

agenda

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

standing items

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

committee updates

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

items for approval

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

closing items

- 18
3.10 Any Other Business
- 19 Details of next meeting:
Thursday 16 November 2023 at 1.30pm
Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

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

Present

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

In Attendance

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

Apologies

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

93/23 Item 1 – Welcome and Apologies

93/23.1	The Chair welcomed everyone to the meeting. Apologies were noted from Mr John Patrick Clayton and Mr Brendan Whittle.
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94/23 Item 2 – Declaration of Interests

94/23.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.
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95/23 Item 3 – Minutes of previous meeting held on 22 June 2023

95/23.1	The minutes of the Board meeting held on 22 June 2023 were
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APPROVED as an accurate record of that meeting.

96/23 Item 4 – Matters Arising

- 96/23.1 For action 1 regarding the COVID Inquiry, the Chief Executive advised that an Inquiries Programme Board has been established within the PHA and that it held its first meeting on Wednesday afternoon. He explained that it will meet fortnightly prior to the Agency Management Team (AMT) meeting. He said that a number of additional staff have been employed to support ongoing Inquiry work.
- 96/23.2 The Chief Executive advised that there needs to be a discussion about getting Non-Executive Director (NED) input and for members to consider how they would like to be kept informed. He said that there is now a page on the PHA Intranet where Statements are uploaded. He noted that going forward there will be issues that pertain to the Board and added that the Inquiry has been requesting minutes of confidential sessions of PHA Board meetings and that PHA's legal representatives are discussing this with the Inquiry. The Chair said that the NEDs would need to have a discussion amongst themselves about how they can be involved.
- 96/23.2 A member said that the Board should see any Statements before they are submitted and agreed that there should be Board oversight. The member added that there is a lot of effort required to support these Inquiries and the staff involved need be looked after. It was agreed that the Chair would organise a Teams meeting with members to discuss NED involvement (**Action 1 – Chair**).

97/23 Item 5 – Chair's Business

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

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

- 98/23.1 Ms Henderson updated members on the recent meeting of the Planning, Performance and Resources (PPR) Committee where she advised that there had been a discussion on the financial planning process for 2024/25. She explained that a paper was presented outlining an approach for staff to identify areas of potential recurrent savings and that a draft Plan will be brought to the Board in October. She noted that this year savings will largely be funded from slippage.
- 98/23.2 Ms Henderson advised that the Committee had discussed the Substance Use Plan. She explained that the Committee had considered the Plan twice and that changes were made to it regarding which organisations were responsible for which parts, and that the Committee is happy to recommend the Plan to the Board today for approval.

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

At this point Ms Mann-Kler joined the meeting.

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

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

99/23 Item 7 – Chief Executive’s Business

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

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

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

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

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

- 99/23.6 The Chief Executive advised that PHA has received confirmation of non-recurrent funding being made available for HSCQI for 2023/24. He added that a permanent funding arrangement needs to be put in place. The Chair said that his understanding was that PHA would receive 2 years of funding. Ms McCaig advised that she is hopeful PHA will receive the 2 years.
- 99/23.7 The Chair said that the hospital reconfiguration programme had come up at a recent Chairs' meeting. He added that while this is a significant and important piece of work, he was not clear why PHA is involved. The Chief Executive explained that PHA is putting forward the public health view and is seeking to ensure that any reconfiguration takes cognisance of equality of access. He added that PHA has a role in service development and providing professional advice. The Chair asked why PHA is chairing a workstream and the Chief Executive explained that a number of Chief Executive are co-chairing different workstreams. The Chief Executive added that it is appropriate that PHA chairs this workstream as it has a regional focus.
- 99/23.8 The Chair asked what would happen if the outcome of this work is not welcomed by political representatives. The Chief Executive explained that PHA's role is only one aspect of this work, and that PHA is not writing the document, but at the same time the work should not be undertaken without PHA. He added that the document produced will be public facing and will be required to be signed off by a Minister and that part of this work is to ensure that all political parties are on board. Ms McCaig said that this work is part of the implementation of the Bengoa Report and that it is appropriate that PHA has a role and that the Chief Executive is chairing a workstream. The Chair said that he wished the Board to be clear on why PHA is involved in this and what its role is. He added that this links back to Public Inquiries and PHA answering questions about areas that are not part of its business. The Chief Executive said that this work is clearly defined in PHA's role.
- 99/23.9 A member said that while they understood why PHA is involved in this work, they remain unclear about PHA's role with regard to commissioning and would welcome a 2/3 page paper explaining what this configuration programme is and what PHA's role is. The Chief Executive explained that PHA has always had a co-joined role in commissioning and it would continue to have that role. The Chair said that he would like to see a paper so there is a record of PHA's involvement **(Action 2 – Chief Executive)**.
- 99/23.10 The Chair asked if PHA is clear in terms of its role within ICS. The Chief Executive replied that it is an evolving picture which is beginning to settle, but PHA's role is two-fold, inputting advice and preparing a population needs analysis. He explained that PHA is working in partnership with the Trust, primary care, local Councils and the community and voluntary sector. He added that what was originally envisaged for ICS has now changed and that it will likely continue to

- evolve. He noted that in Wigan, public health sits within the Council so the set up will be different here. The Chair said that at the recent Chairs' meeting there seemed to be some concern as to where ICS is going and he wished to be assured that PHA is delivering what it is being asked to. The Chief Executive assured members that PHA is doing so, and is part of the decision making authority.
- 99/23.11 A member asked if carrying out the needs analysis is a big piece of work. The Chief Executive said that population health has always been part of PHA's remit and PHA is working on a more agile approach to produce data by developing a dashboard which focuses on the areas that ICS is seeking information on. The Chair asked if this information can be shared with the Board and the Chief Executive suggested that there could be a demonstration of the dashboard. A member asked if this dashboard can measure change and the Chief Executive replied that it could do in the long run.
- 99/23.12 Dr McClean advised that the 3 areas the AIPB is focusing on are frail elderly, mental health and children and the dashboard will contain in-depth information on those areas. She explained that PHA did not wish to develop a tome of information, but rather develop a dashboard which could be demonstrated for the Board. The Chair said that this type of baseline data has never been seen by the Board before and that it should form the basis of PHA's strategic planning, and allow the Board to get a sense of where the public health inequalities are so that this information can be fed into the HSC system. The Chief Executive advised that part of PHA's strategic intention is to have information at the heart of what it does, and that it should have timely information to enable it to be a more agile organisation. He added that PHA should be aiming to use technology to access a whole range of databases to obtain relevant information. He advised that the Department has already signed off on a number of outcomes it wishes to get from ICS.
- 99/23.13 A member asked if it is possible for the dashboard to look back at the data from 3 months ago. Dr McClean explained that the dashboard pulls together information from various sources and then data analytics staff can knit it together. She said that PHA uses data all the time. The Chair commented that he wished to see the data being more visible. A member said that it would be useful to compare present data with previous data, but added that there should always be a back up in place and not to be fully dependent on a dashboard. It was agreed that there would be a demonstration of the dashboard **(Action 3 – Dr McClean)**.
- 99/23.14 A member said that communication is important and that organisations outside the HSC need to be able to access this information. Dr McClean advised that PHA is aiming to carry out the needs assessment in a new way so that the information can be shared with the community and voluntary sector.
- 99/23.15 A member asked if information on health inequalities can be captured,

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

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

100/23.1 This was cover under Item 7 above.

101/23 Item 9 – Finance Update

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

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

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

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

101/23.5	The Chair said that he appreciated that it is difficult to land on a break-even position. Ms McCaig reminded members that the Chief Executive, as Accounting Officer, has a responsibility to ensure that the organisation breaks even.
101/23.6	The Chair asked whether a decision has been made regarding the retraction of £3.2m of R&D funding for this year and if he should write to the Permanent Secretary regarding this. Ms McCaig advised that she had spoken to the Permanent Secretary about this and that she would ask him about it again next month as a decision needs to be made. The Chair said that if PHA feels that this funding is important, this should be reflected back to the Department. Ms McCaig suggested that the Chair should write to the Permanent Secretary (Action 4 – Chair) .
101/23.7	The Board noted the Finance Report.
102/23	Item 10 – Update from Chair of Planning, Performance and Resources Committee
102/23.1	This was covered under Item 6 above.
103/23	Item 11 – Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order (PHA/02/08/23)
	<i>Ms Karen Braithwaite joined the meeting for this item</i>
103/23.1	Mr Wilson advised that the Annual Progress Report to the Equality Commission is structured with various chapters and that PHA has no license to alter this. He gave an overview of what is contained in each chapter.
103/23.2	The Chair agreed that the Report is long and felt that the template does not make it particularly meaningful.
103/23.3	A member asked for an assessment of how the outcomes in this Report are helping to reduce health inequalities and how meaningful a tool the Report is for the PHA. Ms Braithwaite said that the format of the Report is unhelpful, but PHA works with the Equality Unit in BSO to complete it. She commented that the Report ensures that PHA focuses on ensuring that PHA reports on all the work that it does in the area of equality and acts an <i>aide memoire</i> to address areas such as training and the completion of Equality Screenings. She added that a lot of PHA staff have undertaken equality training.
103/23.4	Ms Braithwaite advised that this Report represents Year 5 of a 5-year plan and that there are some actions which were not completed due to the pandemic so there has been a focus on developing new Equality and Disability Action Plans.

- 103/23.5 Ms Braithwaite noted that PHA does not receive feedback from the Equality Commission on this report and so there is a question to be asked about what the investment in for doing this Report, other than it being a statutory duty. A member said that everything PHA does falls within this Report, but there should be a look at the cost and benefit of compiling it. The member asked if there has been a high-level discussion with the Equality Commission. Ms Braithwaite said that PHA is good at doing work which has an impact on equality but is not good at recording it in such a way as it fits within the template of this Report.
- 103/23.6 A member commented that when thinking about PHA's role in terms of health inequalities, this Report does not look at inequalities in terms of poverty and asked how PHA measures this. The Chair said the format of this Report is around changes in organisational development vis-à-vis equality as opposed to societal development. He asked if PHA has had any discussion with the Equality Commission. The Chief Executive commented that this Report shows how PHA is being compliant with the law in terms of its equality obligations instead of how it deals with inequalities as a statutory obligation rather than how PHA conducts its business.
- 103/23.7 The Chair asked if it is worthwhile having a discussion with the Equality Commission. Mr Wilson suggested that it may be useful given PHA has now commenced on a new 5-year Equality Plan. He noted that Programme for Government (PfG) is the main document for driving how Northern Ireland creates a fairer society. A member said that there was formerly an initiative around targeting social need and asked how it has been replaced. Mr Wilson replied that PfG was to replace that. The Chief Executive said that he would be content to arrange a meeting with the Equality Commission and the Chair suggested that whoever is Interim Chair at that time should accompany him (**Action 5 – Chief Executive**).
- 103/23.8 The Board **APPROVED** the Draft Annual Progress Report 2022-23 to the Equality Commission on Implementation of Section 75 and the Duties under the Disability Discrimination Order.
- 104/23 Item 12 – Draft Substance Use Strategic Commissioning and Implementation Plan (PHA/03/08/23)**
- Mr Kevin Bailey joined the meeting for this item*
- 104/23.1 Mr Wilson said that this Plan has been presented to the PPR Committee and that Mr Bailey would give members an overview. He advised that the Plan has been modified to ensure that the PHA's role is clearly defined vis-à-vis that of SPPG. He added that following approval the Plan will go for public consultation in September.
- 104/23.2 Mr Bailey explained that this framework has been developed in response to the Departmental strategy and that over 150 organisations

- have been involved in its development. At the first meeting of the PPR, he said that a number of challenges were highlighted which he has sought to address. He said that the targets that PHA is responsible for have been separated from those of SPPG, but added that there remains some overlap. He advised that following approval a public consultation will commence on 4 September and there will be a series of engagement workshops. Following the consultation, he said that the Plan will be redrafted and a final document brought to the Board which will outline PHA's priorities in this area for the next 4/5 years, and then procurement for regional services can commence.
- 104/23.3 A member said that there has been phenomenal work to produce this Plan and that it now clearly sets out the short, medium and long term objectives as well as those elements for which PHA is responsible. The member added that the Plan has also been considered at the Procurement Board.
- 104/23.4 A member asked what the biggest friction point has been developing this document. Mr Bailey replied that the document was compiled using a co-production approach but there is always a mismatch between what services want and what the service user actually needs. He added that there will be a challenge in terms of keeping a momentum on this work as well as getting additional funding from the Department. He said that PHA will have to reinvest money from one service into another.
- 104/23.5 A member acknowledged that this is a high level document, but asked what outcomes have been determined and how these will be monitored. The member noted that there are financial constraints and asked if the shortfall has been identified. The member said that within the document it indicates that PHA has to reprioritise and asked if there is a matrix for working that through. If no funding is available, the member asked if this means that full implementation will not be achieved and if PHA is prepared to live with that scenario.
- 104/23.6 In terms of outcomes, Mr Bailey responded that it is difficult to include those at a population level. He added that the Chief Medical Officer has asked for a framework to be developed but noted that PHA cannot go outside the statutory outcomes that are within the Department's Strategy and these will be monitored. With regard to the financial context, Mr Bailey said that it would be remiss to not set out that this is tough at present. He said that PHA is currently content with the services on the ground. He advised that this is a high level Plan and PHA will put in place an operational strategy and part of that will look at developing outcomes. He said that a risk matrix has not been developed, but he would take guidance on this. On what would happen if there was no funding, he pointed out that the overall Strategy is about saving lives.
- 104/23.7 The Chief Executive said that he wished to thank Mr Bailey for his work and added that PHA has to commit to this work acknowledging that it may have operational consequences. He explained that there may be

- difficult conversations in terms of whether the actions in the Plan are in line with PHA's Strategy or if funding needs to be reinvested elsewhere. He noted that the Plan will also be signed off by SPPG as it relates to services being provided in Trusts.
- 104/23.8 A member commended the Plan saying that work is important as helping people early will have an impact in their later life. Another member said that this Plan repositions services that go together, thus de-stigmatising those services. Mr Bailey advised that this work links with PHA's Annual Business Plan. The Chair commented that if PHA is in a situation where funding is not available then it needs to have evidence to determine where its priorities lie.
- 104/23.9 The Chair thanked Mr Bailey for his work. Mr Bailey said that thanks should also go to staff in SPPG and PHA Operations.
- 104/23.10 The Board **APPROVED** the draft Substance Use Strategic Commissioning and Implementation Plan.
- 105/23 Item 13 – Performance Management Report (PHA/04/08/23)**
- 105/23.1 Mr Wilson presented the Performance Management Report and said that members will be familiar with its format. He said that of the 37 actions against the 10 priorities in PHA's Business Plan for 2023/24, 1 action has been rated "red". He explained that this relates to HSCQI and represented the position as at the end of June, but that has now changed as per the discussion earlier in the meeting. He advised that of the remaining actions, 15 are rated "amber" and 21 are rated "green".
- 105/23.2 A member asked if there are any major issues to be reported in relation to the action plan targets. Mr Wilson explained that this relates to the Part B Business Plan and that no actions are currently rated as "red".
- 105/23.3 A member asked when the action rated "red" regarding HSCQI will move to "green". Dr Keaney said that she hoped that it would be rated "amber" by the time the next report is produced but there is a slight delay in implementing HSCQI's work plan.
- 105/23.4 A member asked whether the target of a 1% rise in vaccinations is an overall increase, or within each programme. Dr McClean explained that within the pre-school programme many of the vaccination programmes are joined up and that the World Health Organisation target is 95%. She advised that there is an issue with uptake in the Belfast area which is impacting on the figures. She added that there are also data issues as information is captured on different systems. She said that disadvantaged areas have lower uptakes.
- 105/23.5 The Chief Executive advised that he recently met with the Royal College of General Practitioners (RCGP) and the issue of vaccination was discussed at that meeting. He added that PHA will also meet with the

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

105/23.6 Members noted the Performance Management Report.

106/23 Item 14 – Any Other Business

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

107/23 Item 15 – Details of Next Meeting

Thursday 19 October 2023 at 1.30pm

Board Room, County Hall, Ballymena

Signed by Chair:

Date:



Finance Report

August 2023

Tracey McCaig
Director of Finance

September 2023

Section A: Introduction/Background

1. The PHA Financial Plan for 2023/24 has set out the funds notified as available, risks and uncertainties for the financial year and summarised the opening budgets against the high level reporting areas. It also outlined how the PHA would manage the overall funding available, in the context of cash releasing savings targets applied to the organisation. It received formal approval by the PHA Board in the June 2023 meeting.
2. The Financial Plan detailed the quantum of cash releasing savings targets (£5.3m, plus an additional £3.2m in respect of the area of Research and Development), the plans in place in year to address the target applied and the resultant opening forecast deficit of £0.65m. A focus on reducing and closing this gap is continuing as plans are required to meet the target both in-year and recurrently.
3. This executive summary report reflects the draft year-end position as at the end of August 2023 (month 5). Supplementary detail is provided in Annex A.

Section B: Update – Revenue position

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

Table 1: Opening financial position 2023/24

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

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

5. The PHA has reported a surplus at August 2023 of £0.3m (July 2023, surplus of £0.2m) against the year to date budget position for 2023/24. The forecast year-end position is reported as breakeven (July 2023 forecast, £0.28m deficit), with the reduction primarily relating to a movement in the area of Management and Administration.
6. The month 5 position is summarised in Table 2 below.

Table 2: PHA Summary financial position - August 2023

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

Note: Table may be subject to minor roundings.

Note: Table may be subject to minor roundings

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

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

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

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

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

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

Section C: Risks

9. The following significant assumptions, risks or uncertainties facing the organisation were outlined in the Financial Plan.
10. **Recurrent impact of savings made non-recurrently in-year:** The opening allocation letter has indicated that, whilst 2023/24 savings measures may be non-recurrent in nature, the funding reductions are recurrent and therefore PHA is expected to work to ensure savings are made recurrently going forward into 2024/25 where necessary. While PHA has identified a significant element of the £5.3m savings target applied (excluding the £3.2m reduction relating to PHA R&D), there remain challenges in delivering the full requirement in year and recurrently. PHA colleagues have identified savings / budget reductions for £3.6m in-year and are continuing to work on developing savings proposals to address the remaining gap. Savings targets will be monitored throughout the year with the identification of recurrent savings plans finalised well in advance of 2024/25.
11. **R&D revenue retraction:** A further £3.2m funding retraction has been applied in respect of the revenue Research & Development (R&D) budget, which eliminates this budget entirely. The formal allocation letter from DoH indicated that this funding

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

12. EY Reshape & Refresh review and Management and Administration budgets:

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

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

14. Demand led services: There are a number of demand led budgetary areas which are more difficult to predict funding requirements for, presenting challenges for the financial management of the Agency's budget. For example, early initial indications are that there may be expenditure pressures in the area of smoking cessation / Nicotine Replacement Therapy (NRT). The financial position of these budgets are being carefully tracked. These budgets will be kept under close review throughout the year.

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

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

16. **Funding not yet allocated:** At the start of the financial year there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include Pay awards for the 2023/24 financial year. No expenditure will be progressed for any pay award payments to staff until such pay awards are approved by DoH and funding identified and secured.
17. Due to the complex nature of Health & Social Care, there will undoubtedly be further challenges with financial impacts which will be presented going forward into the future. PHA will continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

18. The PHA has an opening capital allocation (CRL) of £13.1m. This currently all relates to projects managed through the Research & Development (R&D) team. The overall summary position, as at August 2023, is reflected in Table 3, being a forecast breakeven position on capital funding.
19. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.
20. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a

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

Table 3: PHA Summary capital position – August 2023

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

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

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

Recommendation

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

Public Health Agency

Annex 1 - Finance Report

2023/24

Month 5 - August 2023

PHA Financial Report - Executive Summary

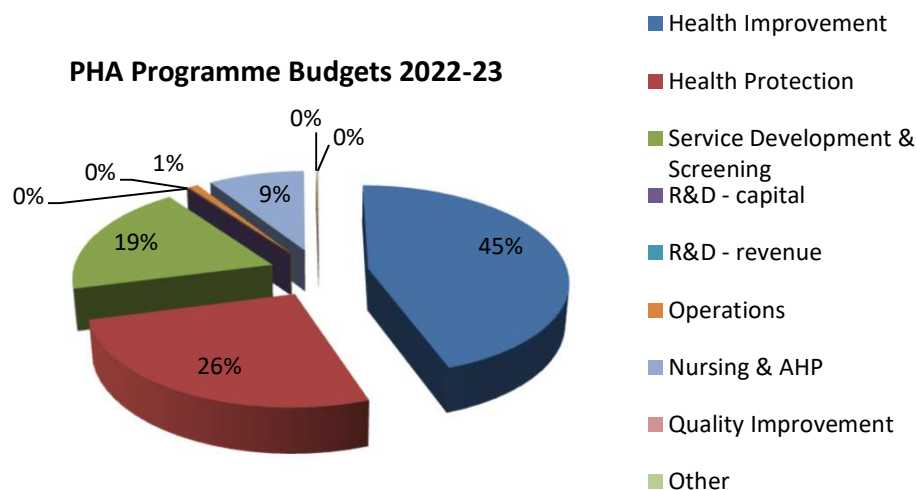
Year to Date Financial Position (page 2)

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

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

Programme Budgets (pages 3&4)

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



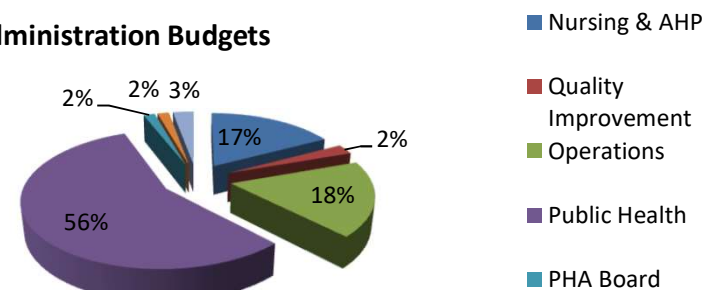
Administration Budgets (page 5)

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

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

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

Administration Budgets



Full Year Forecast Position & Risks (page 2)

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

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

Public Health Agency

2023/24 Summary Position - August 2023

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

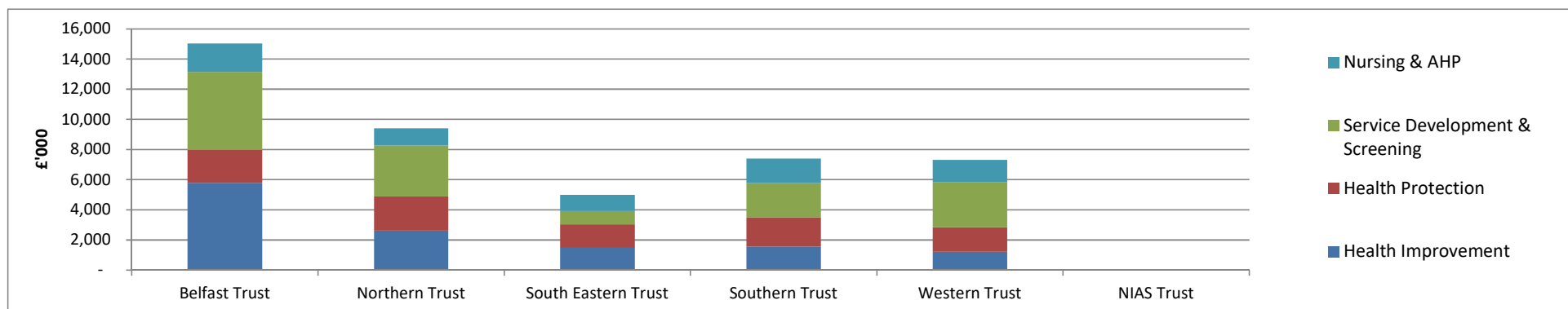
Please note that a number of minor rounding's may appear throughout this report.

* PHA Direct Programme may include amounts which transfer to Trusts later in the year

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

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

Programme Expenditure with Trusts



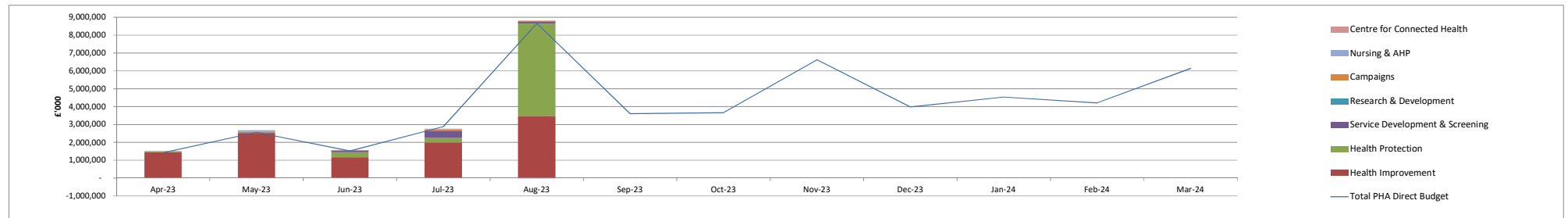
Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	NIAS Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,792	2,619	1,489	1,573	1,216	-	12,690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

Cumulative variance (%)

0.00%

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

PHA Direct Programme Expenditure



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

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

Public Health Agency 2023/24 Ringfenced Position

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

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

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

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

PHA Administration
2023/24 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	4,905	705	4,242	16,449	343	411	589	27,644
Goods & Services	184	12	1,125	242	113	47	251	1,974
Total Budget	5,089	717	5,367	16,691	456	458	840	29,618
Budget profiled to date								
Salaries	2,045	269	1,767	6,852	143	186	245	11,507
Goods & Services	80	5	469	103	16	18	104	794
Total	2,125	274	2,235	6,955	159	204	349	12,301
Actual expenditure to date								
Salaries	1,857	277	1,324	6,098	132	160	242	10,091
Goods & Services	78	1	794	266	11	12	61	1,224
Total	1,935	279	2,119	6,364	143	173	303	11,315
Surplus/(Deficit) to date								
Salaries	189	(8)	443	754	11	26	3	1,417
Goods & Services	1	4	(326)	(163)	5	5	43	(431)
Surplus/(Deficit)	190	(5)	117	591	16	31	46	986
Cumulative variance (%)	8.95%	-1.74%	5.22%	8.49%	9.99%	15.35%	13.19%	8.02%

PHA's administration budget is showing a year-to-date surplus of £1.0m, which is being generated by a number of vacancies, particularly within Public Health Directorate. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be c£2.4m, which is contributing towards PHAs forecast deficit in Programme expenditure in the financial year'

PHA Prompt Payment

Prompt Payment Statistics

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

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

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

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

Present

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

In Attendance

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

Apologies

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

40/23 Item 1 – Welcome and Apologies

- 40/23.1 Mr Stewart welcomed everyone to the meeting. Apologies were noted from Ms Tracey McCaig and Ms Colette Kane.

41/23 Item 2 - Declaration of Interests

- 41/23.1 Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda.
- 41/23.2 Mr Clayton noted that within the Corporate Risk Register, there are references to Public Inquiries, and how the PHA is responding to these, and therefore given Unison's involvement with Inquiries, he felt he should declare an interest.

42/23	Item 3 – Minutes of previous meetings held on 8 June 2023
42/23.1	The minutes of the previous meeting, held on 8 June 2023 were approved as an accurate record of that meeting.
43/23	Item 4 – Matters Arising
	<i>31/23.4 Corporate Risk Register</i>
43/23.1	Mr Stewart advised that a risk around the Reshape and Refresh work remains under consideration by the Agency Management Team (AMT), and that he had discussed this yesterday at a pre-meeting with Mr Wilson. He noted that there a Risk Register for the Project Board, but this will be different to the one of the Agency.
43/23.2	For action 2 on the previous minutes regarding late receipt of payments from the Special EU Programmes Body (SEUPB), Mr Stewart noted that Ms McCaig had updated members on this at a previous Board meeting and he did not consider that any further action was required on his part.
44/23	Item 5 – Chair’s Business
44/23.1	Mr Stewart advised that he had no Chair’s Business.
45/23	Item 6 – Internal Audit
	<i>Internal Audit Progress Report [GAC/28/09/23]</i>
45/23.1	Mr Charles advised that he was presenting two reports today, one following an audit of the management of community and voluntary sector contracts and a second around complaints and claims. He added that Internal Audit has delivered against 31% of its Service Level Agreement for this year and that all KPIs are on track.
45/23.2	Mr Charles reported that a limited level of assurance has been given to the audit of the management of voluntary organisation contracts. He explained that there was a specific focus on mental health and suicide prevention services.
45/23.3	Mr Charles advised that there were 2 significant findings, the first of which related to procurement. He highlighted that 291 contracts (104 of which were mental health and suicide prevention), with a value of £17.6m, have not been subject to a recent competitive award process and have been rolled forward. He added that because PHA had to refocus its resources during the pandemic, procurement timelines have been delayed. He noted that the rolling forward of contracts could mean that there may be similar contracts in different organisations, but at different rates. He said that current contracts are focused on measuring outputs rather than outcomes, but he acknowledged that work on outcomes measurement is at an early stage.

- 45/23.4 Mr Charles said that the second finding relates to contract validation as this process was stood down during the pandemic. He advised that there has been no sample validation of quarterly returns, something which was in place before the pandemic.
- 45/23.5 Mr Charles went through the key findings of the report. He noted that contract leads have not received training in how to complete Progress Monitoring Returns (PMRs), and that organisations have to manually input activity into a Word document rather than an Excel spreadsheet which could add up the data. He added that there are no KPIs in place and that there has been no formal reporting to AMT or the Board. He said that although contract leads have requested documents for review, these have not been reviewed appropriately.
- 45/23.6 Mr Charles advised that a total of 9 recommendations have been made, one of which is a Priority 1, and that management has accepted all of the recommendations.
- 45/23.7 Mr Clayton said that this was a very useful report as this has been an area of concern for the Committee and the Board for a long period. He added that the report gives the Committee a better sense of the issues regarding the current process and outlines what needs to be done going forward. He acknowledged that there has been difficulty for PHA in terms of being able to measure outcomes rather than outputs.
- 45/23.8 Mr Clayton outlined that his main concern was around the Priority 1 recommendation as PHA does not often receive many of those. He noted that there was an implementation date of this recommendation going back to 2015 and then has now been revised to 2026 and there is a significant amount of work to be done to achieve this. He asked if he could get a sense of why it will take this long and how the Committee will be kept updated on how the work is progressing. He acknowledged that there are issues around internal procurement capacity. Looking at the target to undertake 10 verification visits by March 2024, he asked how this number was determined.
- 45/23.9 Ms Mann-Kler said that she echoed many of Mr Clayton's comments and welcomed this report as it highlighted the concerns that the Committee has had. She asked how PHA intends to respond to the findings, acknowledging that management has accepted them. She queried if PHA is adequately resourced to take the recommendations forward and how progress will be communicated to the Committee and the Board.
- 45/23.10 Mr Stewart asked if the implementation date of 31 March 2026 for the Priority 1 recommendation is realistic adding that it is embarrassing having a recommendation that has been outstanding for 11 years.
- 45/23.11 Mr Wilson said that a number of the findings from the audit did not come as a surprise and reflected the operational issues that PHA is

- experiencing. He added that PHA is not adequately resourced in this area and that as part of the Reshape and Refresh work, there is a need to look at where contract management sits and to bring it into the corporate side as this would be a more sensible approach. In terms of reviewing returns and completing validation visits, he conceded that there is a lack of capacity and that area at this time, but he added that the Procurement Board is well aware of these issues.
- 45/23.12 Mr Murray explained that there are legal requirements within procurement and it can take PALS a minimum of 12 months to process an individual tender, and that PHA may have up to 7/10 tenders, each of which will take time to process. He outlined that the one area that PHA is in control of is in relation to pre-procurement planning, but there are capacity issues in what is a complex and difficult area. He said that PHA's Procurement Plan requires many teams working in parallel, but the difficulty is then getting work delivered through PALS as it is working on a regional basis. He agreed that the Reshape and Refresh programme will be important in terms of pushing this work up PHA's agenda. However, he conceded that the timelines may slip and that although the implementation is possible, it is reliant on a number of factors.
- 45/23.13 Mr Stewart said that there is a serious issue if it can take 24 months to complete a procurement. Mr Murray explained that once a certain threshold is exceeded, there is a different process which looks at issues such as TUPE. He added that the nature of PHA's work makes it more open to political challenge. Mr Stewart suggested that there should be an external review of the process as he expressed concern that the deadline of March 2026 is not achievable.
- 45/23.14 Mr Wilson said that the timescale is ambitious, but that PHA does have a plan in place. He reiterated that this is a system-wide issue, not one solely for PHA and he agreed that perhaps having an external perspective may help with some of the internal issues.
- 45/23.15 Mr Clayton said that the recommendations around verification visits and KPIs will help give an oversight of how the system is currently operating. However, in terms of how long it takes for a procurement exercise to be completed, he asked if there is an appreciation about the amount of resource required at an HSC level. He noted that there is a considerable amount of money involved in these contracts for PHA, but across the HSC as a whole it would be much bigger.
- 45/23.16 Mr Murray agreed that procurement capacity is a huge issue across the HSC and that PHA has been raising this for a number of years. He said that a particular skillset is required to complete a procurement exercise. He added that this work is now becoming more complex as GDPR is causing delays of 6/7 months. He reiterated that resourcing is key and that the HSC system has not accepted the scale of resource that is required. He added that PHA is one of the organisations that is most

- likely to get challenged with regard to its procurement.
- 45/23.17 Mr Stewart said that AMT needs to clarify what the requirements are so that if the PHA Chair were to write to BSO, PHA needs to be in a position where its own house is in order.
- 45/23.18 Mr Murray advised that PHA will be undertaking a review of assurance processes and that validation visits have been re-established. He explained that PHA cannot resource any more than 10 visits this year because it is an intense process, and that PHA is dealing with 70/90 providers per year.
- 45/23.19 Mrs McKeown noted that as the implementation date of the Priority 1 recommendation is not until 2026, Internal Audit will not be returning to review this area until then. Mr Murray said that the Procurement Board will be looking at this area and can provides updates to the PHA Board.
- 45/23.20 Mr Charles moved on to the second audit report which related to the management of complaints and claims and advised that a limited level of assurance was being given.
- 45/23.21 Mr Charles advised that there were 4 significant findings emanating from the audit, the first of which related to how information on complaints is stored in PHA. He said that the second finding is that there is no reporting on complaints at either Executive or Non-Executive Director level and that PHA does not produce a report on complaints in line with a Department of Health Circular from 2019. He advised that the third finding relates to the non-reporting on the status of claims at Executive or Non-Executive level. He said that the fourth finding is that staff have not completed training in respect of complaints management.
- 45/23.22 Mr Charles reported that there were 3 key findings, the first of which related to the timely completion of complaint investigations and informing complainants if there was going to be a delay. He added that the second finding was that PHA's Complaints Procedure has not been updated since 2012 and that the third finding was that PHA does not thank complainants for bringing issues to its attention or express sympathy around the complaint.
- 45/23.23 Mr Charles advised that the process for dealing with complaints has moved from the Nursing directorate to the Operations directorate. He added that a total of 10 recommendations have been made and these has been accepted by management.
- 45/23.24 Mr Wilson reiterated that the complaints function has now moved to the Operations directorate and he welcomed the timing of this audit. Going forward, he assured members that there will a more comprehensive approach to dealing with complaints and he was content to take on board all of the findings from the audit. He noted that prior to the pandemic, PHA did not receive many complaints, but the number has

	increased.
45/23.25	Mr Stewart asked Mr Wilson if he anticipated that all of the recommendations would be completed by their due date and Mr Wilson replied that they would be. Mr Stewart noted that complaints is now a standing item of the agenda of PHA Board meetings.
45/23.26	Mr Clayton said that he hoped that the Priority 1 recommendation on complaints records can be rectified quickly. In terms of Board oversight, he noted that while there has been information on complaints in the PHA Annual Report, a separate report on complaints would be helpful. He acknowledged that the number of complaints has been low. With regard to the updating of the Complaints Policy and Procedure, he said that he assumed that this would be brought back to this Committee.
45/23.27	Ms Mann-Kler noted that while the discussion has focused on complaints, compliments are also important. She said that complaints are an important part of the assurance process. She added that she was pleased to see the changes being made to the complaints process and she sought clarity on when the Committee and the Board would receive reports on complaints. Mr Stewart noted that the Chief Executive had given an overview of extant complaints at the last Board meeting and will report on any new complaints at the next month and at the end of the year there will be a cumulative report.
45/23.28	Members noted the Internal Audit Progress Report.
46/23	Item 8 – SBNI Declaration of Assurance [GAC/35/09/23]
	<i>Ms Helen McKenzie joined the meeting for this item</i>
46/23.1	Mr Stewart welcomed Ms McKenzie to the meeting. He noted that within the SBNI Declaration of Assurance there was an issue reported around illegal payments and he wished to be assured that the figure within the report is now accurate. Ms McKenzie advised that following a review the figure is now correct.
46/23.2	Mr Stewart sought assurance that there is now a process for closer scrutiny of payments within SBNI and Ms McKenzie confirmed that there are processes in place with HR, Finance and the Department.
46/23.3	Mr Stewart thanked Ms McKenzie for attending the meeting.
46/23.4	Members noted the SBNI Declaration of Assurance.
	<i>At this point Ms Mann-Kler left the meeting.</i>

45/23 Item 6 – Internal Audit (ctd.)

Internal Audit Annual HSC General Report 2022/23 [GAC/29/09/23]

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

- an External Audit perspective.
- 45/23.36 Mr McCance advised that NIAO has completed around round of contracting and that Cavanagh Kelly will be completing PHA's audit, on behalf of NIAO, for the next three years.
- Internal Audit Charter [GAC/30/09/23]*
- 45/23.37 Mrs McKeown advised that the Internal Audit Charter is a standard document for all clients and outlines the activity of Internal Audit. She said that it has been approved by the Chief Executive and has been reviewed against a model Internal Audit Charter. She advised that there have not been any substantial changes made to the document, but she has extended the commentary in a number of areas.
- 45/23.38 Mr Clayton said that he had no comments on the Charter and that it was a useful document.
- 45/23.39 Members **APPROVED** the Internal Audit Charter.
- 47/23 Item 7 – Corporate Governance**
- Corporate Risk Register as at 30 June 2023 [GAC/31/09/23]*
- 47/23.1 Mr Wilson advised that following a review of the Corporate Risk Register as at 30 June, a new risk has been added regarding Inquiries and a risk regarding financial break even has been removed. He explained that this update represents a further development in the implementation of the 3 Lines Assurance Model and that RAG ratings and risk scores have also been included.
- At this point Mr Irvine re-joined the meeting.*
- 47/23.2 Mr Wilson noted that many of the risks on the Register have been there for some time and the Register needs an extensive review and he hoped to come back to a future meeting with a more streamlined version. Mr Stewart agreed and said that some of the extensive commentary on the risks is not required. Mr Clayton commented that while some of the commentary is helpful, it could be reduced to give an overview of the most recent actions.
- 47/23.3 Mr Stewart reported that at his pre-brief with Mr Wilson yesterday, there was a discussion that the rating of the risk around staffing may be increased to severe. He agreed that there needs to a cleansing of the Register.
- 47/23.4 Mr Clayton asked about risk 55 and suggested that given Internal Audit have carried out an audit on recruitment, progress against recommendations in it should be referenced. He asked if there was any link between staffing issues and the financial position. Mr Wilson

- explained that one of the main issues is that there is a dearth of public health consultants because individuals can avail of improved working terms and conditions in posts in UKHSA or in the Republic of Ireland. He added that there is also a number of staff on long term sick leave and then there is also the degree of uncertainty with the ongoing restructuring. Mr Clayton asked if the staff leaving to work in UKHSA can do more work remotely and Mr Wilson confirmed that this is the case.
- 47/23.5 Mr Stewart advised that it is Mr Wilson's intention to completely revise this risk and bring that forward to the next meeting.
- 47/23.6 Mr Stewart commented that with regard to risk 60, around the migration of HSCB to SPPG, there remains a fog in terms of the relationship between PHA and SPPG and this is an issue that may need to be raised with the Board given that it has been discussed at recent Public Inquiry hearings. He added that it was also an issue he had raised with the Permanent Secretary.
- 47/23.7 Mr Stewart advised that risk 61 relating to Lifeline should be removed by the next review as the issues outlined in the risk are close to being resolved.
- 47/23.8 Members **APPROVED** the Corporate Risk Register.
- Operations Directorate Risk Register as at 30 June 2023
[GAC/32/09/23]*
- 47/23.9 Mr Wilson presented the Operations Directorate Risk Register and noted that while it does not appear that there are many risks on it, this is because the nature of the business of this directorate would lead there to being a higher chance that any risks needed to be placed on this Risk Register would instead be on the Corporate Risk Register.
- 47/23.10 Mr Wilson advised that the first risk on the Register relates to capacity within the information governance team. He said that the second risk relates to website hosting, where it was thought that a solution had been found, but this has not yet been fully worked out so a new Direct Award Contract (DAC) is in place.
- 47/23.11 Mr Stewart commented that the risk on procurement may need to be elevated.
- 47/23.12 Mr Clayton said that the issue of capacity within the information governance team is an important one. He noted that Gartner had recently provided some support in this area in terms of updating paperwork within the health protection directorate, and suggested that there is a capacity issue for the organisation as a whole. He said that the Information Governance Steering Group will keep an eye on this issue.

- 47/23.13 Mr Murray agreed that there is a balance between corporate capacity and focused capacity, e.g. within the health protection directorate. He said that there is a large infrastructure piece that needs to be put in place as GDPR assessments have to be carried out as part of procurement.
- 47/23.14 Members noted the Operations Directorate Risk Register.
- Update on Use of Direct Award Contracts [GAC/33/09/23]*
- 47/23.15 Mr Wilson advised that the number of DACs is reducing and that this report is an analysis of those in place. Mr Stewart expressed concern about the number of DACs relating to SBNI and said that this flags up the uncomfortable nature of the relationship with SBNI. Mr Clayton asked if SBNI completes its own DACs, but Mr Wilson explained that they are signed off by the PHA Chief Executive. Mr Wilson added that there is sometimes an issue as the DACs are retrospective which he explained can be due to the specific nature of the DACs and the need to get the associated work completed quickly.
- 47/23.16 Members noted the update on the use of Direct Award Contracts.
- PHA Business Continuity Plan and Policy [GAC/34/09/23]*
- 47/23.17 Mr Murray advised that PHA is required to have a Business Continuity Plan which sets out the processes and leadership roles when responding to an incident. He said that the Plan has been revised and updated and that there was a test carried out recently, the report of which is contained within the papers. He reiterated that the Plan ensures that individuals are aware of their roles in the event of an incident. He advised that there was a recent water outage incident in Linenhall Street and while the Plan did not need to be implemented, the Health Protection team took the decision to relocate their emergency room to County Hall for a couple of days. Mr Murray said that work is taking place to update directorate operational plans which will support this overall Plan.
- 47/23.18 Mr Stewart said that he would like to see the PHA Board included in the structure diagram within the Plan. He also sought clarity on the point at which, during the operation of the Plan, the PHA Chair is advised of an incident. He asked noted the reference to telehealth within the Plan and asked if that should be in the Plan, but Mr Wilson said that it should be outside the Plan.
- 47/23.19 Mr Clayton asked if any learning from the pandemic has been applied to this Plan, or if the Plan worked well. Mr Wilson explained that work is being carried out at directorate level to look at the learning from the pandemic. Mr Murray said that there needs to be a shift in culture whereby staff have a different mindset in terms of knowing what their “first responder” roles are in an emergency. Mr Clayton sought clarity

that this Plan also links to PHA's emergency preparedness work and Mr Stewart said that any emergency situation would see this Plan implemented.

47/23.20 Mr Clayton noted that some of the appendices have not been included, but Mr Wilson explained that this is for GDPR reasons.

47/23.21 Mr Stewart said that it was useful to read the report on the exercise, which he said was very worthwhile.

47/23.22 Mr Stewart asked why the MAO (Maximum Acceptable Outage) for screening programmes has been set at 10 weeks. Mr Wilson said that he would get clarity on this (**Action 2 – Mr Wilson**).

47/23.23 Subject to minor amendments, members **APPROVED** the Business Continuity Plan and Policy.

48/23 Item 9 – Any Other Business

48/23.1 There was no other business.

49/23 Item 10 – Details of Next Meeting

Tuesday 10 October 2023 at 10am

Fifth Floor Meeting Room (or via Zoom).

12/22 Linenhall Street, Belfast, BT2 8BS

Signed by Chair:

Joseph Stewart

Date: 10 October 2023

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

1 Purpose

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

2 Background Information

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

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

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

3 Key Issues

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

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

- Integrating the care

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

4 Next Steps

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



Transforming
the Culture



Strengthening
the Workforce



Measuring
Improvement



Raising the
Standards



Integrating
the Care



ANNUAL QUALITY REPORT

2022/23



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2. Sharing Learning from Hospital Inpatient Falls 11
3. Mealtimes Matter - Regional Resources 13

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

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

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

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

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

Thank you

Aidan Dawson



Transforming the Culture

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

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

INTRODUCTION

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

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



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

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

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

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

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

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

Outcomes

Leadership, Advice and Guidance

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

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

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



Transforming the Culture



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

Training

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

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

Monitoring

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

This approach to monitoring will further support the HSC to:

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

Leadership, Advice and Guidance

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

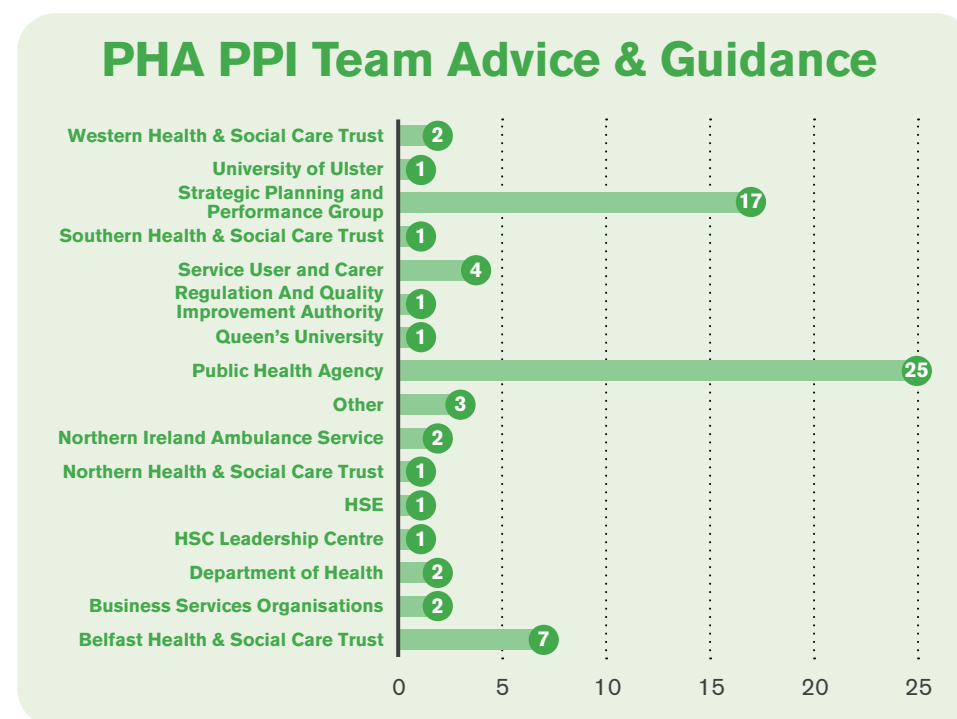


Figure 1: the above graphic shows some of the advice and guidance (71) the PHA PPI Team have provided to the HSC system from April 22 - June 2023.



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

Monitoring Involvement Activity:

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

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

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

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

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



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

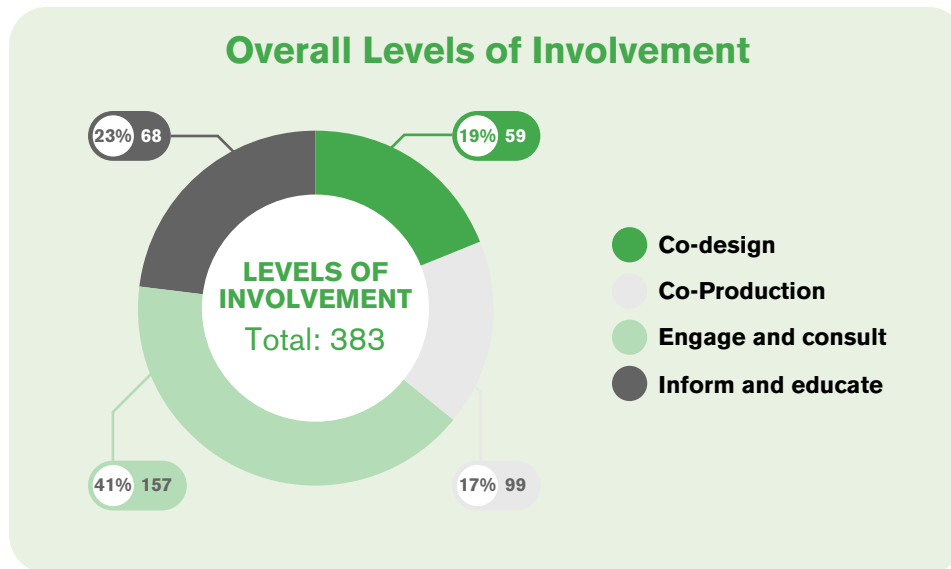


Figure 4, demonstrates the involvement activity per level of involvement across all HSC Trusts from January 2022 to March 2023. The majority of involvement activity fell into Engage and Consult, with a spread across the remaining levels of involvement.

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

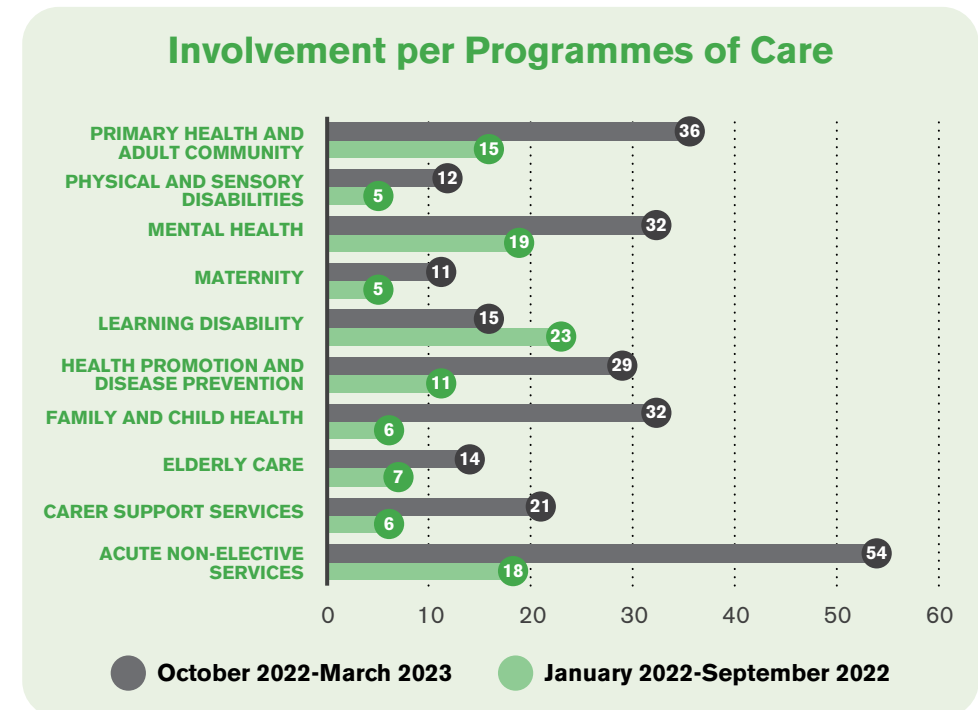


Figure 5, demonstrates the over-all number of involvement activities per Programme of Care across the different HSC Trusts. There is a spread of involvement across the different Programmes of Care, with Acute Non-Elective Services and Primary Health & Adult community showing the majority of involvement.



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

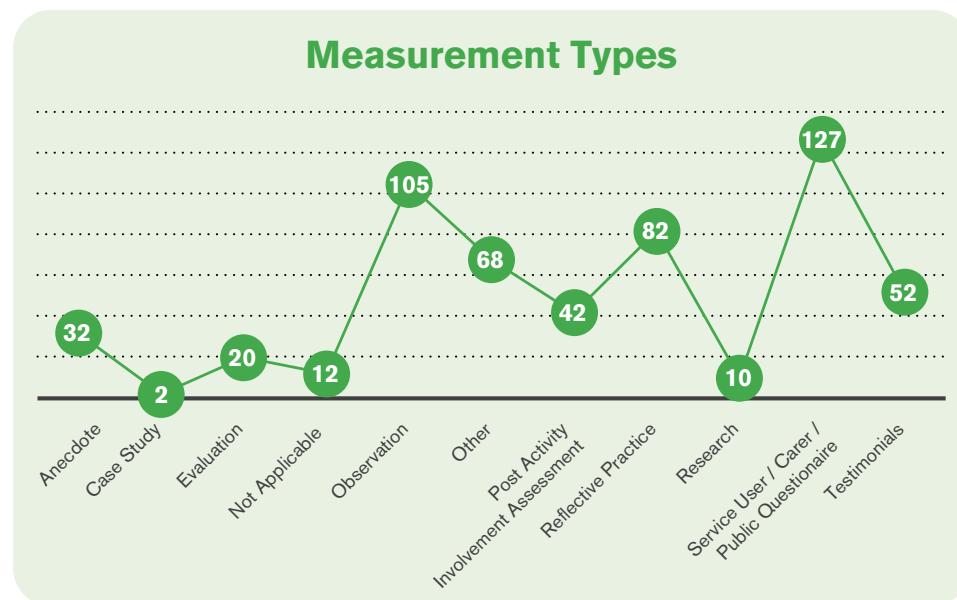


Figure 7, demonstrates the wide range of methods the HSC Trusts have utilised to help determine and measure the impact and outcomes for involvement from January 2022 – March 2023.

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

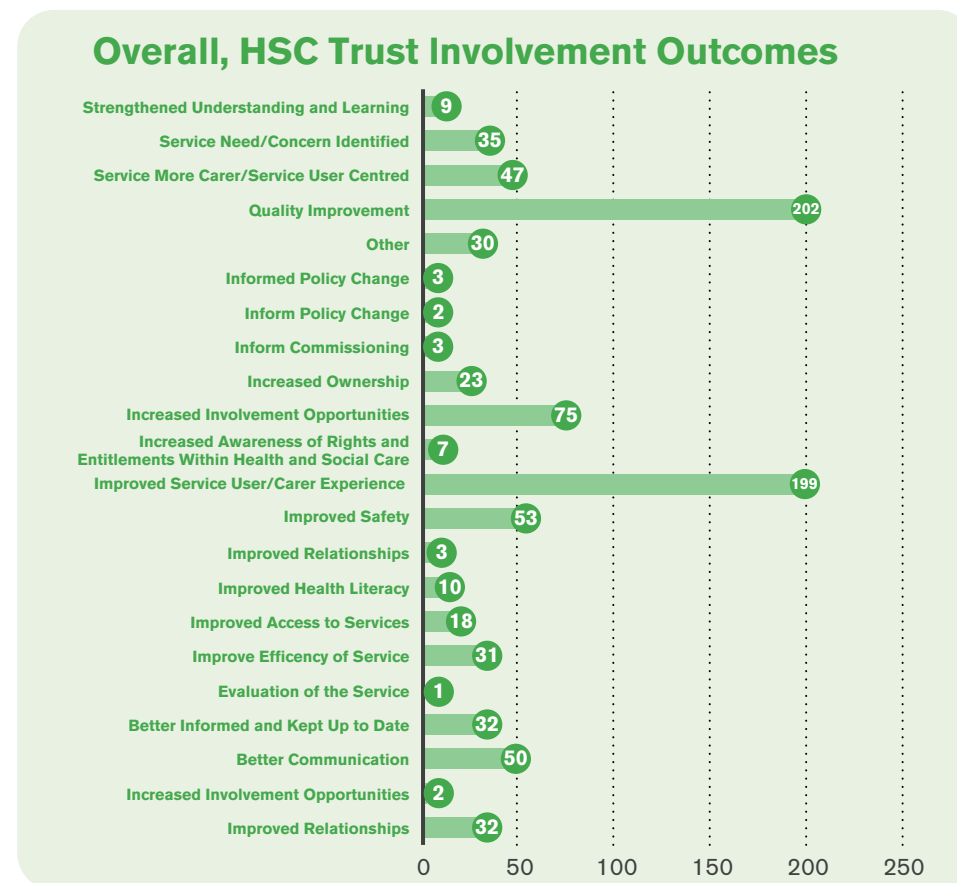


Figure 8, demonstrates the wide range of involvement outcomes and impacts that the 383 involvement activities have made across the HSC Trusts from January 2022 to March 2023.



Involvement Training:

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

A variety of training programmes have been delivered including:

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

involvement and Co-Production training delivered to:

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

13

Service Users and Carers involved in PHA PPI training

49

Applicants for 8th cohort of Leaders in Partnership Programme

72

Undergraduate/Post graduate students attended PPI training

25

Participants begin 8th Cohort of Leadership in Partnership Programme

65

HSC staff attended PPI training

3

webinars commissioned for a 5th series of Tuesday Topics



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

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

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

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

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

Outcomes

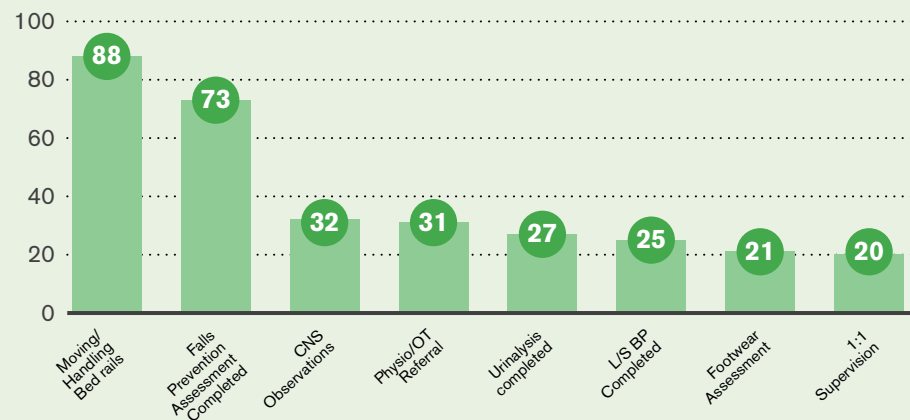
- ▶ A thematic analysis of 123 shared learning forms from incidents of inpatient falls resulting in moderate/major/catastrophic harm was completed. Four thematic headings were used, 'what happened to the patient', 'what went well', 'what we could improve' and 'what we learned'.
- ▶ 3 SAIs had been submitted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

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

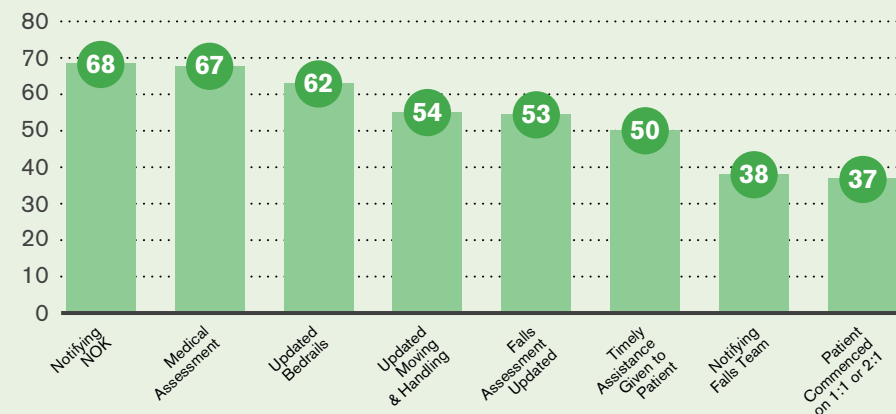
NHSCT	32
BHSCT	38
WHSCT	15
SHSCT	8
SEHSCT	30
Total	123



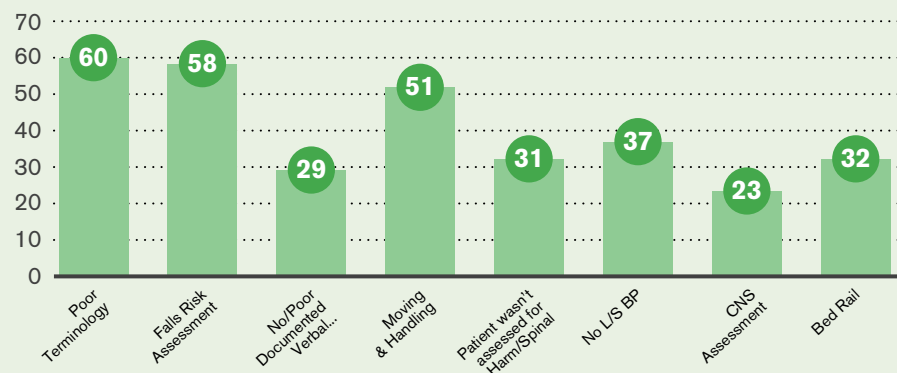
What went well? (Before fall) April 2021-March 2022



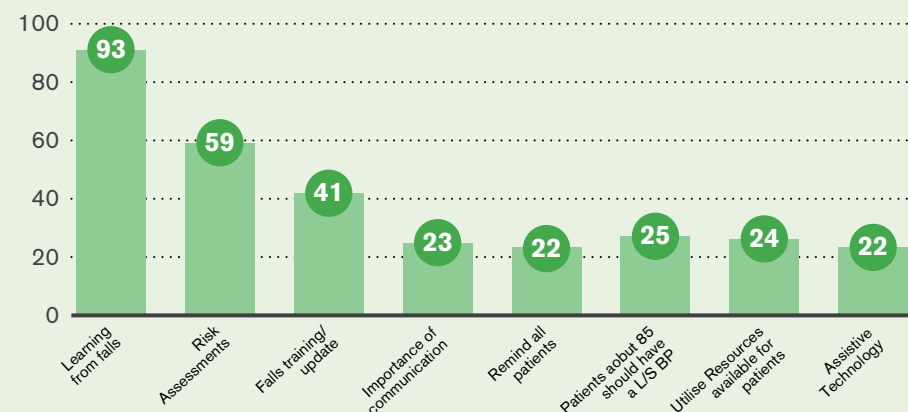
What went well? (After fall) April 2021-March 2022



What could we improve? April 2021-March 2022



What have we learnt? April 2021-March 2022





3. TRANSFORMING THE CULTURE: MEALTIMES MATTER – REGIONAL RESOURCES

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

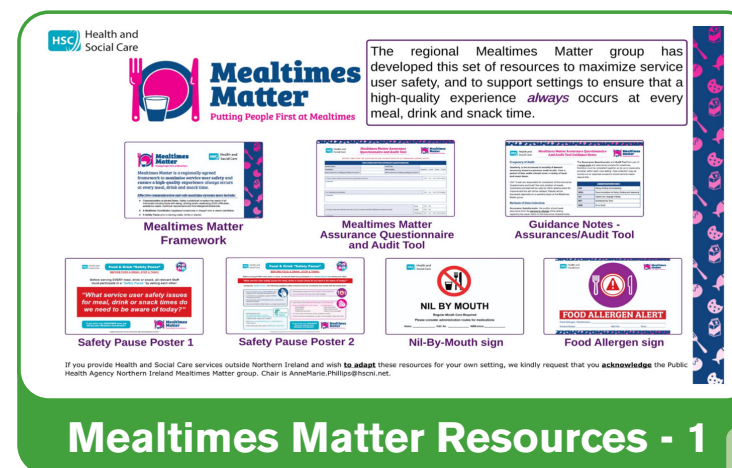
With choking related harm being a significant patient safety issue in Northern Ireland and a Safety and Quality Reminder (SQR) of Best Practice letter issued on in February 2021, the Mealtimes Matter Group chaired by the Public Health Agency co-produced and implemented a number of resources such as;

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

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

Outcomes

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





HSJ  **PATIENT SAFETY AWARDS 2023**

WE ARE PROUD TO BE A FINALIST

EARLY-STAGE PATIENT SAFETY
INNOVATION OF THE YEAR



Our work in action





Strengthening the Workforce

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

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

INTRODUCTION

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

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

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

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

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



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

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

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

Outcomes

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



“I’ve thoroughly enjoyed all the different presenters as well as the opportunity to participate in break out rooms!”

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



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

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

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

“psychological safety was provided within the sessions.”





Serious Adverse Incidents Deteriorating Patient ECHO Network End of Year Survey Objective & Summary

A key theme emerging from SAIs in recent years is 'responding to the deteriorating patient'. Collectively between HSC Trusts, the HSCB and PHA we recognise that there is a lot of learning arising from recent SAIs on this broad area which could be shared with a focused audience.

We believe the ECHO model will provide the appropriate platform and technology in order to collectively discuss the themes, trends, causative factors around the deteriorating patient, share learning from both individual / team experiences, share best practice from experts in particular topic areas.

Networks Objectives - Participants review of Objectives being met:

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



Benefits

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

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



Outcomes

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



Attendance

42% of participants have attended 5+ ECHO sessions.



Quality

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



Applied Learning

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



2. STRENGTHENING THE WORKFORCE: ADVANCED NURSING PRACTICE EDUCATION PROGRAMME

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

Outcomes

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



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

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

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

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

Outcomes

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

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



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

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

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

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

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

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

Outcomes

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



► **Confidence in applying OBA before and after the training:**

The average level of confidence reported before the session was 'slightly confident' (2.2 stars out of 5) and increased afterwards to 'moderately confident' (3.2 stars).

- Before the OBA Sessions NO respondents rated their confidence in applying OBA as 5 out of 5 (extremely confident). Only 3% rated their confidence as 4 out of 5. A third (33%) rated moderate (3 out of 5). Just under half (49%) were slightly confident and 15% were not at all confident.
- Afterwards 4% felt extremely confident (5 out of 5) and a quarter (25%) felt very confident (4 out of 5). A large proportion (62%) gave a 3 out of 5 rating – moderately confident – and only 9% felt slightly confident. NO respondents said they were not at all confident.

- **Likelihood of using OBA in work:** On average, respondents indicated they would be 'very likely' to apply OBA after attending the session.

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

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

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

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

Average Levels of OBA Knowledge

Before Training



(2.4 stars - a little)

After Training



(3.7 stars - a lot)

Average Levels of Confidence in applying OBA

Before Training



(2.2 stars - slightly confident)

After Training



(3.2 stars - moderately confident)



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

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

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

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

Outcomes

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



Measuring Improvement

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

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

Introduction

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



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

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

(1) [Addressee \(health-ni.gov.uk\)](https://health-ni.gov.uk)

Outcomes

Training

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

Recording of results and reporting

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



Procurement

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

Standard operating procedure

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





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

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

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

This multifaceted project has 3 strands:

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

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

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

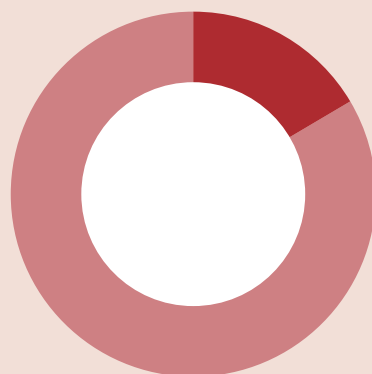
A regional safety alert poster was developed to summarise signs of Eating, Drinking and Swallowing Difficulties to reinforce the content of the eLearning.



Outcomes

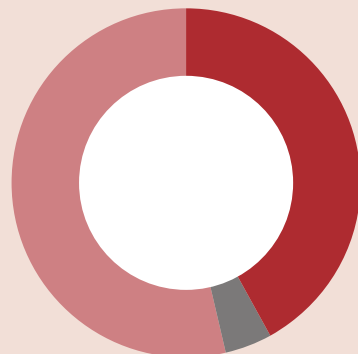
- ▶ Since going live in August 2022 1984 staff have completed the 90-minute awareness training, a 200% increase on numbers who had completed local training in the previous year.
- ▶ Feedback was very positive, 96% reported training was easy or very easy to access, 100% reported training was informative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

How informative was this awareness training?



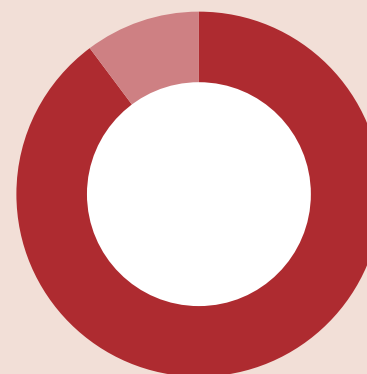
● Informative ● Not Informative
● Very Informative

How easy was the training to access?



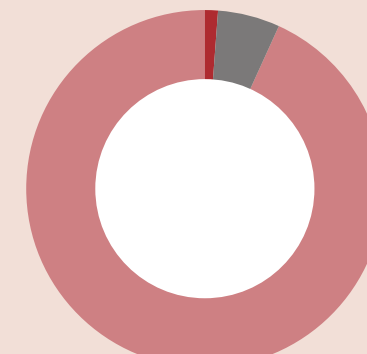
● Easy ● Not Easy ● Very Easy

What did you think about the length of the training?



● Just right ● Too long
● Too Short

Did this training meet your needs?



● No ● To some extent ● Yes



Advancing Healthcare Awards
Northern Ireland 2022

**AWARD FOR PARTNERSHIP
WORKING IN PUBLIC HEALTH**

FINALIST

Reducing Risk ... Improving quality for
children and young people with eating,
drinking and swallowing difficulties in
education settings in Northern Ireland

Alison Ferris,
AHP Consultant
Public Health Agency



Alison Ferris
Alison Ferris
Joint managing director
Chamberlain & Dunn

Will Chamberlain-Walsh
Will Chamberlain-Walsh
Joint managing director
Chamberlain & Dunn



CHILD SAFETY ALERT Signs of Eating and Drinking Difficulties



During or after eating and drinking watch me closely for the following:

**COUGHING /
CHOKING**



Changes to my COLOUR
E.g. if my skin turns red or blue



**Wet or "gurgly"
VOICE**



**EYE-
TEARING**



Changes to my BREATHING
E.g. If I become "wheezy" or
gasp for air; my breathing
rate gets faster or slower



**WEIGHT LOSS /
DIFFICULTY
PUTTING ON WEIGHT**



**Repeated or recurrent
CHEST INFECTIONS:**
Especially if I have no
other symptoms of a cold!



**If you have any concerns about my eating, drinking or swallowing
Please contact the Speech and Language Therapy Team**

This work originated from the Speech and Language Therapy Team in South Eastern Trust



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

Why we did it:

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

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

What:

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

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

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

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

Collaborated with MOOP regarding medicine optimisation

Provided equipment for falls

Phase 1 testing - Dec-Feb 22

Phase 2 testing - May-July 22

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



Outcomes

How:

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

Aim:

Resident wellbeing

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

Falls rate

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

Process Measures

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

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

Other outcomes have been evident:

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

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

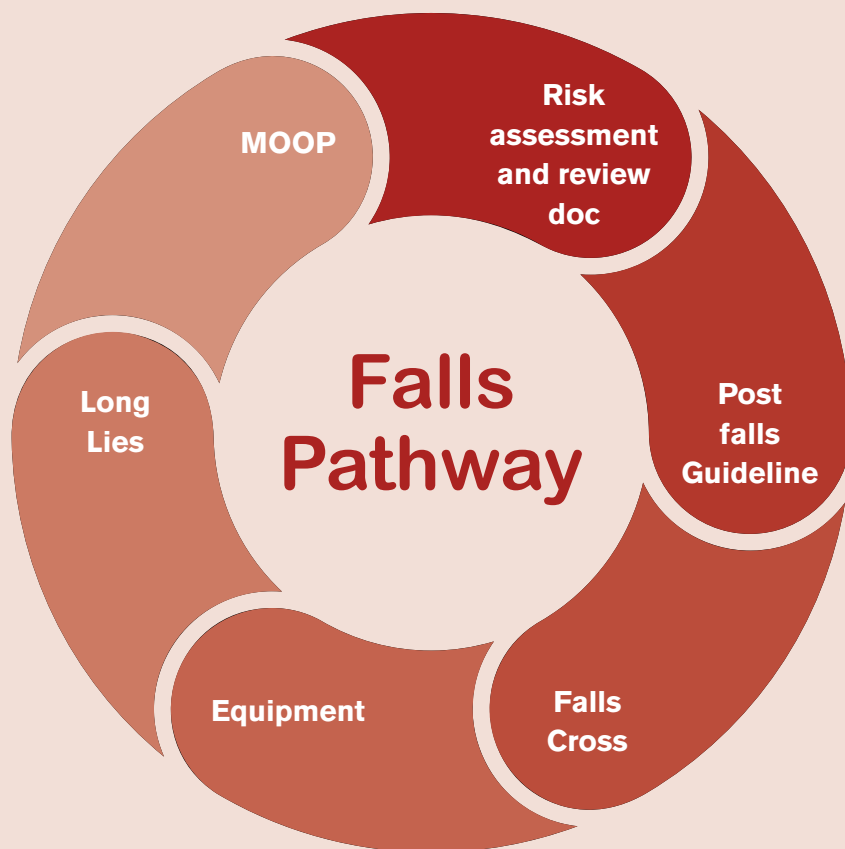
QUOTE FROM CARE HOME MANAGER

“ Families came up with collaborative solutions. Reinforcing learning from falls with their loved one.”

QUOTE FROM CARE HOME MANAGER

“ ...Residents got involved and started to self-manage their own safer mobility better.”

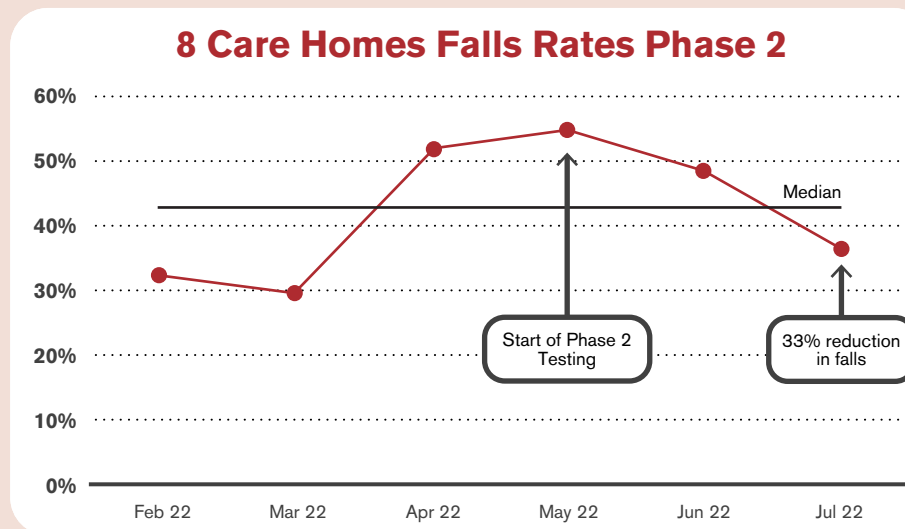
QUOTE FROM CARE HOME



Falls rate run charts

33% reduction in falls in
8 Partner Homes

Aim Achieved



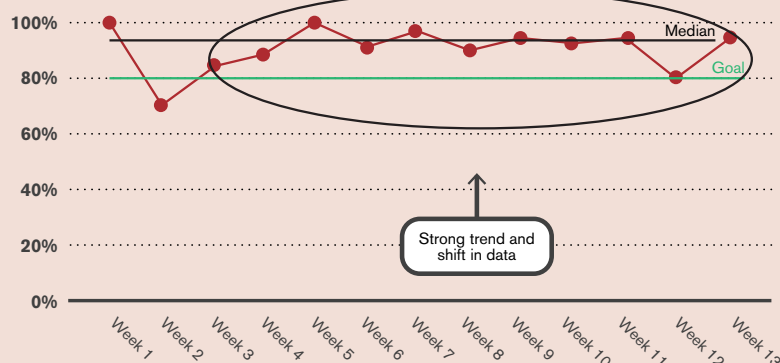


Resident Outcomes

Aim:

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

Resident less fearful about falling



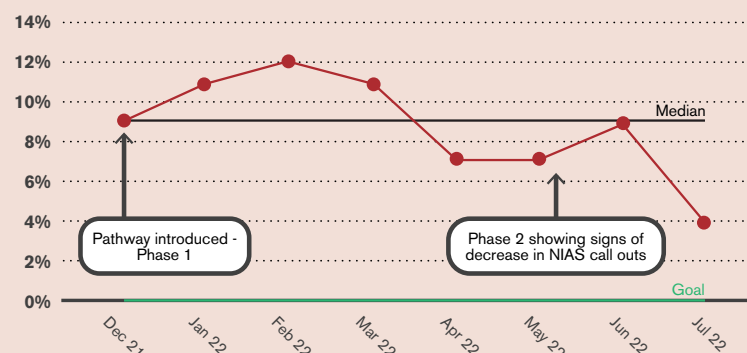
Resident feels safe and confident moving



NIAS Results

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

NIAS Falls Call Outs across the partner Care Homes



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

Improved resident experience of care

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

Better value for money

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

Better staff engagement/experience

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

Falls in Care Homes Project

Better quity

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

Improved safety/health outcomes

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



4. MEASURING IMPROVEMENT: FALLS: GAME CHANGING INNOVATION PROJECT

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

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

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

Who's it for?

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

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

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

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



How the technology works:

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

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

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

Age NI Chief Executive Linda Robinson said,

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

Also link to BBC Newsline article below:

[New technology aims to prevent falls for elderly - BBC News](#)





Raising the Standards

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

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

Introduction

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



1. RAISING THE STANDARDS: NEW MODELS OF PRESCRIBING

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

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

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

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

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

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

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

Outcomes

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



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

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

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

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

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

Outcomes

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

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

The e-learning programme amendments made by Leadership Centre.

Agreed regional training date for Purpose T.

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

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

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



Raising the Standards



Purpose T: Person Centred Assessment Care documentation

Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Mobility status – tick all applicable	Skin status – tick all applicable	Clinical Judgment – tick as applicable	No pressure ulcer not currently at risk
Needs the help of another person to walk	Current PU category 1 or above?	Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids	Tick if applicable
Spends all or the majority of time in bed or chair	Reported history of previous PU?	No problem	Not currently at risk pathway
Remains in the same position for long periods	Vulnerable skin		
Waits independently with or without walking aids	Medical device causing pressure/shear at skin site e.g. O ₂ mask, NG tube		
	Normal skin		
If ANY yellow boxes are ticked, go to Step 2	If ANY yellow or pink boxes are ticked, go to Step 2	If ANY yellow boxes are ticked, go to Step 2	

Step 2 – full assessment

Analysis of independent movement	Sensory perception and response – tick as applicable	Moisture due to perspiration, urine, faeces or exudate – tick as applicable
Extent of all independent movement	No problem	No problem / Occasional
Doesn't move	Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural	Frequent (2–4 times a day)
Moves occasionally		Constant
Moves frequently		
Perfusion – tick all applicable	Medical device – tick as applicable	Diabetes – tick as applicable
No problem	No problem	Not diabetic
Conditions affecting central circulation e.g. shock, heart failure, hypotension	Medical device causing pressure/shear at skin site e.g. O ₂ mask, NG tube	Diabetic
Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease		
Nutrition – tick all applicable		
No problem		
Unplanned weight loss		
Poor nutritional intake		
Low BMI (less than 18.5)		
High BMI (30 or more)		

Current Detailed Skin Assessment – tick if pain, soreness or discomfort present at any skin site as applicable. For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category	Previous PU history – tick as applicable
Skin site	No known PU history
Pain	PU history – complete below
Vulnerable skin	Number of previous pressure ulcer(s)
PU category	Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category).
Normal skin	Approx date Site PU cat Scar No scar
Sacrum	
L Buttock	
R Buttock	
L Ischial	
R Ischial	
L Hip	
R Hip	
L Heel	
R Heel	
L Ankle	
R Ankle	
L Elbow	
R Elbow	
Other as applicable (may be medical device site)	

Step 3 – assessment decision

PU Category 1 or above or scarring from previous pressure ulcers	No pressure ulcer but at risk	No pressure ulcer not currently at risk
Tick if applicable	Tick if applicable	Tick if applicable
Start SSKIN bundle, and Open Wound Observation chart if applicable	Start SSKIN bundle	Not currently at risk pathway
Signature of assessing nurse	First assessment	Date
Signature of assessing nurse	Remains on Green Pathway	Time
	Yes No - If no commence SSKIN bundle	Date
	Yes No - If no commence SSKIN bundle	Time
	Yes No - If no commence SSKIN bundle	



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

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

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

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

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

To assist with the correct use of assistive technology, regional guidelines were developed. The guidelines on the use of Inpatient Falls Assistive Technology required amendment as a result of learning identified from a Serious Adverse Incident. The Regional Inpatient

Falls Group, which incorporates multidisciplinary staff from all Trusts and is chaired by the PHA, Safety, Quality and Innovation Team, updated the guidance highlighting the importance of daily monitoring of any assistive technology that is in use.

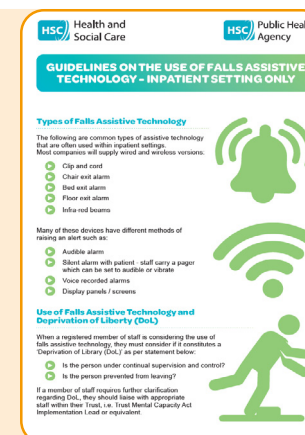
Outcome

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

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

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

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





4. RAISING THE STANDARDS: REGIONAL LEARNING NEWSLETTERS

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

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

All editions are available on the public facing PHA website.

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



Raising the Standards



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IF LEARNING FROM... STROKE

A REVIEW OF SERIOUS ADVERSE INCIDENTS, CLINICAL AND EXPERIENCE
EDITION 01
JULY 2022

- Stroke Symptoms 1
- The Impact of Stroke 2
- Specialist Stroke Teams 3
- Visual Changes 4
- Dizziness 5
- Headache 6
- Reduced Conscious Level 7
- Thrombolysis Transfer Delay 8
- Quality Improvement 9

Dizziness



SAT case study: Patient B presented to the Emergency Department with confusion, dizziness and slurred speech. The initial impression was that this was not stroke and patient B was treated for meningitis and encephalitis. A CT scan was performed which reported a possible meningitis and recommended an MRI scan. Patient B deteriorated over the next 12 hours with fluctuating consciousness so had repeat imaging. Further scans showed a basilar artery thrombus. Despite undergoing clot retrieval, Patient B sustained a catastrophic stroke and sadly died.

Complaint case study: Patient Y presented to the Emergency Department with dizziness, vomiting and neck pain. Due to pressures in the department, the patient waited six hours to be seen and was assessed in a non-clinical area. Following medical assessment, the patient was discharged with a diagnosis of vertigo.

A CT imaging was performed on arrival and confirmed a vertebral artery dissection. Patient Y was admitted under the neurosurgical team.

The dizziness persisted for five days and patient Y contacted their GP who prescribed medication for vertigo. This did not help and, following contact with an out-of-hours GP, an ambulance was arranged to take patient Y to hospital.

Key Learnings:

- ✓ The assessment of patients with dizziness or vertigo should be structured to look for red flag symptoms of stroke.
- ✓ Timing, Triggers and Targeted Examinations (TTATE) is a methodical approach to the dizzy patient.

Learning from Stroke – July 2022



M LEARNING MATTERS

EDITION 20
JUNE 2022
IN THIS EDITION

- STOP Before you block 1
- Optimology 2
- The HSC Hospital Passport 3
- The use of the Electronic Care Record (ECR) and Electronic Patient Choice prior to Patient Discharge 4
- Multidisciplinary Meeting (MDM) 5
- Rural Stroke 6
- Intensive (ICU) Tubes 7
- Haemorrhage (H) Tubes 8
- Haemorrhage (H) Tubes 9
- Link below to previous Learning Matters Edition 20

Welcome to Edition 20 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.



STOP Before you Block

A patient received a nerve block to the wrong site.

A nerve block was administered to a patient by the Consultant Anaesthetist in theatre to facilitate surgery and recovery. Following this, the surgical site was exposed and the anaesthetist identified that the surgical site was not the site the nerve block had been administered to; the block had been administered to the left side, instead of the right side.

The Consultant Anaesthetist notified the surgical team immediately and it was clarified that the nerve block had indeed been administered to the incorrect site. The surgery was able to go ahead and local anaesthetic was subsequently infiltrated into the correct surgical site at the end of the surgery.

On subsequent investigation it was found that no "STOP BEFORE YOU BLOCK" pause or surgical site check had been undertaken immediately prior to administration of regional anaesthesia.

After the surgery the Consultant Anaesthetist made the patient aware of the mistake and the need for investigation into the events.

The patient was monitored as an inpatient for a number of days and suffered no ill effects.



Learning Matters Edition 20

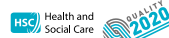


M LEARNING MATTERS

EDITION 21
JUNE 2022
IN THIS EDITION

- The Post-operative Deteriorating Patient: Differential diagnosis following elective laparoscopic cholecystectomy 1
- Resuscitation of a patient with an Artificial Airway 2
- Responding to the deteriorating patient: appropriate recognition, escalation, handover and record keeping 3
- Implications of Language Barriers for Health and Social Care 4
- Management of new presentation of Atrial Fibrillation 5
- Engaging with service users experiencing homelessness 6
- Link below to previous Learning Matters Edition 21

Welcome to edition 21 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.



The Post-operative Deteriorating Patient: Differential diagnosis following elective laparoscopic cholecystectomy

A patient with significant co-morbidities in a high risk category for surgery (American Society of Anesthesiologists (ASA) Classification II: A patient with severe systemic disease. Substantive functional limitations: one or more moderate to severe diseases) was admitted for an elective laparoscopic cholecystectomy. The anaesthetic and surgical procedures were uneventful with the patient remaining stable throughout.

Following surgery the patient was transferred to the recovery ward, however due to ongoing pain requiring regular opiate analgesia, as well as oxygen support for Type 1 respiratory failure, they were admitted to the Intensive Care Unit (ICU) as a high dependency patient.

In ICU a chest x-ray indicated raised right hemi-diaphragm and patchy changes at the left base. It was noted the possibility of Pulmonary Embolism (PE) as cause of poor oxygenation, however the patient was not stable enough to allow the radiology department for Computed Tomography Pulmonary Angiogram (CTPA). A bedside Focused Intensive Care Cardiac Echocardiogram (FICE)

was performed and reviewed by the ICU Consultant. Diagnosis of acute right heart strain was made. Therapeutic Enoxaparin was commenced.

During day 2 following surgery the patient was reviewed regularly by the Consultant Anaesthetist and ICU Consultant. On the evening of day 2 post surgery, at 18:00 hours the patient was becoming increasingly hypotensive. Blood Pressure (BP) was 90/50, Pulse 98 and decreased urine output. There was no response to two 200ml fluid boluses. BP was 62/42 at 23:00 hours. Phenylephrine was used to maintain a CVP central venous line was inserted at 00:30 and Nivamide was commenced. The patient was discussed with the ICU Consultant and Cardiology opinion was requested. Review of the ICU electronic records of day 2 indicate a drop in haemoglobin between 14:00 and 17:00 which coincided with the onset of further hypotension and tachycardia. Haemoglobin reading at 14:00 was 132, and 121 at 17:00.

Learning Matters Edition 21



IF LEARNING FROM FALLS

SEPTEMBER 2022

IN THIS EDITION

- Cause of Falls 1
- Risk Assessment and Plans of Care 2
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 3
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 4
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 5
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 6
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 7
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 8
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 9
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 10
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 11
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 12
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 13
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 14
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 15
- Thematic Analysis of Shared Learning: Patient Safety Incident (PSI) and Serious Adverse Incident (SAI) 16
- Summary 17

The purpose of this Learning from Falls Newsletter, is to share information and key learning derived from incidents of inpatient falls across HSC Trusts, which have been identified from post fall reviews, Serious Adverse Incidents (SAIs) and Patient Experience, as shared with Care Quality.

Falls and fractures in older people are a costly and often preventable health issue. Reducing falls and fractures is important for maintaining health, wellbeing and independence amongst older people.

A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event such as a stroke or overwhelming hazard. Having a fall can happen to anyone. It is an unfortunate but normal result of human anatomy. However, as people get older, they are more likely to fall over. Falls can become recurrent and result in injuries including head injuries and hip fractures. A fall can lead to pain, distress, loss of confidence and loss of independence. Patient falls have both human and financial costs. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and occasionally death. The costs to NHS organisations include additional treatment, increased lengths of stay, complaints and, in some cases, litigation. Falls are a major cause of disability and mortality. In addition, falls frequently bring about a fear of falling which increases risk and reduces independence.

KEY FACT

Falls are among the top 5 most frequent Adverse Incidents reported across Health and Social Care Trusts.



Learning from Falls – Sept 22



M LEARNING MATTERS

EDITION 22
JUNE 2022
IN THIS EDITION

- Failure to act on abnormal results 1
- Accurate identification of high risk patients with history of a VP shunt 2
- Prevention of Maternity Services Assessment and Management 3
- Transferring patients from local units to the regional intensive care unit 4
- Retained umbilical - when a "Rever" event? 5
- Link below to previous Learning Matters Edition 22

Welcome to edition 22 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.



Failure to act on abnormal results

A pregnant patient was initially typed as low risk. However, she presented 4 times to the admissions unit with reduced fetal movements (20-5 weeks), abnormal pain and vomiting (20-6 & 20-11) and vaginal bleeding (20-11). In light of these admissions she was referred for Consultant review.

The assessments carried out were normal, except for a low function fetal (FT). This was noted to be marginally abnormal at 20-6 weeks. Repeat tests were normal, or marginally abnormal until a test at 37-2 weeks was significantly abnormal. Unfortunately this result was not actioned.

The woman was assessed by a consultant in the antenatal clinic when 31-2 and 37-2 weeks pregnant. Both assessments included detailed ultrasound scans which showed estimated fetal growth was appropriate and a healthy environment.

She presented in advanced labour at 38 weeks, unfortunately an intrauterine death was diagnosed when in delivery suite. The baby was born without signs of life later that day. A Coroner's inquest was performed and the cause of death was noted as acute chorioamnionitis, due to Escherichia Coli, and Group B Streptococcus infection.

This event coincided with the peak of the first wave of the coronavirus pandemic and healthcare professionals in place which impacted on the schedule of antenatal review appointments between 31-37 weeks. However, it did not have an impact on the fetal outcome.

KEY LEARNING

- ✓ Referral for consultant review following 4 attendances at admissions is a point of good practice.
- ✓ Transfer from midwifery to consultant care was appropriate, however the accompanying documentation outlining the reason for transfer needs to be completed in full to ensure a comprehensive review is undertaken.
- ✓ A robust, quality assured system for review of test results is vital to ensure timely action of abnormal results and identification of possible risk factors.
- ✓ This system should include how results are communicated to the woman and other members of the multidisciplinary team.
- ✓ New and redeployed staff should be orientated to the system as part of their induction.
- ✓ Abnormal liver function tests require full investigation to rule out obstetric cholestasis and identify other potential causes.
- ✓ During such circumstances as the coronavirus pandemic, when access to face to face contacts may be restricted, contact should be maintained by phone or online.

Useful references

Learning Matters Edition 22

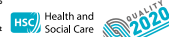


M LEARNING MATTERS

EDITION 23
SEPTEMBER 2022
IN THIS EDITION

- Know, Check, Ask 1
- Incorrect administration of Controlled Drug Medication: Assessing and Reducing the Risk of Venous Thromboembolism (VTE) 2
- Safe Warfarin Discharge 3
- Prescription Writing - When a Quick Fix is Not Enough 4
- Outpatient Treatment 5
- Advice Notes - Think Patient Not Researcher 6
- Right Device but Wrong Insulin 7
- Wrong Person or Wrong Address 8
- Link below to previous Learning Matters Edition 23

Welcome to edition 23 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.



Know, Check, Ask

All medication errors are potentially avoidable and can therefore be greatly reduced or even prevented. Reducing medication errors is a priority for everyone, including healthcare professionals, service users and carers. Medicines are the most commonly used medical intervention in Northern Ireland (NI), and at any one time 70% of our people take prescribed or over the counter medicines to treat or prevent ill health.

The Department of Health launched a medication safety campaign entitled **Know, Check, Ask (KCA)** which has been developed as part of the NI strategy plan 'Transforming Medicines Safety, (TMS)' to support the World Health Organisation (WHO) 'Global Patient Safety Challenge: Medication without Harm'. The aim of the WHO challenge is to reduce severe avoidable harm by 50% globally over the next 5 years.

KCA was launched initially with messages tailored to the general public as part of the **Let's Talk** campaign in community pharmacies. Staff engaged with patients around their understanding of their medicines, and a 'My Medicines List' for people to record their medicines.

The campaign will encourage all healthcare professionals to use the same simple **KCA 3 step checking system** before you prescribe, supply or administer a medication.

- 1 **KNOW** the medicines you are prescribing, supplying or administering, what do they do, what benefits do they have and what are the side effects?
- 2 **CHECK** that they are right for each individual patient, based on their health conditions and any other medications they are taking.
- 3 **ASK** a colleague if you are unsure about, or don't understand anything, or think something is not quite right. Ask the patient if they understand and suggest that keeping a list of their medicines can help them.

Key Guidance

For further information see <https://www.hscni.gov.uk/whatsnew-and-medicines-safety/campaign/medication-safety-know-check-ask/>

Learning Matters Edition 23





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

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

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

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

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

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

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

Outcome





Integrating the Care

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

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

Introduction

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



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

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

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

Issues explored were

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

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

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

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



Outcomes

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

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

- ▶ Staff operators should attend syringe pump training in accordance with the Trust/Organisation policy.
- ▶ Training should highlight that, in accordance with manufacturer DFU
 - ▶ infusion should not be started if volume in syringe does not match volume on display, it should be removed from clinical use. Training will advise the user to check that the volume to be infused correlates with the volume in the syringe, the duration of the infusion is correct and that the rate is correct.
 - ▶ if a System Error occurs a pump should be removed from clinical use.
 - ▶ pumps removed from clinical use should be returned to the clinical engineers detailing error noted and requesting service check.

- ▶ To reduce the low risk of pre-load interruption due to the device being cold, the user should avoid leaving the syringe pump in an environment which is outside the temperature parameters recommended. This should be detailed in the Trust/Organisation policy.
- ▶ A regional Learning From communication has reviewed a number of SAls relating to prescribing and will be published soon.
- ▶ Work is now being taken forward to develop a regional syringe pump guidance to standardise safe practice and inform training. A review of all prescribing and administration documentation is also being progressed.



2. INTEGRATING THE CARE: HEALTH & CRIMINAL JUSTICE

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

- ▶ Benchmark prison health services with rest of the UK.
- ▶ Review the capacity & capability of prison addiction services.
- ▶ Develop an algorithm to assess the suitability of individuals placed in prison Care & Supervision Units.
- ▶ Review capacity & capability of prison psychology services and consider introduction of specialist psychology services for trauma and personality disorder.
- ▶ Align mental health appointments with the Quality Network for Prison Mental Health Standards including a reviewing the capacity and capability of mental health service.
- ▶ Plan, commission and implement a therapeutic approach to personality disorder.
- ▶ Identify options for expediting the transfer of acutely mentally unwell who require hospital admission.

- ▶ Identify a single point of entry to access PICU and acute mental health beds.
- ▶ Develop a regional service specification.
- ▶ Develop metrics to inform ongoing assessment of need including data collection for specific vulnerabilities and develop traffic light dashboard.

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

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



Outcomes

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



3. HSC QUALITY IMPROVEMENT

Health and Social Care Quality Improvement (HSCQI)

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

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

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



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

1 Purpose

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

2 Background Information

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

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

3 Key Issues

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

4 Next Steps

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

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

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

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

1. Governance Framework

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

2. Assurance Framework

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

3. Risk Register

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

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

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

4. Performance against Business Plan Objectives/Targets

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

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

5. Finance

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

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

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

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

6. Information Governance – UK General Data 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 UK GDPR and DPA 2018.

7. External Audit Report

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

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

SBNI unlawful / illegal expenditure

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

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

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

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

Fraudulent payment

The PHA was subjected to a successful fraud during February 2023 where payments totalling £104,332 were made to a fraudulent bank account following a fraudulent request to change the bank details relating to a legitimate supplier.

The HSC Internal Audit service was asked by the Director of Finance to perform a rapid review of the circumstances pertaining to this matter and all resultant recommendations relating to PHA were confirmed by Internal Audit as implemented in the formal follow up exercise on audit recommendations as at March 2023.

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

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

Payroll controls

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

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

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

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

8. Internal Audit

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

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

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

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

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

Management of Voluntary and Community Organisation Contracts

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

Management of Complaints and Claims

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

9. RQIA and Other Reports

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

10. NAO Audit Committee Checklist

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

11. Board Governance Self-Assessment Tool

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

12. Internal Control Divergences

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

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

SBNI – Unlawful expenditure

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

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

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

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

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

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

COVID-19

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

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

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

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

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

Financial Performance

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

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

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

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

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

Management of Contracts with the Community and Voluntary Sector

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

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

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

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

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

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

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

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

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

PHA Staffing Issues / Staff Resilience during COVID-19

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

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

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

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

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

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

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

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

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

- Workforce Development – with a key focus on the roll out of the new Learning Management System this workstream have also taken a lead in promoting and improving the uptake of mandatory training as well as appraisal. New policies have also been introduced including the Hybrid working model which is now due for evaluation to inform the future working arrangements across the Agency. A new skills framework is currently under consideration with development due to commence over the Autumn with a view to having a full framework and audit process ready for connecting to the 24/45 Appraisal round.
- Culture - supporting all of the above is the culture workstream who are developing mechanisms which will support the organisations communication systems with staff to ensure clarity, engagement and effectiveness. This workstream is also now working on approaches to recognition and celebration of the work our staff do which aims to ensure a culture which feels inclusive, rewarding and progressive.

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

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

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

HSCQI

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

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

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

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

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

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

Public Inquiries

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

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

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

Accommodation

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

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

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

Pause on Campaign Programme

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

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

13. Mid-Year Assurance Report from Chief Internal Auditor

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

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

Signed:

Date:

CHIEF EXECUTIVE & ACCOUNTING OFFICER

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

1 Purpose

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

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

2.1 Business Continuity Policy / Plan

PHA Corporate Business Continuity Plan Exercise Report

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

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

Updated PHA Corporate Business Continuity Plan

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

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

2.2 Risk Management Strategy and Policy

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

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

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

2.3 Record Management Policy

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

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

3 Next Steps

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

POLICY ON BUSINESS CONTINUITY MANAGEMENT

Version	2.0
Date version 1 approved by AMT	31/01/12
Reviewed policy approved by AMT	31/03/15
Scheduled review date	31/03/18
Review completed	23/02/18
Version 2 approved by AMT	13/03/18
Scheduled review date	31/03/21

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Glossary

Business Continuity Management (BCM)	Holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if realised, might cause. It provides a framework for building organisational resilience with the capability for an effective response that safeguards the interests of key stakeholders, reputation, brand and value-creating activities.
Business Continuity Management Programme	Ongoing management and governance process supported by top management and appropriately resourced to ensure that the necessary steps are taken to identify the impact of potential losses, maintain viable recovery strategies and plans, and ensure continuity of products and services through training, exercising, maintenance and review.
Business Continuity Plan (BCP)	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level.
Civil Contingencies	Civil contingencies are the events and situations impacting on the community which may or may not occur, but would lead to an emergency if they did. Civil contingencies covers all the hazards and threats which could impact upon human welfare, the environment, national security or the continuity of essentials of life services.
Disruption	Event, whether anticipated (e.g. a labour strike or hurricane) or unanticipated (e.g. a blackout or earthquake), which causes an unplanned, negative deviation from the expected delivery of products or services according to the organisation's objectives.
Emergency	An event or situation that threatens serious damage to human welfare, the environment or the security of the UK.
Emergency Planning	Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency.
Incident	Situation that might be, or could lead to, a business disruption, loss, emergency or crisis
Risk	Something that might happen and its effect(s) on the achievement of objectives.
Risk Management	Structured development and application of management culture, policy, procedures and practices to the tasks of identifying, analysing, evaluating, controlling and responding to risk.
Cyber Risks	Any risk of financial loss, disruption or damage to the reputation of an organisation from failure of its information technology systems.

1 Purpose

- 1.1 The aim of this policy is to detail a comprehensive framework for Business Continuity Management so that the Public Health Agency (PHA) can continue to function through an operational interruption.
- 1.2 This document sets out the general principles and processes for the development, maintenance and review of Business Continuity plans for the PHA.
- 1.3 This Policy is separate from but complements the PHA Risk Management Policy. It has been approved by the PHA Board and is based on BS25999 -1, Business Continuity Management – Code of Practice and ISO 22301:2012 (the new international standard for Business Continuity Management systems).

2 What is Business Continuity Management?

- 2.1 Business Continuity Management is a business-owned, business driven process that establishes a fit-for-purpose strategic and operational framework that:-
 - Proactively improves an organisation's resilience against the disruption of its ability to achieve its key objectives;
 - Provides a rehearsed method of restoring an organisation's ability to supply its key products and services to an agreed level within an agreed time after a disruption; and
 - Delivers a proven capability to manage a business disruption and protect the organisation's reputation and brand.
- 2.2 Business Continuity Management involves managing the continuation or recovery of business activities in the event of a business disruption and management of the overall programme through training, exercises and reviews, to ensure that Business Continuity plans stay current and up-to-date.

- 2.3 Examples of activities which may cause disruption and require activation of the Business Continuity Plan include loss of utilities, loss of a facility, loss of ICT systems, significant loss of staff or Public Health/similar emergency requiring resources or staff to be re-assigned for a significant period of time.

These events can be man-made, natural, deliberate or unintentional – for example, adverse weather, terrorist activity, cyber-attack or systems failure due to poor systems integrity. Events in the local or political arena, most notably EU Exit, may also have an impact requiring business continuity arrangements to be in place.

3 Relationship with Business Planning and Risk Management

- 3.1 Business Continuity Management shall be part of the planning cycle undertaken within the Public Health Agency. The cycle applies to all levels of planning in the Organisation. All levels shall have business plans, risk registers, Business Continuity plans and processes in place for ongoing maintenance and review. Directorate level Business Continuity plans are not mandatory but may be developed if required. The planning cycle is set out in Figure 1 below:-

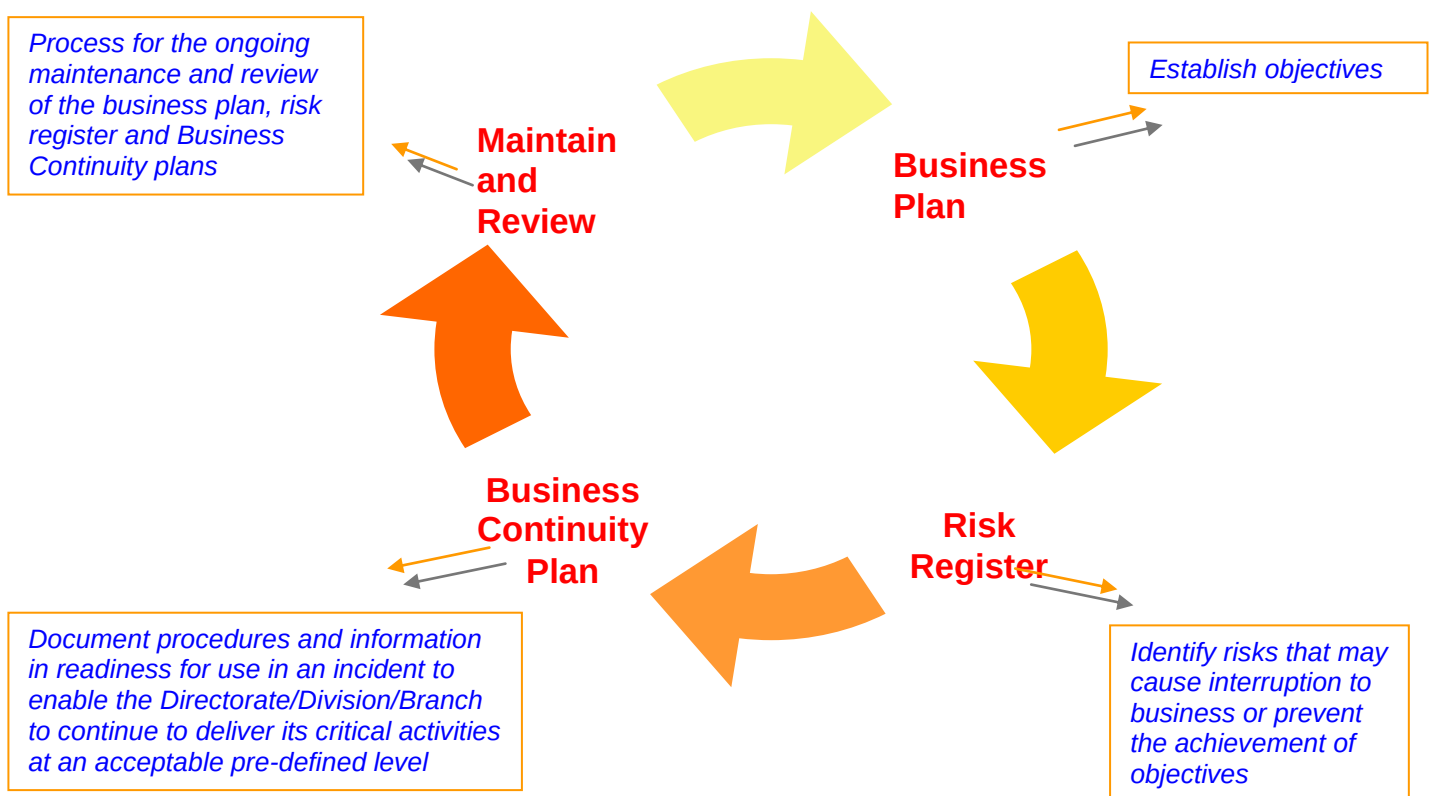


Figure 1

4 Civil Contingencies and Business Continuity Management

- 4.1 Civil contingencies activities are those undertaken by individuals and organisations to prevent emergencies and critical business interruptions, to mitigate and control their effects and to prepare to respond. These activities include horizon scanning, risk assessment, Business Continuity Management, Integrated Emergency Management, preparedness, validation, response and promotion of recovery and restoration.
- 4.2 Business Continuity Management provides an organisation with the resilience to continue to function during an emergency and to return to full functionality effectively and efficiently once the crisis has passed.

5 Policy Statement

- 5.1 PHA is committed to the vision of protecting public health and improving the health and social wellbeing of people in Northern Ireland. It is essential that, irrespective of demands and circumstances, the PHA is able to deliver its critical functions and services.
- 5.2 PHA shall develop, exercise, maintain and review the Business Continuity Plan for its critical functions and services in the event of a service disruption or disaster. The Business Continuity Plan will facilitate the rapid, efficient and cost effective continuity of the Organisation's functions and services.

6 Framework and Approach

- 6.1 PHA shall establish a framework of plans which shall be underpinned by a corporate Business Continuity Plan. The corporate Business Continuity Plan shall take account of the key functions and services in the organisation and plan for their ongoing delivery in the event of an interruption to normal business. Further plans shall be developed at Directorate level to support the corporate plan and ensure resilience of key products and services. Directorate level Business Continuity Plans are not required but may be developed if required.

6.2 PHA shall ensure that it adopts a Business Continuity Management Programme which is compatible with the strategic direction of the organisation and shall integrate Business Continuity Management requirements into the organisation's business processes.

6.3 PHA will strive to conform to ISO 22301:2012.

7 Roles and Responsibilities

PHA Board

The PHA Board is responsible for ensuring that the appropriate Business Continuity arrangements are in place to enable the time critical services and functions to be delivered in the event of an interruption to normal business. The Board will receive assurance through an effective Business Continuity Plan, which is fully compliant with the new International Standard ISO 22301:2012.

Chief Executive

The Chief Executive has overall responsibility for ensuring that the PHA has effective, ISO 22301:2012 compliant, Business Continuity arrangements in place to respond to an incident affecting PHA functions and service provision. Supported by the Agency Management Team, the Chief Executive will champion the Business Continuity Management process and ensure this is fully embedded across the Agency. This commitment will include ensuring the provision of support and training for management and staff as appropriate.

Agency Management Team

AMT is responsible for overseeing the development of the Corporate Business Continuity Arrangements, including approving the Business Continuity Plan for onward transmission to the PHA Board.

Directors will develop and maintain a culture of Business Continuity Management within their areas of responsibility. This includes:-

- Ownership of the Corporate and any Directorate Level Business Continuity Plan(s) for their area of responsibility.
- Raising awareness and ensuring that line managers and all staff are aware of their Business Continuity responsibilities.
- Regularly reviewing the PHA Corporate Business Continuity Plan and the prioritised, time critical functions and continuity strategies identified within the Plan, highlighting any changes required or new threats anticipated.
- Participating in the testing of the Business Continuity Plan.
- Satisfying themselves that Business Continuity incidents are being actively managed, with the appropriate strategies in place and working effectively, and proposing new or alternative strategies as appropriate.
- Ensuring that the PHA meets its legal and regulatory Business Continuity requirements.
- Demonstrating commitment to the continual improvement of Business Continuity Management across the PHA.

Director of Operations

The Director of Operations is the lead Executive Director for Business Continuity Management, with responsibility for ensuring that effective and robust Business Continuity processes and systems are established, implemented and monitored within the PHA.

Assistant Directors

In conjunction with the relevant Director, Assistant Directors are responsible for:-

- Contributing to ownership, implementation and monitoring of the corporate and any directorate level Business Continuity Plan for their area of responsibility.
- Ensuring that staff within their area are aware of their Business Continuity responsibilities.

Line Managers and all Staff

All staff are expected to:-

- Familiarise themselves with their individual roles as set out in the PHA Business Continuity Plan and comply with Business Continuity measures when it is invoked.
- Have knowledge of and comply with the PHA's Policy on Business Continuity Management.
- Alert Management to emerging threats or weaknesses in service provision in accordance with the Business Continuity Management Policy and Business Continuity Plan.
- Participate fully in the regular Business Continuity Plan review process.

8 Equality and Human Rights Considerations

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

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

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

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

RISK MANAGEMENT STRATEGY AND POLICY

Version	2.6
Date version 2.3 approved by AMT	04/02/14
Date version 2.3 approved by GAC	10/04/14
Date version 2.4 approved by AMT	25/07/17
Date version 2.4 approved by GAC	11/10/17
Date version 2.5 approved by AMT	06/08/19
Date version 2.5 approved by GAC	03/10/19
Date version 2.6 approved by AMT	
Date version 2.6 approved by GAC	
Scheduled review date	30/06/26

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1. Introduction

The Public Health Agency (PHA) is committed to developing a robust and effective system of risk management. This Risk Management Strategy and Policy forms a central part of the PHA's internal control and corporate governance arrangements.

It defines the PHA's approach to risk management throughout the organisation. It also ensures a consistent approach to dealing with risks which may have an impact on the PHA's ability to achieve its strategic aims and objectives. It outlines the key aspects of the risk management process, and identifies the main reporting procedures.

The policy is subject to regular revision as the risk management process is embedded throughout the PHA, and will be updated as necessary to reflect the changing environment.

2. Background

The Health and Social Care (HSC) Regional Model for Risk Management (including a Regional Risk Matrix) was endorsed by the HSC Chief Executive's Forum in September 2018. The model, which was developed by a Working Group comprising senior managers working in risk management across the HSC, is based on the principles of the ISO 31000:2018¹ standard. This standard largely has the same broad principles, framework and processes as the AS/NZ standard which was previously used by HSC organisations. All HSC organisations, including the PHA, have agreed to adopt the 'spirit' of ISO 31000:2018 ~~but will not be without~~ seeking accreditation.

The PHA risk management system conforms to the principles of the ISO 31000:2018 Standard, and meets HSC requirements in respect of managing risks, hazards, incidents, complaints and claims.

Adhering to the ISO 31000:2018 Standard will ensure that all HSC bodies have the basic building blocks in place for managing risk through development and implementation of a comprehensive risk management system. The PHA Risk Strategy and Policy shows how the organisation's risk management system meets this standard.

Following an Internal Audit Review of risk management in 2022/23, the PHA has adopted the 3 lines model of assurance for its Corporate Risk Register. This will ensure that controls identified to manage risks are actually operational and that they are effective in managing risk.

This Strategy and Policy, together with the Corporate Governance Framework, Standing Orders and Standing Financial Instructions, provides the basis for statutory reporting through the Governance Statement as required by the Department of Health (DoH).

¹ BSI ISO 31:000: 2018: Risk Management Guidelines

The PHA recognises that the principles of good governance must be supported by an effective risk management system that is designed to deliver improvements in services as well as the safety of its staff and the public.

3. Definition of Risk

While there are many definitions that are used in the area of risk management, HSC organisations are using the following definition based on the ISO 31000:2018 standard:

Risk is the “*effect of uncertainty on objectives*”.

Risk is also often expressed in terms of a combination of the consequences (impact) of an event (including changes in circumstances) and the associated likelihood of occurrence. This definition of risk makes a direct connection between risk and the objectives of the organisation as set out in the PHA Corporate Plan and Annual Business Plans.

4. Managing Risk according to ISO 31000:2018

ISO 31000:2018 has three components for managing risk:

- (a) The core principles of risk management
- (b) Risk management framework and
- (c) Risk management processes

4.1 Principles of Risk Management

To be fully effective, any risk management process must satisfy a minimum set of principles or characteristics. ISO 31000:2018 identifies eight principles which provide the foundation for managing risk and should be considered when establishing the organisation's risk management framework and processes and ultimately will help the organisation manage the effects of uncertainty on its objectives.

The principles are that risk management should be:

Integrated

Risk management should be integrated within all organisational activities.

Structured and comprehensive

A structured and comprehensive approach to risk management contributes to assurances in the Governance Statement.

Customised

The risk management framework and process should be customised and proportionate to the organisation's external and internal context related to its objectives.

Inclusive

Appropriate and timely involvement of stakeholders needs to be considered. This will better inform the organisation's risk management system.

Dynamic

Risks can emerge, change or disappear as an organisation's external and internal context changes. The risk management system needs to respond to these changes in a timely manner.

Best available information

Information should be timely, clear and available to relevant stakeholders.

Human and cultural factors

Human and cultural factors significantly influence all aspects of risk management.

Continual improvement

Risk management is continually improved through learning and experience and will feed into the organisation's quality improvement framework/systems.

4.2 Risk Management Framework

ISO 31000:2018 sets out five key elements of a Risk Management Framework, as follows:

Leadership and Commitment

Management needs to ensure that risk management is integrated into all organisational activities and demonstrate leadership and commitment by implementing all components of the framework. This in turn will help align risk management with its objectives, strategy and culture.

Integration

Integrating risk management relies on an understanding of organisational structures and context. Risk is managed in every part of the organisation's structure and everyone in an organisation has responsibility for managing risk.

Design

The organisation should examine and understand its external and internal context when designing its risk management framework.

Implementation

Successful implementation of the framework requires the awareness of all staff within the organisation.

Evaluation

The organisation should periodically measure its risk management framework against its purpose, implementation plans, risk management key performance indicators and expected behaviour. This will ensure it remains fit for purpose.

Improvement

The organisation should continually review, monitor and update its risk management framework to ensure it is fit for purpose.

4.3 Risk Management Process

The third component for managing risk under ISO 31000: 2018 is the risk management process, comprised of the following:

- (a) Communication and consultation
- (b) Scope, context and criteria
- (c) Risk Assessment
 - Risk identification
 - Risk Analysis
 - Risk Evaluation
- (d) Risk Treatment
- (e) Monitoring and Review
- (f) Recording and Reporting

The PHA Risk Management Strategy and Policy incorporates the ISO 31000:2018 components as set out above.

4.4 3 Lines Model of Assurance

This defines assurances received that key controls are effective across the 3 lines model (1st line - Directorate; 2nd line - Organisational Oversight and 3rd line - Independent Assurance). Assurances are then aligned to key controls over which they are providing assurance (focusing more on the gaps in assurance, rather than the gaps in control). A RAG (red, amber, green) rating of the control effectiveness is then applied, based on the assurances available. Page 2 of Annex 3, the Regional Risk Matrix, provides further definition of the RAG ratings.

Risks are categorised using the Regional HSC “5x5” risk matrix (see Annex 3). In assessing the Likelihood and Impact, it categorises risks at four levels – extreme, high, medium or low. A colour coding is used in a traffic-light system (green, yellow, amber and red). The Risk Analysis Tools Impact Table, also included in Annex 3, gives detail of the impact definitions to be used when assessing each identified risk.

Undertaking assurance mapping on the Corporate Risk Register ensures that:

- Controls recorded are actually operational
- Controls recorded are effective
- Actions to address risk are identified
- Further risks should not materialise
- Corporate objectives will be achieved.

5 The Purpose of Risk Management in the PHA

Risk Management is an essential part of good management and governance which staff already perform on a day-to-day basis. Identifying and taking action to address risks, will aid the achievement of business objectives. A formal systematic approach to risk management should improve decision-making, accountability and performance as well as fostering an environment of *'no surprises'*.

The purpose of risk management is to manage and control risks, not eliminate them — the management of risk rather than risk aversion. It can be defined as:

"A systematic process by which potential risks are identified, assessed, managed and monitored" ("An Assurance Framework: a Practical Guide for Boards of ~~HSSPS~~ DHSSPS Arm's Length Bodies" March 2009).

When Risk Management processes are in place:

- there is regular and ongoing monitoring and reporting of risk including early warning mechanisms;
- an appropriate assessment is made of the cost of operating particular controls relative to the benefit obtained in managing the related risk;
- the organisation conducts, at least annually, a review of the effectiveness of the system of internal control in place;
- the organisation reports publicly on the results of the review, and explains the action it is taking to address any significant concerns that are identified; and
- Corporate and Directorate Risk Registers are aligned to allow the escalation and de-escalation of risks at a corporate level. Maintaining the Corporate Risk Register is both a top-down and bottom-up process.

Risk management should be a continual process, embedded in the culture of the organisation helping to keep a focus on performance improvement. As such it also complements the corporate and business planning processes. It is not a process for avoiding risk. Rather, when used well, it can actively encourage an organisation to take on activities that have a higher level of risk,

because the risks have been identified and are being well managed so that the exposure to risk is both understood and acceptable.

Risk management is a key element of the PHA's Assurance Framework and the system of internal control, contributing to the achievement of business objectives.

6 The Benefits of Risk Management

A comprehensive and sound Risk Management Strategy will bring the following benefits:

- A clear assessment of the risks affecting the achievement of the PHA's business objectives, providing a supporting role to the corporate and business planning process.
- Enhanced communication within and between Directorates through a greater appreciation and understanding of the risks facing the organisation.
- Better use of resources, by directing these to areas of most need.
- The promotion of a culture of continuous improvement.
- More effective tailoring of internal audit programmes to target areas of high risk.
- A reduction in unwelcome surprises / shocks.
- Reassurance to stakeholders, particularly the DoH, that the PHA is continually reviewing the environment and actively identifying and managing risk.

7 Risk Management Process within the PHA

The key elements of the PHA's risk management process are:

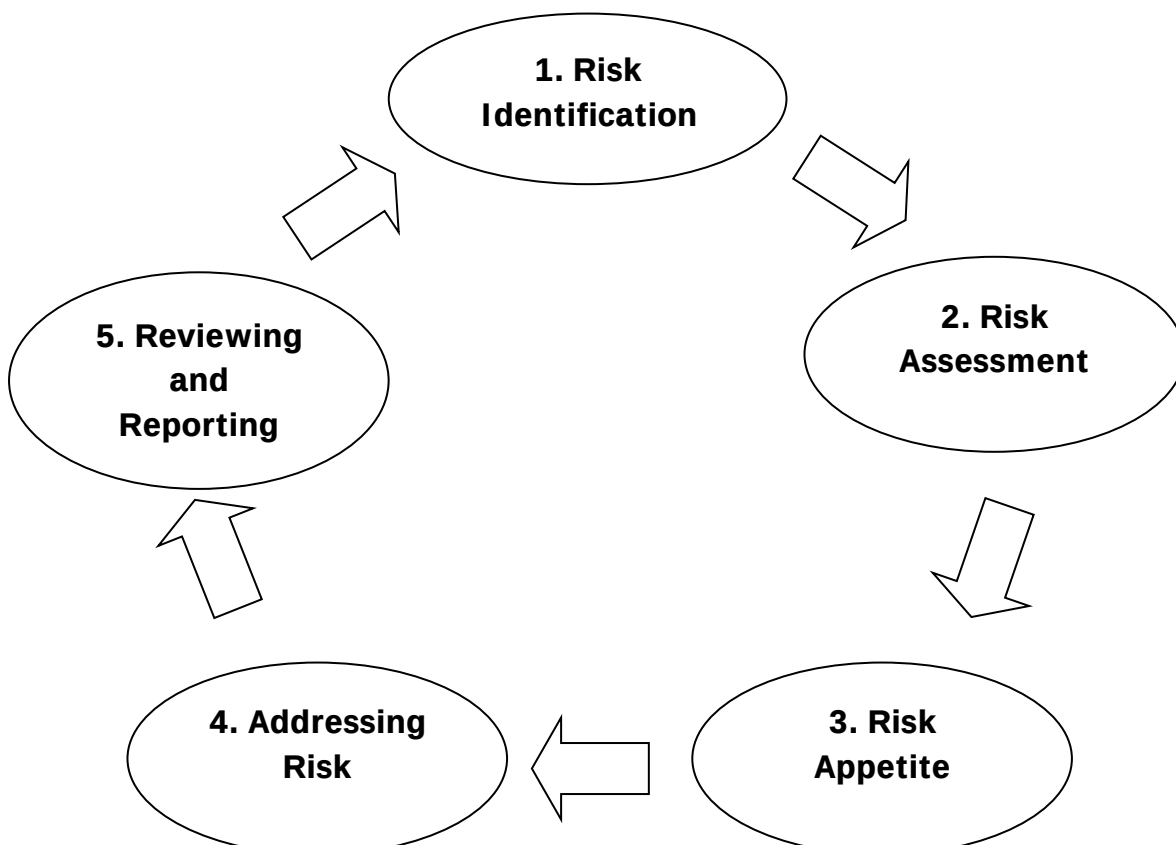
- Board and senior management commitment to risk management – a clear sense that risk management is integral to planning and achieving objectives
- An understanding that certain risks simply have to be accepted and managed accordingly
- A consistent approach is taken across the organisation to identify and analyse risks whether those risks are strategic or operational, financial or organisational or related to safety and quality and to assessing their likelihood and consequences.

- That there are established procedures within the organisation for the co-ordination of risk management processes.

Within the PHA there are systems and processes established to effectively identify, assess, manage, record and review risk management activity. These include:

- Risk Management Strategy and Policy
- Corporate Risk Register (see template at Annex1)
- Directorate Risk Registers (see template at Annex 2)
- Governance Statement and Mid Year Assurance Statement
- Review of Corporate and Directorate Risk Registers by the Agency Management Team on a quarterly basis
- Corporate Risk Register submitted to the Governance and Audit Committee on a quarterly basis
- Corporate Risk Register brought to the PHA board at least annually.
- Corporate Risk Register used as the basis for developing the Internal Audit activity plan for the year

Stages in PHA Risk Management Process



- | | |
|---------|--|
| Stage 1 | <u>Risk identification</u> – the process of identifying risks which may impact on the organisation's ability to achieve its objectives |
| Stage 2 | <u>Risk assessment</u> – assessing the 'likelihood' of a risk occurring and its potential 'impact' on the relevant business objective. |
| Stage 3 | <u>Assessment of risk appetite</u> – the extent of exposure to risk that is judged tolerable for the organisation |
| Stage 4 | <u>Addressing the risk</u> – the response to the risk can be one of four options – Terminate, Tolerate, Transfer or Treat. |
| Stage 5 | <u>Recording and Reviewing risk</u> – the risk management process is evidenced through the maintenance of risk registers (both Corporate and Directorate). |

Communication and consultation with appropriate external and internal stakeholders should take place within and throughout all steps of the risk management process.

The 3 Lines Model of assurance mapping, as detailed above, has a key role to play in each stage of the risk management process.

Stage 1 - Risk Identification

Risks are identified in a number of ways and at all levels within the organisation (corporately, by Directorate and by individual staff members (see Annex 5 for risk identification template for all staff). Risks can present as external factors which impact on the organisation but which the organisation may have limited control over or operational which concern the service provided and the resources/processes available and utilised.

Importantly within the organisation risk identification is related to the organisation's objectives (as detailed in the PHA Corporate Plan and Annual Business Plan). Each risk identified is correlated to at least one of the corporate objectives.

Risks are also aligned with the relevant HSC domain as identified in the HSC paper Performance and Assurance Roles and Responsibilities (MIPB 74/09) issued in April 2009 which sets out performance and assurance roles and responsibilities in relation to four key HSC domains. The four domains are as follows:

Corporate Control – the arrangements by which the PHA directs and controls its functions and relates to stakeholders.

Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' needs.

Finance – the arrangements for ensuring the financial stability of the PHA, for ensuring value for money and ensuring that resources allocated by the Minister/DoH are deployed fully in achievement of agreed outcomes.

Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Governance and Ministerial targets and required service improvements.

Stage 2 - Risk Assessment

After risks are identified they are they assessed to establish:

- o The **impact** that the risk would have on the business should it occur, and
- o The **likelihood** of the risk materialising.

Risks are categorised using the Regional HSC “5x5” risk matrix (see Annex 3). In assessing the Likelihood and Impact, it categorises risks at four levels – extreme, high, medium or low. A colour coding is used in a traffic-light system (green, yellow, amber and red). The Risk Analysis Tools Impact Table, also included in Annex 3, gives detail of the impact definitions to be used when assessing each identified risk.

Stage 3 - Risk Appetite

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

Risk appetite can be defined as the *“amount and type of risk that an organisation is prepared to seek, accept or tolerate”*. ISO defines risk appetite as an *“organisation’s approach to assess and eventually pursue, retain, take or turn away from risk.”*

The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, stakeholders and the organisation alike. Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA’s business viability or reputation is significantly high and may outweigh any benefits to be gained.

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

An **acceptable (or residual) risk** is when there are adequate control measures in place and the risk has been managed as far as is considered to be reasonably practicable and/or to reach the level of risk appetite of the PHA for that risk (Annex 4).

Stage 4 - Addressing the Risk

The four traditional responses to addressing risk are:

Terminate – decision is made to cease the activity which causes the risk.

Tolerate – decision is made to accept the risk, eg where it stems from an external source or the impact/likelihood is low and therefore can be carried by the organisation.

Transfer – where another party can take on some or all of the risk more effectively,

Treat – where action is taken to mitigate the risk by adopting actions to reduce or eliminate the risk to an acceptable level.

In practice within the PHA the vast majority of risks are managed via the “Treat” or “Tolerate” route – both of which are underpinned by the identification of an action plan to reduce and ultimately eliminate the risk.

Stage 5 - Recording and Reviewing Risk

Within the PHA the risk management process is recorded and evidenced through the maintenance of Risk Registers.

A **Corporate Risk Register** is in place and on a quarterly basis all Directorates review the corporate risk register, paying particular attention to the corporate risks which fall within their Directorate work area. The Corporate Risk Register details risks of a strategic nature.

Also, each Directorate manages their own **Directorate Risk Register**. These tend to detail risks which are more operational in nature. Again this is reviewed within Directorates on a quarterly basis.

However, both Corporate and Directorate Risk Registers are viewed holistically within the organisation. Risks can be **escalated** to the Corporate Risk Register and also **de-escalated** from the Corporate Risk Register to Directorate Risk Registers in line with quarterly reviews of actions taken to address risks and control measures in place.

The Corporate Risk Register is presented to the Agency Management Team (AMT) on a quarterly basis for review and approval to forward to the Governance and Audit Committee (GAC). It is forwarded for consideration at a PHA board meeting at least annually.

8 Roles and Responsibilities

Chief Executive

The Chief Executive, as the Accounting Officer, has ultimate responsibility for managing the risks faced by the PHA. As Accounting Officer, he/she is required to sign an annual Governance Statement as part of the preparation of the Annual Report and Statutory Accounts. In order to fulfil this responsibility, the risk management process must be fully embedded and operational within the PHA.

The Chief Executive as Accounting Officer will champion the risk management process, and ensure that appropriate commitment from the organisation is given. This commitment will include ensuring the provision of appropriate risk management training for management and staff.

Governance and Audit Committee (GAC)

The GAC supports the PHA board and Accounting Officer by providing an independent and objective review of the completeness of assurances to satisfy their needs and of the reliability and integrity of the assurances. The Committee remit is ultimately to give an assurance to the board each year as to the adequacy and effectiveness of the system of Internal Control.

The GAC has therefore responsibility for scrutinising and advising on governance and finance issues. This includes overseeing the risk management process and reviewing and challenging the Corporate Risk Register to provide assurances that the arrangements are actively working in the organisation. The GAC will review the Corporate Risk Register on a quarterly basis.

PHA board

The PHA board is responsible for ensuring that appropriate systems are in place to ensure effective risk management, across all the services for which the PHA is responsible. These systems should be in line with the key elements detailed within the PHA's Governance Framework and associated policies and procedures. The Corporate Risk Register is presented to the full board at least annually.

The PHA board is responsible for reviewing the effectiveness of the internal controls –financial and organisational. The board is required to give assurance that it is doing its reasonable best to manage the PHA's affairs efficiently and effectively through the implementation of controls to manage risk. The PHA Corporate Risk Register is an important tool for recording all risks and the controls in place to remove or reduce those risks. The board should also ensure this arrangement is reviewed annually or when procedural, legislative or best practice changes occur.

Agency Management Team (AMT)

AMT members will develop and maintain a culture of risk management within their area of responsibility. This includes:

- Determining what types of risks are acceptable and which are not.
- Ensuring that line managers and all staff are aware of their risk and control responsibilities.
- Determining the level of risk that the PHA will carry in relation to specific major activities or projects across the organisation as a whole.
- Approving major decisions affecting the organisation's risk profile or exposure.
- Identifying risks and monitoring their management and control.
- Satisfying themselves that the less significant risks are being actively managed, with the appropriate controls in place and working effectively.
- Annually reviewing the PHA's approach to risk management and approving changes or improvements to key elements of its processes and procedures.
- Ownership of Directorate Risk Registers for their area of responsibility.
- Complying with the process as set out in the "Serious Adverse Incidents Policy" and implementing controls to address weaknesses where appropriate.
- Ownership and approval of the Corporate Risk Register through quarterly review at AMT meetings.

Directors

Director of Operations

The Director of Operations is the lead executive Director with responsibility for ensuring that effective and robust risk management processes and systems are in place to ensure good corporate governance within the PHA.

All Directors

Each Director is responsible for ensuring that risk management processes are adopted within their Directorate and that risks are appropriately and timely managed, ie included in Directorate/Corporate risk registers and escalated/de-escalated between these registers as necessary.

Director of Finance

The ~~SPPGHSCB~~ Director of Finance is responsible for providing financial services to the PHA and is accountable to the Chief Executive for ensuring that effective processes and systems are in place to ensure good financial governance within the PHA.

Assistant Directors

In conjunction with the relevant Director, Assistant Directors will be responsible for ensuring that an effective risk management system is put in place for their area of responsibility. This should reflect the overall governance arrangements within the PHA.

Line managers and staff

All line managers and staff are expected to:

- Have a knowledge of and comply with the PHA Risk Management Strategy and Policy and related policies.
- Alert management to emerging risks or control weaknesses. The Risk Identification template (See Annex 5) is available for all staff to use.
- Participate fully in the regular risk review process.
- Assume responsibility for risks and controls within their own areas of work.

Internal Audit

Although risk management and internal control are management's responsibility, Internal Audit supports the maintenance of effective internal control through its annual programme of work and subsequent reports. The Head of Internal Audit adopts a risk based approach to planning their work, referring to the PHA risk registers in identifying topics for review across all Directorates. Individual audit reports are presented to the GAC throughout the year, with a mid year and annual internal audit report prepared giving the Head of Internal Audit's opinion on risk management, control and governance to support and inform the Chief Executive's (Accounting Officer) Mid Year Assurance Statement and Governance Statement.

"The work of Internal Audit is likely to be the single most significant resource used by the Audit Committee in discharging its responsibilities. This is because the head of Internal Audit, in accordance with the Government Internal Audit Standards, has a responsibility to offer an annual audit opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes." (HM Treasury – Audit Committee Handbook).

Internal Audit also has a role to play in:

- Acting as an independent advisor by providing advice on the management of risk, especially those issues surrounding the design, implementation and operation of systems of internal control.
- Monitoring, reporting and providing assurance on the effectiveness of the risk and control mechanisms in operation.
- Promoting risk management and control concepts across the PHA.

9 The Reporting of Risk

The process of regularly updating and reviewing the Corporate Risk Register will be monitored by the GAC.

Alternative Format

Every effort will be made to provide information in an alternative format if written format is not accessible to a member of staff.

Equality Considerations

This policy has been screened in accordance with the PHA's statutory duty and is not considered to require a full impact assessment. The screening outcomes will be published on the PHA website.

Human Rights Act

This policy is compliant with the requirements of the Human Rights Act 1998.

Corporate Risk Register Template

ANNEX 1

Corporate Risk				
RISK AREA/CONTEXT:				Date Risk Added:
DESCRIPTION OF RISK:				
LINK TO ASSURANCE FRAMEWORK: (Domain)				
Link to Annual Business Plan 20xx/xx:				
GRADING	LIKELIHOOD	IMPACT	RISK-GRADE	
LEAD OFFICER: (Lead Director):				
Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date

Corporate Risk XX					
RISK AREA/CONTEXT:					
DESCRIPTION OF RISK:					DATE RISK ADDED:
LINK TO ASSURANCE FRAMEWORK: Corporate Control / Safety and Quality / Finance / Operational Performance and Service Improvement					
LINK TO ANNUAL BUSINESS PLAN 20XX/20XX: Corporate Objective XX					
GRADING	LIKELIHOOD	IMPACT		RISK GRADE	
Current					
Target					
LEAD OFFICER: Director of XX					
Existing Controls	1st, 2nd & 3rd lines of Assurance	Gaps in Controls and Gaps in Assurances	Control Effectiveness RAG rating (RED)	Action Plan/Comments/ Timescale	Review Date

Directorate Risk Register Template

ANNEX 2

DOMAIN: RISK TITLE: Date Added to Risk Register:									
Risk Ref	Description of risk	Existing Controls	Likelihood	Impact	Risk Rating	Treatment / Action Plan & Timescale	Lead Officer	Status	Review Date

ANNEX 3

HSC Regional Impact Table – with effect from April 2013 (updated June 2016 and August 2018)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE (Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)	Near miss, no injury or harm.	- Short-term injury/minor harm requiring first aid/medical treatment. - Any patient safety incident that required extra observation or minor treatment e.g. first aid - Non-permanent harm lasting less than one month - Admission to hospital for observation or extended stay (1-4 days duration) - Emotional distress (recovery expected within days or weeks).	- Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). - Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). - Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	- Long-term permanent harm/disability (physical/emotional injuries/trauma). - Increase in length of hospital stay/care provision by >14 days.	- Permanent harm/disability (physical/emotional trauma) to more than one person. - Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES (Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)	- Minor non-compliance with internal standards, professional standards, policy or protocol. - Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	- Single failure to meet internal professional standard or follow protocol. - Audit/Inspection – recommendations can be addressed by low level management action.	- Repeated failure to meet internal professional standards or follow protocols. - Audit / Inspection – challenging recommendations that can be addressed by action plan.	- Repeated failure to meet regional/ national standards. - Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. - Audit / Inspection – Critical Report.	- Gross failure to meet external/national standards. - Gross failure to meet professional standards or statutory functions/ responsibilities. - Audit / Inspection – Severely Critical Report.
REPUTATION (Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)	- Local public/political concern. - Local press < 1day coverage. - Informal contact / Potential intervention by Enforcing Authority (e.g. HSE/NIFRS).	- Local public/political concern. - Extended local press < 7 day coverage with minor effect on public confidence. - Advisory letter from enforcing authority/increased inspection by regulatory authority.	- Regional public/political concern. - Regional/National press < 3 days coverage. Significant effect on public confidence. - Improvement notice/failure to comply notice.	- MLA concern (Questions in Assembly). - Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. - Criminal Prosecution. - Prohibition Notice. - Executive Officer dismissed. - External Investigation or Independent Review (eg, Ombudsman). - Major Public Enquiry.	- Full Public Enquiry/Critical PAC Hearing. - Regional and National adverse media publicity > 7 days. - Criminal prosecution – Corporate Manslaughter Act. - Executive Officer fined or imprisoned. - Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS (Protect assets of the organisation and avoid loss)	- Commissioning costs (£) <1m. - Loss of assets due to damage to premises/property. - Loss – £1K to £10K. - Minor loss of non-personal information.	- Commissioning costs (£) 1m – 2m. - Loss of assets due to minor damage to premises/ property. - Loss – £10K to £100K. - Loss of information. - Impact to service immediately containable, medium financial loss	- Commissioning costs (£) 2m – 5m. - Loss of assets due to moderate damage to premises/ property. - Loss – £100K to £250K. - Loss of or unauthorised access to sensitive / business critical information - Impact on service contained with assistance, high financial loss	- Commissioning costs (£) 5m – 10m. - Loss of assets due to major damage to premises/property. - Loss – £250K to £2m. - Loss of or corruption of sensitive / business critical information. - Loss of ability to provide services, major financial loss	- Commissioning costs (£) > 10m. - Loss of assets due to severe organisation wide damage to property/premises. - Loss – > £2m. - Permanent loss of or corruption of sensitive/business critical information. - Collapse of service, huge financial loss
RESOURCES (Service and Business interruption, problems with service provision, including	Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service.	Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service.	Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service.	Loss/ interruption 8-31 days resulting in major damage or loss/impact on service.	Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service.

<i>staffing (number and competence), premises and equipment)</i>	- No impact on public health social care. - Insignificant unmet need. - Minimal disruption to routine activities of staff and organisation.	- Short term impact on public health social care. - Minor unmet need. - Minor impact on staff, service delivery and organisation, rapidly absorbed.	- Moderate impact on public health and social care. - Moderate unmet need. - Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. - Access to systems denied and incident expected to last more than 1 day.	- Major impact on public health and social care. - Major unmet need. - Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	- Catastrophic impact on public health and social care. - Catastrophic unmet need. - Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL <i>(Air, Land, Water, Waste management)</i>	Nuisance release.	On site release contained by organisation.	- Moderate on site release contained by organisation. - Moderate off site release contained by organisation.	Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC Regional Risk Matrix – April 2013 (updated June 2016 and August 2018)

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016 and August 2018)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

Likelihood Scoring Descriptors	Impact (Consequence) Levels				
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

Acceptable/Residual Risk

- The PHA acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, service users and others. The PHA will therefore make all efforts to reduce risk or ensure that risks are contained and controlled so that they are as low as reasonably practicable.
- It is not always possible to reduce an identified risk completely and it may be necessary to make judgements about achieving the correct balance between benefit and risk. A balance needs to be struck between the costs of managing a risk and the benefits to be gained.
- Where a risk has been reduced to the point where the cost of further controls to reduce the risk outweigh the benefit they may provide, it may not be considered reasonably practicable to implement those controls. However, where risk controls are available it is the duty of the organisation to demonstrate that the cost of implementation outweighs the benefit, or, that alternative effective control measures have been implemented. Risks requiring a cost benefit analysis must be fed into the PHA risk register process for wider debate and decision on 'acceptability'.



RISK IDENTIFICATION TEMPLATE FOR ALL STAFF

All staff have a role in how governance and areas of risk are managed within the Public Health Agency (PHA)

Each Directorate within the PHA has a risk register detailing specific risks. Each risk is assessed according to likelihood of it happening and impact it will have on the organisation. Each risk will have an action plan to mitigate the risk.

Please use this form to inform your manager without delay of any areas of risk or concern you may be aware of and which you feel should be considered as a possible Directorate risk. This might be about a system of work, a policy/protocol or something specific to your area of work.

Description of Risk	What action could be taken to manage this risk?

Directorate: _____

Date: _____

The Following PHA Policies should be read in conjunction with this Strategy/Policy:

- Assurance Framework
- Corporate Governance Framework
- Health and Safety Policy
- Security Policy
- Incident and Near Misses Reporting Policy and Procedure
- Policy on Business Continuity Management
- Standing Orders
- Standing Financial Instructions
- Whistleblowing Policy
- Fraud Response Policy and Plan
- Gifts and Hospitality Policy
- Standards and Guidelines for Monitoring and Handling of Complaints
- ISO 31000:2018 Standard

Records Management Policy

Version	1.4
Approved by IGSG	
Approved by AMT	
Approved by GAC	
Review Date	

Version Control

Version	Changes	Approval Process
1.1		IGSG 07/06/2012 and approval of implementation plan by AMT on 26/7/2012
1.2	Presentation changes	IGSG: 19/01/2016 GAC: 04/02/2016 Board: 18/02/2016
1.3	Presentation / clarification changes including removal of Appendix 1 and editing of Appendix 2 (now renamed Appendix 1)	Reviewed by RMWG on: 16/01/2020 Approved by IGSG on: 29/01/2020 Approved by AMT on: 11/02/2020 Approved by GAC on: 28/02/2020

~~January 2020~~
September 2023

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1. Introduction

This Records Management Policy sits within the context of the Information Governance Strategy (~~2018 2023~~ to ~~March December 2026 2022~~). The Information Governance Strategy sets out the framework in which the **Public Health Agency** (PHA) meets its obligations for planning, developing and implementing records management policies and procedures which are consistent with legislation and the business requirements of the PHA.

This Records Management Policy:

- Sets out the requirements that must be met for the records of the PHA to be considered as a proper record of the activity of the PHA;
- Outlines the requirements for a PHA records management system and processes;
- Should be considered alongside the Department of Health ~~and Social Services and Public Safety (DHSSPS)~~ publication Good Management Good Records (GMGR) ~~2017 November 2011 (and subsequent updates)~~ which has been officially adopted as the PHA Retention and Disposal Schedule;
- Highlights the quality and reliability standards which must be maintained to provide a valuable information and knowledge resource for the PHA;
- Sets out the arrangements for monitoring compliance.

It relates to all corporate, clinical and non-clinical operational records held in any format by the Public Health Agency as detailed in the Department of Health ~~and Social Services and Public Safety (DHSSPS)~~ publication Good Management Good Records (GMGR) November ~~2017 2011~~ ¹.

The Policy is supplemented by detailed procedures, as set out in Section 5.

¹ ~~<http://connect.publichealthagency.org/policy/records-management-good-management-goodrecords-or-http://www.dhsspsni.gov.uk/gmgr.htm>~~ [Records Management Policy | PHA Connect \(hscni.net\)](#)

2. Policy Statement

Information is a corporate asset and the records of the PHA are important sources of information including patient/client, administrative, financial, legal, evidential and historical information. They are vital to the PHA in its current and future work, for the purposes of accountability, and for an awareness and understanding of its history. They are the corporate memory of the PHA.

The PHA will create, use, manage and destroy or preserve its records in accordance with all statutory requirements.

Systematic records management is fundamental to the PHA's efficiency. It ensures that the correct information is:

- captured, stored, retrieved and destroyed or preserved according to need;
- fully utilised to meet current and future needs, and to support change;
- accessible to those who need to make use of it; and that the appropriate technical, organisational and human resource elements exist to make this possible.

3. Aims

The records management system aims to ensure:

- a consistent systematic and planned approach to records management covering records from creation to disposal;
- compliance with statutory requirements and to increase efficiency by improving the flow of information, and greater coordination of records and storage systems;
- awareness of the importance of records management and the need for responsibility and accountability at all levels.

All staff of the PHA who create, use, manage or dispose of records have a duty to protect them and to ensure that any information that they add to the record is necessary, accurate and complete. Confidentiality must always be of primary concern to PHA staff. Appropriate training and guidance will be provided on the management of records.

4. Scope

The Records Management Policy should be read in conjunction with other relevant PHA governance policies and documents including:

- PHA Information Governance Strategy and Information Governance Framework
- PHA Data Protection and Confidentiality Policy
- Data Breach Incident Response policy
- PHA Access to Information Policy
- ~~Information Management~~
- PHA ICT Security Policy and Associated Policies
- Risk Management Policy
- ~~DHSSPS DoH~~ Guidance Document 'Good Management, Good Records' (GMGR) 2017 ~~(and subsequent updates)~~

5. Records Management Process

Implementing and maintaining an effective records management system depends on the knowledge of what records are held, where they are stored, who manages them, in what format(s) they are made accessible, their relationship to organisational functions and their appropriate and timely disposal.

The process includes:

- Classification of the records into a records management system, with meaningful titles and a consistent reference code.

- Individuals creating records being responsible for classifying them appropriately and ensuring that they are recorded and maintained correctly.
- Having sequences of reference codes that can facilitate both paper and electronic (where appropriate) records to enable tracking and recall, and eventually align with a single PHA records management system, ~~and that~~ to enable tracking and recall of records.
- Checking that the correct records have been allocated to the appropriate reference code and that meaningful titles are used.
- Auditing to ensure that the records management system makes sense and records are traceable.
- Ensuring good records management practice is applied to all files – business/corporate files and patient/client/staff files through all stages of the record cycle from creation to disposal. All PHA staff have a responsibility to ensure records are retained and ultimately destroyed in accordance with this guidance.

The detail of the records management processes are defined in a suite of records management factsheets which outline the procedure for each stage of the record lifecycle. The procedures relate to records regardless of formats, throughout their lifecycle, from planning and creation through to disposal, ensuring that all records are kept in an accessible format. The factsheets have been developed in line with Good Management Good Records (GMGR) and include the following:

- File Covers and File Content
- Closing Files
- Disposal of Records
- Contemporaneous Notes and Marginalia
- The Use of Folio Numbering and Folio Sheets
- Management of Handwritten Notes / File Notes

- Preparing Agendas and Minutes
- Managing Electronic Records including E-mails /File Naming Conventions
- Version Control
- Preparing Records for Archive
- Transporting Records
- Security of Records
- What is a master file and what is a working file?
- Accessing External Confidential Waste Disposal Company
- Protective Markings on File Covers
- Filing Systems

6. Off-site Records Management

It is not possible to store all records locally; therefore, some will be stored in secure off-site storage through the regional contract. The principles set out in this policy also apply to the management of off-site records.

All records held in off-site storage should have a review or retention date recorded. It is the responsibility of the relevant information asset owner to ensure that these dates are recorded for each record.

7. Accountability

All records created by the PHA are public records as defined in the Public Records Act (Northern Ireland) 1923.

7.1 Statutory Responsibility

“Good Management Good Records” states that the Permanent Secretary, Departmental Information Manager, Chief Executives and senior managers are personally accountable for records management within their organisation and have a duty to make arrangements for the safe keeping and eventual disposal of those records under the overall supervision of the Deputy Keeper of Public Records at PRONI.

Organisations are also required to take positive ownership of, and responsibility for, the records legacy of predecessor Organisations and/or obsolete services.

Robust records management procedures are required to meet the requirements set out under the Data Protection Act 2018 (DPA 2018), UK General Data Protection Regulations (UK GDPR), the Freedom of Information Act 2000 (FOI Act 2000) and the Environmental Information Regulations 2004 (EIR 2004).

7.2 Roles and Responsibilities within PHA

The formal roles and responsibilities relating to records management are set out in section 3 of “Good Management Good Records”. Within the PHA these roles and responsibilities are as follows:

- **All Staff** – All staff have a responsibility to comply with the records management strategy, policy and associated procedures.
- **Chief Executive** – The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DoH directives.
- **Senior Information Risk Owner (SIRO)** – The SIRO (Director of Operations) is the focus for the management of information risk at Board level. The SIRO should lead and foster a culture that values, protects and uses information for the public good. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process.
- **Data Protection Officer (DPO)** - The DPO is the first point of contact for the ICO and for individuals whose data is processed (employees, members of public etc).

- **Assistant Director Planning and Business Services** (AD P&B) Operational Services – The AD P&B has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda including records management.
- **Governance Manager** – The Governance Manager is operationally responsible for the day to day implementation of all aspects of Information Governance including records management.
- **Office Managers** – Responsibility for coordinating and overseeing implementation of records management within their offices.
- **The Personal Data Guardian (PDG)** – The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the ‘conscience’ of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.
- **Information Asset Owners (IAOs)** – are senior individuals whose primary role is to understand what information is held and~~The IAO's primary role is to~~ manage and address risks associated with the information assets within their function. They are required ~~and~~ to provide assurance to the SIRO on the management of those assets. Each Assistant Director or other senior manager is the IAO for their function and ~~also~~ sit on the Information Governance Steering Group.
- **Information Asset Assistants (IAA's)** – IAAs may be identified in each function to support the IAO.

- **Information Governance Steering Group (IGSG)** – Consisting of representatives from all PHA Directorates the primary function of the IGSG will be to lead the development and implementation of the Information Governance framework across the organisation. The Group will be chaired by the SIRO, or their deputy, and will meet not less than three times per year.
- **Records Management Working Group (RMWG)** – Chaired by the Assistant Director of Planning and Business, or their deputy, this Group will address the Records Management function within the PHA developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will in turn cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.
- **PHA Governance and Audit Committee (GAC)** – The GAC has responsibility for providing the PHA board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress against the Information Governance Strategy.
- **PHA Agency Management Team (AMT)** – AMT will receive updates on Information Governance matters (including Records Management) on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The PDG will also report on matters relating to patient identifiable information where appropriate.

Appendix 1 outlines the relevant legislation and drivers in relation to legal and professional responsibility for records management.

8. Monitoring Compliance

Compliance with this policy and associated procedures will be monitored by audits of sample records and records storage areas as well as through self-assessment of the Information Management Assurance Checklist and Internal Audit audits as appropriate.

Records Management will also be subject to periodic audit by internal and external audit. These audits will seek to:

- identify areas of good practice which can be used throughout the PHA;
- highlight where non-conformance with the procedures is occurring; and
- if appropriate, recommend changes to the records management system and processes and to how compliance can be achieved.

9. Review of Policy

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

This policy will be reviewed in August 2027 or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

10. Equality and Human Rights Screening

This policy has been screened in accordance with the PHA's requirements under Section 75 of the Northern Ireland Act 1998. Cognisance has also been taken of human rights. The policy and screening outcomes are published as part of our agreed process for publication.

APPENDIX 1

Relevant Legislative Compliance, Standards, Guidelines and Policies

- The Access to Health Records (Northern Ireland) Order 1993
- The Access to Personal Files and Medical Reports (Northern Ireland) Order 1991
- The Common Law Duty of Confidentiality
 - Confidentiality: DHSSPS code of practice (PDF 111KB)
[The \(DoH\) Code of Practice on protecting the Confidentiality of Service User Information \(April 2019\)](#)
- The Computer Misuse Act 1990
- [UK](#) General Data Protection Regulations (GDPR) [2018](#)
- The Data Protection Act (DPA) 2018
- The Data Protection (Processing of Sensitive Personal Data) Order 2000
- The Electronic Communications Act 2000
- ~~The Environmental Information Regulations 2004~~
- The Electronic Communications Act 2000
- The Environmental Information Regulations 2004
- The Freedom of Information Act (FOIA) 2000
- The Privacy and Electronic Communications (EC Directive) Regulations 2003
- Public Health Act (Northern Ireland) 1967
- The Public Interest Disclosure (Northern Ireland) Order 1998
- The Public Records Act (Northern Ireland) 1923
- Disposal of Documents Order (Northern Ireland) 1925
- The Re-use of Public Sector Information Regulations 2005

- Lord Chancellor's Code of Practice on the management of records issued under Section 46 of the Freedom of Information Act 2000
- DoH Good Management Good Records, Guidance for Management of Records 2017
- PRONI, The Northern Ireland Records Management Standards (NIRMS)
- Professional Codes of Conduct
- BS ISO/IEC 17799:2005 BS ISO/IEC 27001:2005 BS 7799-2:2005 (Information Security management)
- ISO 15489 International Standards on Records Management
- ISO 19005 – 1:2005 Electronic Document File Format for Long Term Preservation
- BSI DISC BIP 0008 British Standards on Electronic Information Management

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Information Governance Strategy / Framework
Reference	PHA/06/10/23
Prepared by	Information Governance Team
Lead Director	Stephen Wilson
Recommendation	For Approval ☒ For Noting ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the updated PHA Information Governance Strategy / Framework.

2 Information Governance Strategy / Framework

A review has been carried out of the PHA Information Governance Strategy incorporating the Information Governance Framework.

Changes to the Policy are minimal following this review, consisting mainly of formatting changes and some updates to Section 2 (Scope) and Section 6.2 (Roles and Responsibilities). All suggested changes are highlighted in red.

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

3 Next Steps

Following approval by the PHA Board, the updated Strategy / Framework will be shared with PHA staff.



Information Governance Strategy

incorporating the

Information Governance Framework

~~2018 – 2022~~
2023 – 2026

Version	3.0
Version 3 approved by	IGSG: 28/07/2023 GAC: PHA Board:
Version 2 approved by	IGSG: 06/11/18 GAC: 12/12/18 PHA Board: 20/12/18
Version 1 approved by	IGSG: 13/01/15 GAC: 19/02/15 PHA Board: 19/03/15
Review Date	December 2026 or sooner if required by PHA Reshape and Refresh programme

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1.0 Introduction

The Public Health Agency (PHA) is heavily dependent on the information and records it holds and considers all of the data it processes as an asset. It recognises that its records and information must be appropriately managed, handled and protected to serve its business needs and acts openly, while at the same time ensuring that personal and sensitive data is protected. It must demonstrate compliance with all relevant legislation¹ as well as standards set by the Department of Health (DOH).

In recognising its public accountability, the PHA will make every effort to ensure that information is efficiently managed and that appropriate policies, procedures and management accountability and structures provide a robust governance framework for information management. The framework will ensure that information is accessible while also ensuring the confidentiality of personal data (client and staff), and corporately sensitive information, through adopting robust security measures to protect that information from accidental loss, accidental disclosure or deliberate unauthorised disclosure.

2.0 Scope of Information Governance

The effective use of information is central to the planning and delivery of care across the Health and Social Care Environment. The effective use of information will assist in addressing the Quadruple aim outlined in the Bengoa Report, 'Systems not Structures' ie. enhancing patient experience, improving population health, reducing costs and improving the work life of staff.

The Information Governance Strategy sets out the framework to ensure that the PHA meets its obligations in respect of information governance; it will also be the vehicle for improving information governance in the PHA. The Strategy covers the 3 year period from 2023 to 2026 and will be supported by annual Action Plans setting out how it will be implemented. The action plans will be monitored by the Information Governance Steering Group², chaired by the Senior Information Risk Owner (Director of Operations) or deputy. A report will be submitted to the PHA Governance and Audit Committee on a regular basis.

3.0 Purpose

The general purpose of the Information Governance Strategy is to provide clear direction to the PHA in delivering the requirements of information governance including legislative requirements and associated policies. The strategy will assist in establishing and maintaining a robust and effective Information Governance Framework³ that allows PHA to fully discharge its strategic duties, ensuring that overall corporate compliance is met both in relation to legal and statutory obligations and in meeting all relevant codes of practice.

The Information Governance Strategy cannot be seen in isolation as information is central to all areas of work in the PHA. It outlines the necessary engagement with PHA

¹ Appendix 1 Legislation and Guidance

² Appendix 2 PHA Information Governance Steering Group (IGSG) Terms of Reference (TOR)

³ Appendix 3 PHA Information Governance Framework

Information Asset Owners, providing specialist advice and support, helping to build robust Information Asset Registers.

Information Governance is also a key element of corporate and clinical governance. This strategy is, therefore, closely linked with other strategies, policies, procedures, guidance and staff training to ensure integration with all aspects of the Agency's business activities.

4.0 Benefits

Benefits of a robust and fully implemented Information Governance strategy can be summarised as follows:

- Ensures that decisions are based on readily accessible, high quality information;
- Ensures that information is held and handled securely, and that personal and sensitive information is safeguarded;
- Reduces risks associated with poor and unregulated systems and processes;
- Reduces data losses and the negative impact such losses have on corporate image;
- Ensures that legal and other DOH requirements are met;
- Supports good corporate governance and underpins the assurance framework and corporate risk register;
- Ensures that information and information assets are managed in a coherent manner reducing duplication of effort and increasing availability.

5.0 Objectives

The key objectives of this strategy are to ensure the effective management of Information Governance by:

- Complying with all legislation - Data Protection Act (DPA) 2018 and EU-UK General Data Protection Regulation (GDPR), ~~Environmental Information Regulations 2004~~
- Complying with DOH recommendations and best practice;
- Establishing, implementing and maintaining policies for the effective management of information;
- Recognising the need for an appropriate balance between openness and confidentiality in the management and use of information;
- Providing assurance that all information risks are identified, managed and, where possible, mitigated;
- Minimising the risk of breaches and inappropriate use of personal data;
- Ensuring that the public are effectively informed and know of their right of access (subject access requests) ~~how to access their information and exercise their right of choice;~~
- Ensuring that all PHA staff are sufficiently trained and enabled to follow and promote best practice in regard to the management of information;
- ~~Achieving and improving compliance with the~~ Completion of the regional Information Management Assurance Standard Checklist.

6.0 Information Governance Framework

The Information Governance Framework⁴ is an overarching framework which is intended to pull together the various strands of policy and activity covered by 'Information Governance'. This is important as there are several policies⁵ which impinge on Information Governance. It will enable PHA to set out and promote a culture of good practice around the processing of information and use of information systems throughout the organisation. That is, to ensure that information is handled to ethical and quality standards in a secure and confidential manner. The PHA requires all employees and Non-Executive Board Members (Members) to comply with policies, procedures and guidelines which are in place to implement this framework.

6.1 Information Governance Policy Statement

A clear policy framework is critical to ensuring a coherent approach to Information Governance across all PHA functions and locations. This strategy is supported by a suite of information governance policies⁶. All Information Governance related policies will be reviewed and updated as necessary on a regular basis.

6.2 Roles, Responsibilities and Reporting Arrangements

- **Chief Executive** – The Chief Executive, as Accounting Officer, has responsibility for ensuring that the PHA complies with its statutory obligations and DOH directives. The Chief Executive is required to provide assurance through the Governance Statement that all risks, including those relating to information, are effectively managed and mitigated.
- **PHA board** – The PHA board is responsible for ensuring appropriate systems are in place to ensure effective Information Governance across all of the services for which PHA is responsible. An Information Governance report (included in the PHA Annual Report) will be presented to the PHA Board annually.
- **PHA Governance and Audit Committee (GAC)** – The GAC has responsibility for providing the PHA Board with an independent and objective review of governance processes and an assurance on the adequacy and effectiveness of the system of internal control within the PHA. It will formally review progress on the implementation of this Strategy on an annual basis.
- **PHA Agency Management Team** - AMT will receive updates on Information Governance matters on both a formal and informal basis via the Director of Operations who fulfils the role of Senior Information Risk Owner (SIRO) and Chair of the Information Governance Steering Group. The Personal Data Guardian (PDG) will also report to AMT on matters relating to patient identifiable information where appropriate.

⁴ Appendix 3 PHA Information Governance Framework

⁵ Appendix 4 PHA Information Governance Policies

⁶ Appendix 4 PHA Information Governance Policies

- **Information Governance Steering Group (IGSG)** - Consisting of representatives from all PHA Directorates (Information Asset Owners or their representatives) the primary function of the IGSG will be to lead the development and implementation of the Information Governance Framework across the organisation. The Group will be chaired by the SIRO and will meet at least three times a year, on a quarterly basis, in line with its Terms of Reference.
- **Senior Information Risk Owner (SIRO)** - The SIRO (Director of Operations) is the focus for the management of information risk at board level. The SIRO will advise the Accounting Officer on the Information Risk aspect of the Governance Statement and will own the overall information risk and risk assessment process. The SIRO is a member of the Regional Cyber Security Programme Board.
- **The Personal Data Guardian (PDG)** - The PDG (Director of Public Health/Medical Director) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. The PDG is the 'conscience' of the organisation in respect of patient information, and will also promote a culture that respects and protects personal data. The PDG works closely with the SIRO and Information Asset Owners (IAOs) where appropriate, especially where information risk reviews are conducted for assets which comprise or contain patient/service user information.
- **Information Asset Owners (IAO's)** - Each IAO is responsible for the processing of data within their area/s of responsibility and must maintain and review, on an annual basis, an information asset register for their Directorate. The IAO is also responsible for the management and addressing of risks associated with the information assets within their function and providing an assurance to the SIRO on the management of those assets. Each PHA Assistant Director is the IAO for their function and also sits on the Information Governance Steering Group.
- **Information Asset Assistant** — The Information Asset Assistant has responsibility delegated from the IAO to support them in the management of the information assets within their function.
- **Assistant Director Planning and Business Operational Services (AD P&B)** - The A/D P&Ops-B has responsibility delegated from the SIRO for ensuring that effective systems and processes are in place to address the information governance agenda. The Assistant Director is also the Data Protection Officer.
- **Data Protection Officer (DPO)** - The DPO has responsibility for monitoring and ensuring compliance with this policy, UK GDPR and other, relevant data protection legislation, acting as the contact point with the Information Commissioners' Office, training staff, advising on data protection impact assessments (DPIAs) and conducting internal audits as necessary across the organisation.
- **Senior Operations Manager (Delivery)** - The Senior Operations Manager (Delivery) is operationally responsible for the day to day implementation of all aspects of Information Governance.

- **Records Management Working Group (RMWG)** – Chaired by the Senior Operations Manager (Delivery), this Group will address the Records Management function within the PHA, developing and implementing an effective system across all offices. Membership consists of representatives from each Directorate. Members will, in turn, cascade progress across all teams within their Directorate. The RMWG reports to the IGSG.
- **All Staff** - All staff have a responsibility to comply with this strategy and all information governance policies and procedures including the completion of Information Governance Awareness and Cyber Security mandatory training on an annual basis. and three yearly basis respectively
- Cyber Security Cyber Security is managed by the BSO

6.3 Leadership

Effective leadership is essential to create and nurture a corporate culture conducive to effective Information Governance. A culture of corporate and individual ownership and responsibility is essential when looking to effective compliance with all statutes and codes of practice.

6.4 Supporting Staff

Clear accountability arrangements will ensure that staff are accountable for the work that they do and the information assets they process and manage. There should be an open and supportive environment in which errors, mistakes or concerns can be raised immediately, with management and corrective measures implemented swiftly and processes changed accordingly.

This culture will further mitigate risks associated with the handling and processing of sensitive information, both corporate and personal in nature.

6.5 Communication

It is important to ensure that staff are aware of Information Governance issues, with updates provided as required. Effective and timely communication of Information Governance matters to all PHA staff is essential if the PHA is to meet the aims and objectives associated with this strategy.

As well as ensuring compliance with this strategy and associated policies and procedures, the wider Information Governance agenda within the Public Sector is a fast moving and quickly developing one. It will often be necessary to communicate new directives or initiatives to staff. Communication to staff must be handled with care to ensure that the message is not lost amongst a wealth of material.

6.6 Training

It is also essential to ensure that all staff understand and have the knowledge and skills necessary to put the Information Governance Strategy and associated policies and procedures into operational use. The PHA will ensure that appropriate training is developed and available to up-skill existing staff and for new staff entering the service. This will include the use of the e-learning platform. All staff are required to undertake mandatory Information Governance training. The responsibility for ensuring that staff participate in these programmes rests with the relevant IAO and line managers, with support from the Information Governance Steering Group. Members should also avail of relevant information governance awareness and training.

6.7 Implementation and Performance Monitoring

An Information Governance Action Plan will be prepared annually. This will also provide a mechanism by which progress can be monitored. The following reporting arrangements will apply:

- ~~Quarterly~~ Progress reports on the Information Governance Action plan will be agreed through the Information Governance Steering Group;
- ~~Quarterly~~ Reports on progress against the Information Governance action plan will be provided to the Governance and Audit Committee following each IGSG meeting;
- Reports to the Agency Management Team as required;
- An annual report will be brought to the PHA board as and when required.

Performance will also be monitored annually through the Information Management Assurance Checklist (IMAC). The IMAC includes an assurance, signed by the Chief Executive, to be returned to the DoH. An assurance on the management of information risk is also provided through the Mid-Year Assurance Statement and the Governance Statement.

7.0 Summary and Conclusion

Information Governance is a vital and integral part of the PHA's overall Governance programme. The implementation of the Information Governance Strategy and its subsequent policies, procedures, protocols and guidelines will ensure that the PHA has the appropriate framework in place to meet legislative and organisational requirements and it will drive the development and implementation of improvement plans year on year.

8.0 Equality and Human Rights Considerations

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

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

8.3 This policy is included in the PHA's Equality Screening Documentation.

9.0 Review of Policy

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

9.2 This policy will be reviewed by December 2026, or earlier if relevant guidance is issued.

Appendix 1

Legalisation and Guidance

There are a number of pieces of legislation and guidance which have a significant impact on records management and information governance. A selection of these is listed below.

Public Records Act (Northern Ireland) 1923

All HSC records are public records under the terms of the Public Records Act (Northern Ireland) 1923. Chief Executives and senior managers of all Health and Social Care organisations are personally accountable for records management within their organisation. They have a duty to make arrangements for the safekeeping and correct disposal (under the Disposal of Documents Order (Northern Ireland) 1925) of those records under the overall supervision of the Deputy Keeper of Public Records whose responsibility includes permanent preservation.

Data Protection Act 2018 and ~~EU~~ UK General Data Protection Regulations (GDPR) 2018

The Data Protection Act (DPA) 2018 places a statutory responsibility on the PHA to protect the personal data, which it holds. In relation to records management this means that the PHA must implement measures to:

- Maintain the accuracy of records held;
- Protect the security of personal data;
- Control access to the personal data; and
- Make arrangements for secure disposal once the record is no longer required.

The ~~EU~~ UK General Data Protection Legislation (GDPR) gives individuals additional rights about how their personal data is used by organisations and applies to all UK and EU organisations that control and or process personal data. It is based on the premise that individuals ('data subjects') should have knowledge of what data is held about them, how it is held, how long for and how it is used.

Confidentiality and Data Protection Act

All HSC bodies and those carrying out functions on behalf of the HSC have a common law duty of confidence to patients/clients and a duty to maintain professional ethical standards of confidentiality. Everyone working for or with the HSC who records, handles, stores or otherwise comes across personal information has a personal common law duty of confidence to patients/ clients and to his/her employer. The duty of confidence continues even after the death of the patient/client, or after an employee or contractor has left the HSC.

The Data Protection Act (DPA) 2018 includes electronic and manual records. The Act, which applies to the whole of the United Kingdom, sets out requirements for the "processing" of personal data (i.e. meaning obtaining, recording or holding the information or data or carrying out any operation or set of operations on the information or data).

A "data subject", namely, a living individual who is the subject of personal data, has a right of access to their personal data and, in certain circumstances, can have their data corrected or even deleted.

The [UK](#) GDPR sets out 7 key principles which lie at the heart of data protection, and must be followed by all data controllers and processors:

Personal data shall be:

“(1) processed lawfully, fairly and in a transparent manner in relation to individuals (**‘lawfulness, fairness and transparency’**);

(2) collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be considered to be incompatible with the initial purposes (**‘purpose limitation’**);

(3) adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed (**‘data minimisation’**);

(4) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay (**‘accuracy’**);

(5) kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the GDPR in order to safeguard the rights and freedoms of individuals (**‘storage limitation’**);

(6) processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures (**‘integrity and confidentiality’**).”

Additionally,

“(7) The controller shall be responsible for, and be able to demonstrate compliance with, principles (1) – (6) above (**‘accountability’**).”

The Information Commissioner, who has responsibility for the enforcement of this legislation, provides guidance on the application of data protection legislation.

Further information on the Data Protection Act 2018 and [UK](#) GDPR is available from the Information Commissioner’s Website (<https://ico.org.uk/>).

Freedom of Information Act 2000

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (with some exemptions). The Act makes provision for the Lord Chancellor to issue guidance on how records systems should be maintained in order to facilitate public access to information held. In particular S46 (1) states:

"The Lord Chancellor shall issue, and may from time to time revise, a code of practice providing guidance to relevant authorities as to the practice which it would, in his opinion, be desirable for them to follow in connection with the keeping, management and destruction of their records".

The Act was brought fully into force on 1 January 2005. The HSC has two main responsibilities under the Act. The HSC has to maintain its 'Publication Scheme' (effectively a guide to the information which is publicly available) and to deal with individual requests for information.

Anyone can make a request for information, although the request must be made in writing (including email). An Environmental Information Regulation (EIR) request, may, however, be verbal. The request must contain details of name and address of the applicant and the information sought.

The HSC is obliged to produce information recorded both before and after the Act was passed. It is vital that records are held within a structured Records Management system in order to meet the HSC obligations under the Act. It should be noted that the responsibility for responding to information access requests lies with the authority that holds the information. The Act is intended to change the way in which public authorities do business, making them more accountable. The foreword to the Code of Practice on Records Management published by the Lord Chancellor under Section 46 of the Act states:

"Any freedom of information legislation is only as good as the quality of the records to which it provides access".

This highlights the importance of good Records Management in the PHA. Further information on the Freedom of Information Act is available from: <https://ico.org.uk/>.

Good Management, Good Records

These guidelines offer an overview of the key issues, solutions and best practice for HSC teams to follow when preparing a records management strategy. It represents the joint view of DOH and the Public Records Office (PRONI) view of how records should be administered and sets the standard required of the HSC.

The Disposal Schedule has been approved by PRONI. It sets out minimum retention periods for HSC records of all types, except for GP medical records, and indicates which records are most likely to be appropriate for permanent preservation. It also explains the reasoning behind the determination of minimum retention periods, including legal requirements where relevant.

The Schedule does not replace the requirement for PHA to develop and agree their own disposal schedules with PRONI, however, it should form the basis for such schedules.

<https://www.health-ni.gov.uk/articles/gmgr-records-management>

The PHA has in place a systematic and planned approach to the management of **all** records which ensures that, from the moment a record is created until its ultimate disposal, the PHA can control both the quality and quantity of information it generates; can maintain that information in a manner that effectively services its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

Information Management Assurance Checklist (IMAC)

The PHA will complete the Information Management Assurance Checklist (IMAC) and submit to the Department of Health annually.

Legislation, in particular the Data Protection Act 2018, [UK](#) GDPR, Freedom of Information Act 2000, the Environmental Information Regulations (EIR) 2004 and Access to Health Records (Northern Ireland) Order 1993 impact significantly on the record keeping arrangements in public authorities.

ISO 15489: International Standard on Information and Documentation Records Management

The International Standard on managing recorded information, initially based on an earlier Australian standard, was adopted by ISO in 2001. The Standard acts as an enabler towards accreditation and renewal of ISO 9001 and other quality standards. It also provides a specification against which record management practices may themselves be audited.

PHA INFORMATION GOVERNANCE STEERING GROUP (IGSG)

Terms of Reference (Reviewed June 2022)

Purpose

The purpose of the PHA Information Governance Steering Group, is to lead the development and implementation of the Information Governance Framework across the organisation. It will report to the PHA Agency Management Team (AMT) and Governance and Audit Committee (GAC) providing assurance for the PHA board on the effectiveness of Information Governance systems and practices within the PHA.

Remit

- Ensure that information governance systems are in place across the PHA, in line with the PHA Information Governance Framework and relevant Standards and legislation.
- Develop Strategic solutions to Common Information Governance problems.
- Provide a forum to raise awareness and share experience and best practice in Information Governance.
- Provide direction to the work of Records Management Working Group.
- Act as direct point of contact for Information Governance related issues such as Freedom of Information, Information Security and Data Protection etc.
- Agree and monitor the information governance action plan, ensuring actions are taken forward.

Working Arrangements

- The Group will meet at least three times a year.
- The Group may from time to time call upon advisors e.g. ICT Security Manager.
- The Group will be chaired by the SIRO, or his nominated deputy.
- The Governance Manager will provide the secretariat for the meeting.
- The agenda and papers will be issued no less than 3 working days in advance of the meeting. Minutes of meeting will be produced and agreed with the chair prior to issue. Draft minutes will be circulated as soon as possible after the meeting, and brought to the next meeting for approval.
- The Group will review its TOR every three years, or sooner if required.

Reporting Arrangements

The Group will report to:

- AMT
- PHA Governance and Audit Committee

Membership List

SIRO

Director of Operations – Chair

PDG

Director of Public Health

Governance & Audit Committee Representative

Non-Executive Director

IAOs

Please note if an IAO cannot attend, their Deputy IAO, or IAA should attend to represent them. Appendix A provides a more detailed list of IAOs, IAO Deputies and their IAAs.

Operations

Assistant Director Planning and Operations

Assistant Director Communications and Knowledge Management

Public Health

Assistant Director Health Protection

Assistant Director Screening

Assistant Director Service Development

Assistant Director Health & Social Wellbeing Improvement

Assistant Director Research and Development

Nursing

Assistant Director AHP &PPI

Assistant Director Nursing (CYP)

Assistant Director Nursing

Assistant Director Nursing

Assistant Director Nursing

Assistant Director Nursing

(NB. Normally, one Assistant Director Nursing will attend on behalf of all the Assistant Directors in Nursing in addition to the Assistant Director AHP & PPI)

Health and Social Care Quality Improvement

Clinical Director HSCQI

Connected Health

Programme Director

SBNI

Professional Officer

Governance Team

Senior Operations Manager (Delivery)

Assistant Governance Manager

Further details on the membership of this Group is available at Appendix A.

Appendix 3 – PHA Information Governance Framework

INFORMATION GOVERNANCE FRAMEWORK		
Heading	Requirement	PHA Structure
Senior Roles	- IG Lead - Senior Information Risk Owner (SIRO) - Personal Data Guardian (PDG) - Data Protection Officer (DPO)	- The Chief Executive as Accountable Officer has overall accountability for IG and is required to provide assurance that all risks to the PHA are effectively managed. - SIRO for the PHA is Director of Operations & Chair of the Information Governance Steering Group. - PDG for the PHA is Director of Public Health / Medical Director. - IAOs for the PHA are Assistant Directors within each Directorate. - DPO is the Assistant Director of Planning and Operational Business Services (P&Ops)
Policy	- Over-arching IG Policy Data Protection Act, UK GDPR and Data Protection and Confidentiality Policy - Organisation Security Policy - Information Lifecycle Management (Records Management) Policy - Corporate Governance Policy	- Corporate Governance Framework - Information Governance Strategy Incorporating the Information Governance Framework - Information Governance Policy Statement Data Protection/Confidentiality Policy - ICT Security Policy - Secure Mobile ICT Equipment - Use of the Internet Policy - Use of Electronic Mail Policy - Use of ICT Equipment Policy - Records Management Policy - Freedom of Information Procedures - Access to Information Policy - Data Breach Incident Response Policy

Key Governance Bodies	IG Board/Forum/Steering Group	• PHA Governance & Audit Committee • PHA Information Governance Steering Group • PHA Records Management Working Group
Resources	Details of key staff roles and dedicated budgets	• Assistant Director of Planning & Operational-Business Services • Senior Operations Manager (Delivery) • Governance Administrative Officer (NB none of the above 3 posts are full time Information Governance)
Governance Framework	Details of how responsibility and accountability for IG is cascaded through the organisation.	• All staff contracts include IG clauses • Staff responsibility set out in IG Strategy • Information Asset Register • Notices on Intranet Site (Connect)
Training & Guidance	• Staff Code of Conduct • Training for all staff • Organisation Security Policy • Training for specialist IG roles	• Code of Conduct • IG e-Learning Training mandatory for all staff • PHA ICT Security Policy • SIRO, PDG and IAO's training completed
Incident Management	Documented procedures and staff awareness	• PHA Risk Management Strategy and Policy • Information Sharing Protocol • Guidance for reporting IG related incidents • Data Breach Incident Response Policy (including reporting mechanisms to GAC) • IG Leaflet • Incident and Near Miss Reporting Policy and Procedure

Extract from IM CAS:

The Information Governance Framework may be described in a single one page standalone document or incorporated within an over-arching IG Policy or an IG Strategy and should provide a summary/overview of how an organisation is addressing the IG agenda

Appendix 4 – PHA Information Governance Policies & Guidance

[PHA Information Governance Strategy and Framework 2023 - 2026](#)

[PHA](#) Records Management Policy (reviewed at GAC xx/09/23)

[PHA Short](#) Protocol for the handling of requests for information made under the Freedom of Information Act 2000-/Data Protection Act 2018 (reviewed at IGSG 28/7/2023)

[PHA FOI Act Information Handler's Guidance](#) (reviewed at IGSG 28/7/2023)

PHA Freedom of Information Internal Review Procedures (reviewed at IGSG 28/7/2023)

PHA Data Breach Incident Response Policy

[PHA](#) Data Protection/Confidentiality Policy

[PHA](#) Guidance on transferring hard copy personal information

[PHA Access to Information Policy](#)

[PHA Data Protection Impact Assessment Policy and Guidance](#) (reviewed IGSG 4/04/2023)

[PHA Information Governance: What you need to know leaflet](#) (reviewed at IGSG 28/7/2023)

[PHA Information Security Leaflet](#)

[PHA Email Top Tips Guide](#)

[PHA Small Cell Sizes Disclosure Protocol](#) (due for review at IGSG on xx/10/23)

~~[PHA Corporate and Public Affairs: Corporate Social Media Policy and Guidelines 2014](#)~~

[DoH](#) Records Management - Good Management Good Records

[DoH Code of Practice on protecting the confidentiality of service user information](#)

[Regional Guidance on the use of Digital Recorders](#)

[~~BSO ITS~~](#) ~~PHA~~ ICT Security Policy

[~~BSO ITS~~](#) Procedure for provisioning new starts with access to IT services

[~~PHA~~](#) Data Access Agreement

[~~BSO ITS~~](#) Application for mobile phone

[~~BSO ITS~~](#) Application form for provision of an encrypted USB memory stick

[~~BSO ITS~~](#) Safestick/[Kingston User Guide](#) SafeXS usage

[~~BSO ITS~~](#) Application form to enable access to removable media

[~~BSO ITS~~](#) Application form for secure remote access

[~~BSO ITS Regional~~](#) HSC Secure Email Service User Guide

[~~BSO ITS~~](#) Use of Email Policy [2015](#)

[~~BSO ITS~~](#) Sophos Antivirus Software for Home use [2019](#)

[~~BSO ITS~~](#) Use of PHA ICT Equipment [2015](#)

[~~BSO ITS~~](#) Securing Mobile ICT Equipment [\(adopted by PHA\) 2012](#)

Title of Meeting	PHA Board Meeting
Date	19 October 2023
Title of paper	Equality and Disability Action Plans 2023/28
Reference	PHA/07/10/23
Prepared by	BSO Equality Unit
Lead Director	Stephen Wilson
Recommendation	For Approval ☒ For Noting ☐

1 Purpose

The purpose of this paper is to seek PHA Board approval of the PHA's Equality and Disability Action Plans 2023/28.

2 Equality and Disability Action Plans 2023/28

Following feedback from the Joint Consultation co-ordinated by BSO Equality Unit this paper presents the finalised PHA Equality and Disability Action Plans 2023-28 for PHA Board approval.

In line with advice received from BSO Equality Unit the plans were submitted to the Equality Commission in draft before 30th September and the finalised version to be submitted following their approval at today's PHA Board meeting.

3 Next Steps

Following approval by the PHA Board, the Plans will be formally submitted to the Equality Commission.

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

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

What we will do	What we are trying to achieve and who for (i.e. which Section 75 category specifically)	Performance Indicator and Target	By whom and when
Service Development and Screening Support the implementation of an online booking system for diabetic eye screening. *	Disability, Dependants, Age The online booking system allows participants to select a date for screening more suitable to them via a link within their invitation letter. The objective of this system is to give more flexibility to individuals with caring responsibilities, young people and those of working age. It is also hoped that this in turn will reduce the number of clinic DNAs.	Usage of the system will need to be restricted until the programme has recovered sufficiently and has capacity to offer a variety of screening clinic slots online. The other impact will be the implementation of a low risk pathway in 2023/24, the effects of this new pathway will not be realised until 2025/26 as eligible patients will be moved in a phased approach over 2 years. The impact of the system will be reviewed by the Belfast HSC Trust along	The implementation and management of the booking system is the responsibility of the Belfast HSC Trust, however the PHA will support the implementation and the impact of the system will be kept under review by the NIDESP Operational Group (with PHA and Belfast HSC Trust membership) Aim to have full implementation by March 2026.

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Specific action 2 - The development of an integrated model of support across the health and educational sector that can assist to meet the child and young person's needs holistically and which meets requirements within the Children's Services Co-operation Act (2015).	CYP will benefit from a holistic approach to addressing their AHP needs within the school environment, reducing duplication and enhancing consistent messaging.	Review of training programmes provided by health and education towards model with greater regional consistency and evidence of cross organisational partnership working.	PHA AHP by Sept 2024
Cancer Screening Raise awareness and promote informed choice in cancer screening, focusing on those communities and population groups who are less likely to participate in screening, including in particular people from ethnic minority backgrounds, people with a disability, and lesbian, gay and bisexual people Take forward a process to retender for the contract with an external organisation with	Ethnicity, Disability, Sexual Orientation Empower those from the above range of S75 groups and deprived areas across NI (whose uptake of screening invitations tends to be lower) to make an informed choice to participate in cancer screening. To engage with those in the above S75 groups and deprived areas across NI to	The service provider will deliver 240 Cancer Screening Awareness Sessions annually, in an accessible manner, to participants in target groups and living in socially deprived areas across NI. The annual average number of session attendees from target groups will be approx.	Tender process led by Lead Consultant and Project Manager in Screening (working with PALs and Operations). Contract will be awarded to a service provider in Q1 2023/24, to undertake this work for the next 4 years (at a minimum).

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community links to undertake this work. Once tender is awarded, manage contract and monitor progress to ensure targets are met and target groups reached. PMR, session impact data and equality data will be submitted quarterly and Annually. Contract review meetings will be undertaken quarterly.	raise awareness of cancer signs and symptoms.	2,400. (N.B. targets would be revised in light of future waves of the pandemic.) Increase session attendees' awareness of the Cancer Screening Programme by 40% Increase session attendees' intention to attend cancer screening when next invited by 20%. Increase session attendees' knowledge of cancer signs and symptoms by 20%.	Contract management will be undertaken on an ongoing basis, by Project Manager in Screening with input from Lead Consultant and others as appropriate.

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Infectious diseases in pregnancy screening (IDPS): - Ensure that all women from section 75 categories have access to IDPS early in pregnancy and that there is equality of access into clinical care for those screening positive for infections. 1. We will provide information leaflets about the IDPS programme in an accessible format in different languages. 2. We will liaise with community groups if necessary who can provide transport for women to clinic appointments if necessary. 3. We will monitor the programme to reduce potential inequalities within it especially for those women requiring referral to specialist services.	Persons from ethnic minority groups, asylum seekers and migrants. 1. We are trying to ensure that people from the above groups know how to access services and have the information they need in the appropriate language, in order to make an informed choice about IDPS screening. 2. We are trying to ensure that women who need to attend specialist services can access the service and attend appointments required for the health of themselves and their baby.	1. Quarterly statistics will be collected from each Trust to show performance against National standards and these will provide evidence of IDPS uptake and attendance at specialist appointments. The target would be that performance against each standard would reach the acceptable level and hopefully achieve the achievable level (top level) 2. Audit in progress around women screened positive for hepatitis B- this will highlight inequalities of access	PHA Regional antenatal infection screening programme co-ordinator–data collected quarterly.

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		amongst women attending specialist services.	
Health Improvement Refugees, Asylum seekers, Minority Ethnic & Migrant communities should have the opportunity of equal access to Health and Social Care services in Northern Ireland. - Engage with SPPG & DoH to consider additional funding needs in the short term and to develop a regional Northern Ireland New Entrants Service (NINES) which is consistent & effective across NI - Submit a paper to SPPG to highlight the issues to be addressed and develop a business case for the funding requirements.	Persons of different racial groups Equal access for all Asylum Seekers, Minority Ethnic & Migrants to initial health assessments and associated screening across the Region	Written evidence of engagement and paper submission Formation of working group to address issues relating to capacity for NINES/allied services, membership to include PHA and SPPG commissioning/primary care	PHA Nursing and PHA Health Protection End March 2024

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HSC LGBTQ+ Staff Forum Facilitate a minimum of 4 annual meetings the HSC LGBTQ+ Staff Forum. Work in partnership with other HSC organisation promote membership of the HSC LGBTQ+ Staff Forum. In partnership with members outline the key priorities for the HSC LGBTQ+ Staff Forum. Participate in and contribute to Diversity Champions events with other LGBTQIA+ Staff Networks in NI.	Gender, Sexual Orientation Provide an opportunity for HSC LGBTQ+ Staff to: • have a space to have their voice heard in the HSC. • be able to contribute to decision making that affects LGBTQ+ people. • Provide a community where LGBTQ+ people can feel better supported, recognised and included by the HSC. take an active role in promoting inclusion and diversity in the HSC	Population outcome: LGBTQ+ staff working in the HSC see the HSC values realised. Performance accountability: • Promotion of the Staff forum in each HSC organisation • Increase in HSC LGBTQ+ Staff Forum membership and in active participation. Production of a document outlining Staff Forums key priorities.	PHA Health Improvement with support from Employment Equality Leads in all HSC organisations by March 2024

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Equality Monitoring Commitment to collect additional equality data and outline planned analysis to be carried out on specific data that will be collected.	All S75 Groups Gather additional information relating to S75 groups and explore how this can be used to inform wider decisions	Audit what information is currently gathered and develop plan to identify opportunities to collect additional data Identify data that allows further analysis to be carried out	PHA Health Improvement and Operations End Mar 2028
Equality Working Group Establish a PHA Equality Working Group	All S75 Groups Ensure Equality is considered at a strategic level within PHA Aim to change culture of organisation to ensure equality issues are being considered and addressed	Group established and meeting regularly – TOR agreed and action plan in place	PHA Planning and Operational Services End Mar 2028

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Develop and introduce an equality specific section for all Involvement training commissioned / delivered by the PHA.	All S75 Groups Aim to ensure best practice is followed in terms of equality issues, in respect of involvement matters in the PHA and to influence practice across the wider HSC	Equality specific section developed for use in all Involvement training commissioned / delivered by the PHA. Increase in understanding of the rationale for embedding best practice in equality matters.	Lead by the PHA PPI Team, with guidance from BSO Equality colleagues, HSC partners and service users and carers

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

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

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Service Development and Screening Infectious diseases in pregnancy screening (IDPS) programme Since people living with HIV are protected under the Disability Discrimination Act, it is important that we ensure that pregnant women screened positive for HIV are not discriminated against. 1.We will continue to encourage all staff involved in the care of pregnant women to attend HIV awareness training at least every 3 years. 2.The PHA will develop a regional power point training presentation on the IDPS, which includes HIV. This	Promoting positive attitudes and Encouraging participation in public life To ensure equality of care for all pregnant women screened positive for HIV.	Regional Power point training presentation for the IDPS programme developed.	PHA Regional antenatal infection screening programme co-ordinator, by early 2024.

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will ensure standardisation of training regionally . 3.The PHA will work with HSC Trusts to strengthen their internal quality assurance function within the IDPS programme so that assurances can be given that all staff are attending training as recommended i.e. three yearly.	To ensure that Trusts take responsibility for ensuring that their staff are attending training in the IDPS programme.	QA structures for the IDPS programme agreed and implemented. (will be resource dependent)	PHA Consultant responsible for the IDPS programme and Regional antenatal infection screening programme co-ordinator by end 2025
Awareness Days Raise awareness of the lived experience of people with specific disabilities and conditions.	Promoting positive attitudes: Increased staff awareness of a range of disabilities and conditions.	2 awareness days profiled every year. >50% of staff taking part in the evaluation indicate they know more about people living with disabilities and conditions as a result of the awareness days.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Placement Scheme Create and promote meaningful placement opportunities for people with disabilities.	Promoting positive attitudes and Encouraging participation in public life: People with a disability gain meaningful work experience. People with a disability are successful in applying for paid employment after they have completed a placement.	At least 3 placements in the PHA offered every year. Feedback through annual evaluation of scheme indicates that placement meets expectations. At least 1 placement participant every year is successful in applying for paid employment within 12 months of completing their placement.	Agency Management Team (AMT) with support from BSO Equality Unit. End Mar 2028
Tapestry Network Promote and encourage staff to participate in the disability staff network and support the network in the delivery of its priorities.	Encouraging participation in public life: Staff with a disability feel more confident that their voice is heard in decision-making. Staff with a disability feel better supported.	Tapestry staff survey Increase in Tapestry membership or in participation at meetings	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Strategic Planning Teams Create and promote opportunities for people with disabilities to participate in PHA's strategic planning process to ensure the needs of people with disabilities are appropriately reflected when setting commissioning priorities.	Encouraging participation in public life: People with a disability are meaningfully involved in setting commissioning priorities initially in the following areas (to be regularly reviewed): • Mental Health • Older People • Alcohol and Drugs	Review current participation opportunities Develop and implement engagement plan	PHA Planning and Operational Services AD End Mar 2028
Providing information in signed video format Undertake an audit of PHA websites to: 1) identify key information to be made available in signed video format and 2) ensure relevant contact details are available and up to date in relation to requesting signed format versions.	Encouraging participation in public life: Ensure that content is accessible to people who are deaf	Complete audit to identify key information to be made available and where contact details are provided	PHA Planning and Operational Services End Mar 2028

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Disability Training Plan Working together with Tapestry, we will co-produce, commission and deliver, and evaluate a training plan for staff on disability equality.	Promoting positive attitudes: Raise awareness of issues facing those with a disability and identify/develop suitable training and development opportunities	Engage with Tapestry to identify training required and explore how this can be implemented.	Agency Management Team (AMT) with support from BSO Equality Unit End Mar 2028
Pro-actively use the Engage Website to promote & encourage involvement of service users and carers with a disability. Liaise with Tapestry, HSC partners, Disability Action & other advocacy groups, to identify ways in which the Engage website might be more effectively used to advance meaningful involvement of service users and carers in the work of the HSC	Encouraging and facilitating participation in public life. Help to inform HSC staff how they could support and encourage active involvement of service users and carers with a disability. Inform and encourage service users and carers with a disability to avail of involvement opportunities with the HSC	Production of a Guide targeted at informing staff about ways in which to support involvement of service users and carers with a disability. Increasing numbers of service users and carers with a disability availing of HSC Involvement opportunities	PHA PPI Team in collaboration with Tapestry, 3rd sector Advocacy organisations – ongoing during 2023-28

What we will do	What we are trying to achieve	Performance Indicator and Target	By whom and when
Work with HSC partners to develop guidance and mechanisms to take forward remuneration of service users and carers in line with the policy direction laid down in the Co-Production Guide	Encouraging and facilitating participation in public life. Helping to address barriers to participation by service users and carers, many of whom are living with a disability and who are less likely to get involved due to additional financial pressures and costs.	Have in place guidance and mechanisms to facilitate remuneration of service users and carers in agreed, appropriate and defined circumstances. Increasing numbers of service users and carers with a disability, availing of remunerated HSC Involvement opportunities.	PHA PPI Team working in collaboration with the DoH, HSC partners & the PCC by the end of 2024.
Work with HSC partners to develop mechanisms for feedback which are accessible to the wider population of Northern Ireland	Improve opportunity for people of NI to provide feedback on experiences across HSCNI	All campaigns and promotion material will be supported by translation and adapted to encourage feedback from people with a disability	PHA PCE Team working in collaboration with HSC partners and charitable partners; Complete by the end of 2024