR PURPOSE: Protecting people, strengthening systems, and responding with speed and expertise to emerging public health threats.



PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Joint PHA, SPPG and BSO Annual Report on Emergency Preparedness 2025-2026

Reference PHA/09/10/26

Prepared by Mary Carey / Catherine Curran (PHA), Philip Martin (SPPG),
Darren Sessions (BSO)

Lead Director Dr Joanne McClean

Recommendation

For **Approval** ☒

For **Noting** ☐

1 Purpose

The purpose of this paper is to bring the Joint Emergency Planning Report to the Board for approval. It provides the Board with an overview of Emergency Preparedness, Resilience and Response (EPRR) activity undertaken jointly by the Public Health Agency (PHA), Strategic Planning and Performance Group (SPPG) and Business Services Organisation (BSO) during 2025/26, and to seek endorsement of the assurance position and identified improvement priorities.

2 Background Information

The annual EPRR report outlines organisational activity undertaken to meet statutory and policy requirements under the Northern Ireland Civil Contingencies Framework and HSC Emergency Planning Policy Circular HSC (44/2022). The report provides assurance regarding preparedness arrangements across PHA, SPPG and BSO and highlights key areas of risk, mitigation and future development.

During the reporting period, the organisations maintained active participation in regional, national and multi-agency preparedness structures and supported planning for major events, including The Open Championship and Fleadh Cheoil na hÉireann 2026. A significant programme of exercising was also completed, including participation in Exercise Pegasus (UK Pandemic Preparedness Exercise) and Exercise Echo Trail (regional CBRNe exercise programme).

3 Key Issues

The report concludes that overall emergency preparedness arrangements remain effective and that substantial compliance has been achieved against HSC Emergency Planning Core Standards. However, several strategic risks require ongoing attention and investment:

3.1 CBRN Preparedness

The most significant strategic risk relates to HSC Chemical, Biological, Radiological and Nuclear (CBRN) capability, including:

- Limited specialist training capacity and a shortage of trained instructors.
- Absence of a local accredited CBRN training provider.
- Ageing decontamination infrastructure.
- Requirement for replacement Powered Respirator Protective Suits (PRPS) and associated equipment.
- Findings from the regional capability review highlighting sustainability concerns and future investment requirements.

3.2 Pandemic Preparedness

Lessons identified through Exercise Pegasus highlighted a number of strategic considerations, including:

- Workforce resilience and surge capacity.
- High Consequence Infectious Disease (HCID) preparedness.
- Critical care capacity.
- Information management and situational awareness arrangements.
- Digital interoperability and data-sharing capability.
- Long-term preparedness funding requirements.

3.3 Workforce Competence

Assurance returns identified areas requiring improvement in emergency planning competency, particularly command and control training, exercising and specialist operational skills. Actions are in place to strengthen training provision across the HSC.

3.4 Business Continuity and Cyber Resilience

Cyber risks continue to represent a significant threat to health services. Exercises undertaken during the year identified opportunities to strengthen ICT resilience, communications arrangements and recovery planning.

Mitigation and Improvement

A range of actions are currently being progressed, including:

- Participation in regional CBRNe exercising and capability development programmes.
- Audit and replacement planning for specialist CBRN equipment.
- Development of sustainable specialist training arrangements.
- Establishment of new Department of Health governance arrangements for pandemic preparedness.
- Strengthening workforce resilience, information management and HCID planning.
- Development of a regional HSC Mass Casualty Planning Group.
- Ongoing assurance, exercising and continuous improvement activity through the Joint Emergency Planning Board work programme.

Assurance Position

The report provides assurance that PHA, SPPG and BSO maintained emergency preparedness arrangements throughout 2025/26 despite significant operational pressures. While capability gaps remain in several strategically important areas, programmes of work are established to address these issues and support continued compliance with statutory and policy requirements.

4 Next Steps

Following approval, the Report will be submitted to the Department for publication.

PHA Board Meeting

Title of Meeting PHA Board Meeting

Date 22 October 2026

Title of paper Update on Progress against the Screening Programmes Internal Audit Recommendations and the Cytology Action Plan

Reference PHA/10/10/26

Prepared by Tracy Owen / Danny Wilson

Lead Director Dr Joanne McClean

Recommendation

For **Approval** ☐

For **Noting** ☒

1 Purpose

The purpose of this paper is to update the Board on progress against the recommendations contained in a 2025/26 Internal Audit report on PHA Screening functions, which received a limited assurance.

2 Key Issues

As the Internal Audit report is aligned with improvement work which was already being undertaken in relation to cervical screening, a progress update against the PHA actions identified from the various reports associated with the Southern Trust Cervical Cytology Review is also included.

These updates provide assurance that a significant number of actions have already been closed and others are on track for completion within identified timescales.

Number of recommendations	Internal audit	Cervical screening improvement plan
Completed	4	12
On track for completion	4 (March 2027)	5 (December 2026)
Total	8	17

A significant quality improvement project associated with the audit of invasive cervical cancers has been undertaken over the last year and addresses a number of the recommendations.

A presentation will also be given to the Board on the QuIP project for the cervical cancer audit.

3 Next Steps

Progress against the recommendations contained within both reports will be monitored by the Screening Programme Board and with updates on the implementation of the Internal Audit recommendations provided to the Governance and Audit Committee.

Summary Paper

Screening Internal Audit Recommendations and Cytology Action Plan – Progress update

22nd October - PHA BOARD MEETING

Internal Audit –

Recommendation	Status	BRAG
Programme specific operating models for quality assurance will be developed for each programme.	All programmes are progressing the development of their operating models. The focus of this work is to consolidate separate elements across different documents into a coherent and consistent approach.	ON TRACK - Mar27
2.1 The PHA will develop appropriate documentation to describe the roles and responsibilities of each organisation involved in programme delivery. This work will be phased, proposing to take this forward for three programmes during 2026/27.	Cervical, NHSP and AAA are taking this work forward initially. Cervical due to the Cytology Incident Action Plan had already began work on this and so it is in its final phase. AAA and NHSP have begun drafting.	ON TRACK - Mar27
4.1 The PHA will develop a commissioning framework for screening programmes.	Completed and closed	COMPLETE
5.1 The PHA will introduce the use of governance tools, including risk registers and actions logs for all screening teams	All programmes have begun initiation of Risk registers and action logs for their systems and are bedding them in over the coming months	ON TRACK - Mar27
5.2 The PHA will review and update the Terms of Reference of the groups as recommended	Completed and closed	COMPLETE
6.1 The PHA will ensure the appropriate BSIMS SLA documentation is finalised and signed.	Completed and closed	COMPLETE

6.2 The PHA will undertake a review of user access to BSIMS and ensure a process for annual review is captured in the bowel screening operating model for quality assurance	Completed and closed	COMPLETE
7.1 The PHA will review and update the suite of policies, procedures and guidance within the breast screening programmes	Work is ongoing to ratify the suite of policies with Breast/VHR screening that fall under the scope of this recommendation. This work is on track for completion in March	ON TRACK - Mar27

Cytology Action Plan –

Recommendation	Action	BRAG
Establish a formal annual process for sharing learning arising from Invasive Cancer Audits with all Trusts.	Creation of Guidance Doc for Disclosures. Regional Audit MDM established, which embeds how learning is shared	COMPLETE
Ensure robust workforce planning, succession arrangements and business continuity plans are in place across the cervical screening pathway.	Lab service specification in place as part of commissioning process and business continuity arrangement established via an SLA between Belfast Trust and Gateshead.	COMPLETE
Implement enhanced annual performance monitoring at individual screener level, supported by assurance of improvement plans where required.	This is now part of annual lab review. Fully detailed in new Lab Performance work instruction.	COMPLETE
Review and strengthen the authority, accountability and governance arrangements of the Hospital Based Programme Coordinator role.	Covered in detail within the new Audit Framework document and the Cervical Roles and Responsibility Document.	ON TRACK - Dec26
Strengthen commissioner-provider agreements to clearly define responsibilities, governance arrangements and escalation pathways.	- A laboratory service specification is in place which includes requirement for Trust laboratory provider to have clear governance structure in place. - Cervical Roles and Responsibilities document at final draft sets out clear guidance across all	ON TRACK - Dec26

	organisations involved in the screening programme - Overarching governance framework for population screening describes escalation pathways.	
Establish and chair regional Programme Boards to provide strategic oversight and assurance of cervical screening services.	Regional Cervical Screening Operational Group established with agreed ToR	COMPLETE
Develop a standardised regional letter of invitation for involved in the audit process.	Included within the new regional audit documentation and operational across all Trusts.	COMPLETE
Provide confirmation to the lab that the calculation of statistics are aligned with NHSCSP guidance.	This is documented in a work instruction relating to screener performance data which has been agreed with the lab and operationalised.	COMPLETE
Designate a lead Hospital Based Programme Coordinator for inter-Trust cases to oversee audit and disclosure processes.	This is documented in the new Regional Audit Guidance.	COMPLETE
Review and improve disclosure processes to enhance consistency and patient experience.	Disclosure process has been reviewed as part of the QULP. This is supported by Guidance Document, SoPs and a regional training event	COMPLETE
Review and update the regional QA framework to clearly define the scope of QA activity and distinguish it from commissioning functions.	The Population Screening Governance Framework has been revised. A Cervical Screening QA Operating Model sets out the detail and scope of QA activities.	ON TRACK - Oct26
Develop and implement comprehensive QA operating processes and procedures across all screening programmes.	A new Cervical Screening QA Operating Model has been development with underpinning SOPs and work instructions being updated. .	ON TRACK - Dec26
Establish dedicated leadership capacity to drive the development and continuous improvement of QA processes.	Staff Member in Post.	COMPLETE
Strengthen service specifications to make participation in QA activities a contractual requirement.	Included in laboratory service specification and in new Roles and Responsibilities document for all organisations.	COMPLETE
Establish robust QA advisor arrangements with clear roles, responsibilities and independent professional input.	Developed job description and external laboratory QA advisor in post.	COMPLETE

Develop and publish Northern Ireland QA guidance for screening services.	Undertake a mapping of NHSCSP guidance and produce a summary table which indicates applicability to NI and links to guidance.	ON TRACK- Dec26
Implement communication to GPs on the appropriate referral and management pathways for symptomatic patients	Reminders on symptomatic referrals included in PHA Screening Matters Newsletter which is distributed to all GP practices. This was also included in smear take update training in June 2026	COMPLETE