2010
2011

HSC Public Health Agency

ANNUAL REPORT

Public Health Agency

Getting in touch

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www.publichealth.hscni.net

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

Using this report
This report highlights the broad range of work carried out by the PHA and shows how this work has contributed to meeting our objectives.

The online Portable Document Format (PDF) file of this report also has live web access to relevant websites.

This report is intended to be an overview of the year's main accomplishments.

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

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Other formats
Copies of this report may be produced in alternative formats on request. A PDF file of this document is also available to download from our corporate website at www.publichealth.hscni.net

Contents

Chair's statement

The core mission of the Public Health Agency is to improve the health of the population of Northern Ireland and to reduce health inequalities within that population.

As Chair of the PHA, I believe this is a great responsibility and I am proud that in the last year my colleagues have risen to the challenge admirably.

As well as hard work, professionalism and dedication, which PHA staff display in abundance, tackling enduring health inequalities requires close cooperation with colleagues throughout Health and Social Care (HSC). Equally, collaborative work with local government and the community and voluntary sectors is crucial.

Accordingly, this year the PHA funded over 600 community organisations who are working to reduce health inequalities and to improve the health outcomes for children, the elderly and people from disadvantaged areas across Northern Ireland.

As individuals, citizens and health professionals, we all must continue to build on this excellent work, investing in early interventions and community infrastructure, changing our environment for the benefit of everyone, supporting good health and tackling issues such as obesity, smoking and alcohol abuse.

The PHA also has a duty to protect public health, and in 2010/11 we faced a number of challenges in this area.

After last year's pandemic flu, in 2010/11 we worked to inform the public of the continued risks of swine flu infection, especially for pregnant women and people in at-risk groups.

In cooperation with HSC colleagues we are now running successful screening programmes for bowel and cervical cancer, and have continued to work to improve the mental and sexual health of our population.

Our greatest asset in our mission is our staff, and I congratulate the Chief Executive and all our staff for all their hard work, professionalism and commitment.

On a final note I would like to personally thank the members of our board for all their dedication and support. I would also like to thank our colleagues throughout the wider HSC and in the Department of Health Social Services and Public Safety (DHSSPS) for all their assistance and advice.

I look forward to working with you all to achieve our common goals.

Mary McMahon
Chair

Chief Executive's statement

The work of the Public Health Agency is as important as it is challenging.

We continually work to fulfil our core objectives of improving public health and reducing health inequalities, while on a day-to-day basis we must respond quickly and professionally to a changing health care environment and any emerging public health issues.

I am pleased to say that throughout the year PHA staff have performed these duties admirably.

Later in this report the PHA Executive Directors, Dr Carolyn Harper (Public Health), Mary Hinds (Nursing and Allied Health Professionals) and Ed McClean (Operations), explain the work of their teams throughout the year.

A consistent feature of this has been the efforts by the PHA to build strong relationships in particular with colleagues across Health and Social Care, with the wider public sector and with our many partners in the voluntary and community sector.

The need for collaborative working was highlighted clearly in November 2010 when the PHA hosted a major series of events and seminars on reducing health inequalities.

'Focus on health inequalities' saw professionals, policy makers and local community groups from Northern Ireland and beyond come together to share their experience of tackling this most crucial of challenges.

The programme was a great success, and participants came away with a greater understanding of the issues at stake.

Men living in our areas of deprivation, on average, die seven years earlier than their more affluent neighbours. We must reduce this gap.

By reducing health inequality, we will significantly improve the health of our population – the reason the PHA exists.

We don't expect to achieve this alone. That is why collaborative working with colleagues from throughout the HSC, local government and the community and voluntary sectors is at the very heart of the PHA agenda.

We have made great strides in joint working throughout the year, and we will continue to develop good working relationships right across Northern Ireland.

During the year, I have been fortunate to meet many inspirational people working to improve lives in their communities. But two events in particular have left images which will remain with me forever. In September, I had the privilege of joining the Walk out of Darkness into the Light to Belfast City Hall in support of those who have lost loved ones through suicide. This was one of the most moving and dignified events I have ever witnessed, and I will never forget the sight of lanterns rising over the Belfast skyline as dawn was breaking. Another lasting image was from the British Transplant Games in Bath where the under fives, all with transplants, competed in the 50 metres sprint to show everyone what the gift of life of organ donation really means.

As we look forward to another year, I would like to thank the Board of Directors and each member of staff for their admirable dedication to our objectives.

Dr Eddie Rooney
Chief Executive

Directors' report: Public Health

Dr Carolyn Harper

The PHA was created to:

- protect public health;
- improve the health and social wellbeing of people in Northern Ireland;
- reduce inequalities in health and social wellbeing through targeted, effective action.

During the past year the PHA has undertaken a broad range of activity to support these goals.

To protect public health the PHA has put in place a flexible and effective response system and dealt in a timely fashion with public health issues as they have arisen.

During 2010/11 these public health issues have included the continued danger from flu, a rabies outbreak in Turkey that had the potential to affect holiday makers, the deaths of several people by carbon monoxide poisoning and a severe disruption to the water supply for many people in Northern Ireland.

To improve the health and social wellbeing of people in Northern Ireland we have continued with a range of programmes targeting the most fundamental health issues facing our society, including mental health, obesity, smoking, alcohol and drug misuse and sexual health.

We have continued to target a reduction in inequalities in health and social wellbeing and in October 2010 the PHA organised 'Focus on health inequalities', a month-long calendar of events that brought together people from health and social care, the voluntary sector and government.

Reducing health inequalities

In our efforts to reduce health inequalities, we have been systematically examining the evidence of best practice and effectiveness to ensure that investment and joint working will bring clear benefits.

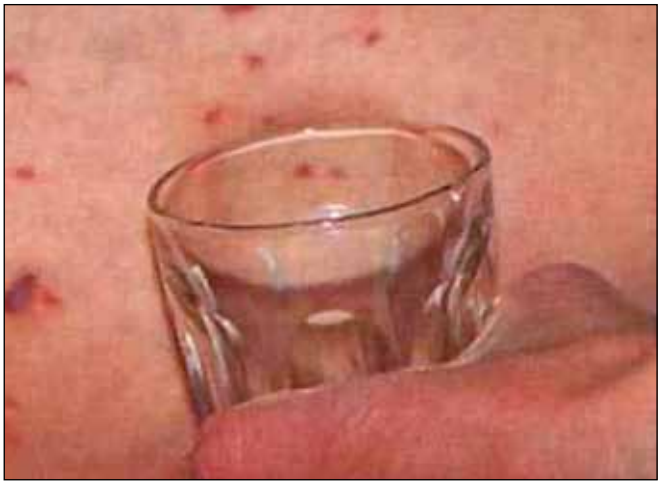
We have chosen four key themes for our work:

- Give every child and young person the best start in life: Investment in early years brings significant benefits later in life across areas such as health and wellbeing, education, employment, reduced violence and crime. We are committed to pursuing strongly evidenced programmes to build resilience and promote health and wellbeing.
- Ensure a decent standard of living for all: Lower socioeconomic groups have a greater risk of poor health and life expectancy. We will focus efforts in a number of areas where, working with partners, we can impact on achieving a decent standard of living for all.
- Build sustainable communities: The views, strengths, relationships and energies of local communities are essential in building effective approaches to improving health and wellbeing. We are committed to community development, engaging people in decision making and in shaping their lives and social networks.
- Make healthy choices easier: Creating an environment that encourages and supports health is critical. We are committed to working across a range of settings to ensure that healthier choices are made easier for individuals.

Specific areas that we have focused on during the year include:

Meningitis awareness

During the winter months we sought to raise awareness in the community and across all age ranges of the signs and symptoms of the potentially life-threatening disease meningitis.



Meningitis is a serious disease, so it is vital everyone becomes more vigilant of the signs and symptoms to be able to detect the disease earlier. It is critical that the symptoms are noticed at the earliest opportunity, to allow early invention with antibiotics.

Parents were encouraged to take up the meningitis C childhood vaccine when offered and also to remain vigilant to the symptoms of the disease.

Bowel cancer screening

The Northern Ireland bowel cancer screening programme was launched in April 2010. Bowel cancer is a significant cause of ill-health and premature death. Symptoms often develop late in the disease, leaving limited scope for treatment and potential cure.

The bowel cancer screening programme allows early detection and treatment, significantly improving outcomes for those with the disease.

After only six months we began to see the benefits. To mid-October 2010, 8584 individuals had completed a bowel cancer screening test kit, 237 had received a positive screening result, and 14 had been diagnosed with screen-detected cancer, some of which were identified at a very early stage of the disease. Another 30 people, considered to be at high or moderate risk of cancer, had been entered into a surveillance programme for follow-up colonoscopy.

Provisional data over the initial few months suggest that approximately 45–49% of people invited for screening subsequently complete a test kit. This is encouraging for such a new programme and is a similar level to that seen elsewhere in the UK.

Improving outcomes for children is a key PHA priority. This year we set up Child Health Development Board to do this.

An important strand of this work is the development and implementation of the Roots of Empathy programme.

Roots of Empathy

The programme focuses on improving social and emotional understanding in children and has been shown to lead to a reduction in aggression and bullying.

Roots of Empathy
Racines de l'empathie

Roots of Empathy involves a baby and parent visiting school classrooms every three weeks over the school year. An instructor coaches the pupils to observe the baby's development and identify the baby's feelings.

This experiential learning model is used to help children identify and understand not only their own feelings and emotions but also how their actions affect the feelings of others.

Ultimately the goal is to help children develop their own "emotional literacy" and lifelong capacity to have empathy for others as well as realising their contribution to the emotional health and wellbeing of others.

The launch of the Roots of Empathy programme in Belfast City Hall.

Live kidney donor programme

Over 800 patients in Northern Ireland are receiving regular dialysis for loss of kidney function.

For most people, kidney transplantation provides better long-term survival than staying on dialysis, and the PHA is committed to increasing donation rates. To this end the chief executive of the PHA chairs the Northern Ireland organ donation taskforce, which coordinates action to increase donation rates.

In Northern Ireland, 262 people are on the transplant waiting list – an increase from 100 in 1997. Until recently, the majority of transplants used kidneys from deceased donors.

On average, a kidney from a live donor will last twice as long as one from a deceased donor. Patients who receive live donor kidneys also live longer. In 2010 for the first time the number of live donor transplants has exceeded the deceased donor cases.

This trend has significant positive implications for patients' survival and quality of life. During 2010/11, more than 50 people from Northern Ireland received a live donor kidney.

However the expansion of the live donor programme does not remove the need to continue to receive as many deceased donor kidneys as possible. All HSCTs now have local clinical lead consultants and donor committees. Relatives will be asked if they would be willing to donate in cardiac death cases as well as in the more usual brain death donations.

Tobacco campaign

Adult smokers aged between 20–49 were the primary focus of a major new public health information campaign launched by the PHA in January 2011. The new campaign was developed because smoking is the largest preventable cause of ill-health and premature death in Northern Ireland, contributing not only to lung cancer, heart disease, bronchitis and asthma, but also to many other diseases. It claims between 2,700 and 3,000 deaths per year.

Although we have seen a reduction in smoking rates, there is still some way to go. For example, we know that 34% of semi-skilled and 36% of unskilled manual workers currently smoke. This new campaign aims to raise awareness of the health effects of smoking and the range of smoking cessation support that is available. What we want to see is an increase in the numbers of adult smokers making a quit attempt.

Conclusion

The areas outlined above are only examples of PHA activity in the last year; further information can be found in the *Director of Public Health Annual Report 2010*, available on the PHA website.

Finally, I would like to sincerely thank all those involved in supporting our public health work during the last year.

The PHA organ donation stand at the Balmoral Show, Belfast.

Directors' report: Nursing and Allied Health Professionals

Mary Hinds

The PHA Nursing and Allied Health Professionals directorate is responsible for:

- professional, service and public health issues relating to nursing , midwifery, health visiting and the allied health professionals (AHPs);
- the Health and Social Care Safety Forum;
- the European Centre for Connected Health.

The directorate also provides:

- Regional leadership for Personal and Public Involvement;
- Regional leadership for issues related quality, safety and patient/client experience.

Nursing incorporates midwifery, health visiting, health care assistants and other support staff, while allied health professionals represent dietetics, occupational therapy, orthoptics, physiotherapy, podiatry, radiography and speech and language therapy.

Commissioning – regional and local arrangements

This year nurse and allied health professional consultants were appointed to all of the five local commissioning groups. These post holders represent their respective professions in the commissioning structures including eleven service groups, service reviews and specific service framework groups.

Team members at a local level work closely with their colleagues in the Local Commissioning Groups, focusing not only on commissioning but on responding to service pressures and concerns, supporting HSCT colleagues in service development and innovation and responding to serious adverse incidents (SAIs), local reviews and emerging crises and issues which effect the community they serve.

Mental health, learning disability and prison health care

We provide leadership on the Bamford specialist high support services steering group and associated workstreams, which includes forensic services, personality disorder services, low secure services and prison mental health. The work of these groups has resulted in:

- the design and development of a draft forensic care pathway due to be implemented later in the year;
- development of a therapeutic care model for low secure inpatient provision;
- identification of capital funding for low secure inpatient beds;
- approval by commissioning team of investment proposal templates for the development of personality disorder services;
- provision of research funding to enable a rapid review to be undertaken in the field of personality disorders.

We are also leading the implementation of a range of focused groups:

- The implementation of the regional strategy for perinatal mental health, including developing a regional integrated care pathway, service developments and improvements, and developing, planning and delivering training and awareness.
- A review of addiction services in the Belfast and South Eastern Trust areas. This work has been used to take forward a regional review of inpatient addiction beds across Northern Ireland.
- The development of the DHSSPS strategic framework *Delivering excellence support recovery: a professional framework for mental health nurses in Northern Ireland (2011–2016)*
- The regional review of use of special observation across adult psychiatric inpatient beds.
- The implementation of the directly enhanced service for people with learning disabilities across Northern Ireland.

We continue to provide nurse advice and support in the management of potential suicide clusters and suicide prevention and represent the PHA on the Criminal Justice Project Board, taking forward the implementation of the criminal justice inspection report *Not a marginal issue: mental health and the criminal justice system in Northern Ireland*.

FNP nurse with participating mum and baby.

Child health

The PHA is leading the implementation of a range of initiatives including:

- The first Family Nurse Partnership (FNP) with the Western Health and Social Care Trust (HSCT). The FNP is a licensed programme with structured inputs and well-tested approaches. It is a nurse-led preventive programme offered to young mothers having their first baby with an intensive home visiting programme beginning in early pregnancy through to the baby's second birthday. The programme taps into every parent's instinctive desire to protect and do the best for their child, which is particularly strong in pregnancy and around the birth of their baby. This programme has been developed over thirty years and is a thoroughly evaluated parenting programme achieving remarkable outcomes for both parents and the children involved.
- The review of health visiting and school nursing. We continue to work with our colleagues in general practice, integrated care and HSCTs to ensure childhood immunisations are maintained as a key public health priority.
- Pre-school speech, language and vision guidance for all health care professionals.
- Review of the levels of AHP input into special schools across Northern Ireland. The aim of this work is to enhance the partnership approach between health, education and parents to develop a model of care to best meet the health and development needs of children with special needs, whether in a special school or in a mainstream school.
- Supporting children with communication needs as early as possible through the review of Sure Start programmes.

We are also completing a scoping exercise on the delivery of childhood vaccinations in primary and community care and led the development and implementation of World Health Organization growth charts, the continuing implementation of the electronic family health assessment and the development and implementation of the revised child health promotion programme, *Healthy Child, Healthy Futures*.

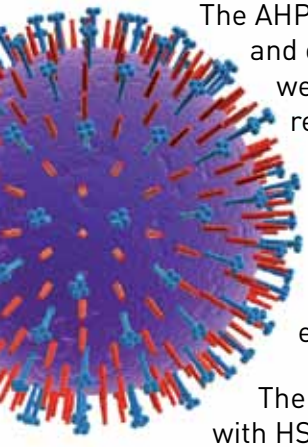
Primary care nursing

This year we have undertaken a number of initiatives focusing on developing and strengthening support to nurses working in general practice. Examples of the work include:

- Facilitation of a workshop to agree the annual work plan for the primary care nurse advisors and completed a training needs analysis of GP-employed nurses in the Western HSCT;
- Development of standardised clinical and operational protocols and procedures for implementation within primary care nursing, including GP-employed nurses;

- Review of the management of swine flu (H1N1) by GP-employed nurses, focusing on the administration of immunisations.

Health protection

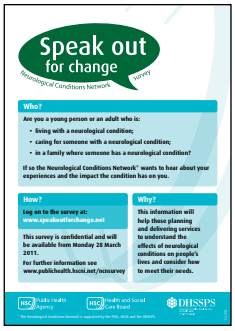


The AHPs have a key role in health protection and one of the important pieces of work we have completed is a review of regional AHP swine flu (H1N1) plan, the first of its type in the UK. All AHP patients were categorised on basis of clinical risk to support regional consistency when stepping down services. This approach is in place to ensure patient quality and safety.

The nursing team have worked closely with HSCT colleagues to ensure nursing staff have access to approximate training and support during periods of peak activity.

Neurological Conditions Network

Through the Assistant Director Allied Health Professionals, we chair the Neurological Conditions Network and have just begun an exciting new exercise to give people living with neurological conditions and their carers a say in what would make their lives better.



In particular, this process aims to take a holistic approach to finding out the challenges faced by people with neurological conditions in their day-to-day lives.

Lymphoedema Network Northern Ireland

The Lymphoedema Network Northern Ireland (LNNI) coordinates and supports the development of lymphoedema services across the five HSCTs in the form of a managed clinical network.

Throughout the first six months of the third year LNNI have achieved much, including:

- updated education and communication strategies;
- continued development of the website www.lnni.org, a resource for patients, the public and health care professionals;
- raised the profile of lymphoedema via various regional, national and international conference presentations, including master's level teaching;
- the award of a commendation by the British Medical Association for the new non-cancer awareness booklet.

Health and Social Care Safety Forum

The Health and Social Care Safety Forum supports HSC organisations to implement evidence-based interventions known to save lives and reduce harm, and to work with individuals and organisations who continuously strive to make a difference for patients and clients.

The HSC Safety Forum has played a role in:

- implementation of the WHO Surgical Site Checklist by all HSCTs;
- reductions across the region in rates of ventilator-associated pneumonia (VAP), central line infections and crash calls for cardio-respiratory arrest;
- satisfactory progress on mental health measures.

The HSC Safety Forum also organised 'Involving patients in improving patient safety', a regional conference on 10 May 2010 that was attended by over 100 HSC staff.

The team, now lead by Dr Gavin Lavery, is currently exploring patient safety ideas and themes with HSCT colleagues and patient/client representatives to ensure our priorities for 2011/12 focus on what is important to our patients, clients and the staff who care for them.

This work not only supports HSCT colleagues to provide safer more effective care but saves distress and injury to patients and their families and saves scare resources. In the case of central line infections in one Hospital in one year the costs avoided were approximately £919,999.

European Centre for Connected Health

The European Centre for Connected Health (ECCH) has led the regional work on developing a remote telemonitoring service for Northern Ireland. (RTNI)

The core objective of RTNI is to establish a mechanism through which professionals are provided with the information they need to provide targeted interventions to people suffering from chronic disease at the appropriate time. Achievement of this objective, matched with the delivery of effective local services, will lead to a number of benefits for patients and for the HSC as a whole. Patients will:

- experience improvements in the quality of care they receive and in the quality of their life, including more timely access to specialist clinical opinion when this is required;
- experience fewer exacerbations of their condition worsening to the extent that they require medical attention and referral to hospital;
- receive more care at home rather than in a hospital or residential care home, optimising the potential for independent living;
- receive more and better targeted proactive support, enabling them to take greater control in the management of their own disease;
- develop a greater understanding of how their behaviour, diet and medication can impact on the development of their chronic disease and on their general health and wellbeing.

In 2010/11 the team, led by Eddie Ritson, have successfully completed a complex procurement process and awarded the first regional contract for remote telemonitoring in Northern Ireland.

Implementation of regional strategy and development of regional policy

The PHA has the lead in the implementation of a range of strategic plans and regional guidance developed by the DHSSPS, including:

- *Living Matters, Dying Matters*, a review of palliative and end of life care;
- *Healthy Child, Healthy Future*, a review of health visiting and school nursing;
- NICE guidance for perinatal mental health.

This work involved leading multidisciplinary and multiagency teams to improve services to key groups in Northern Ireland.

Nursing and midwifery

The PHA nursing and midwifery team are regulated by the Nursing and Midwifery Council (NMC). The nursing team have developed a professional nursing and midwifery forum for all nurses and midwives working in the phase two organisations. This group is chaired by the Director of Nursing and Allied Health Professionals and works to help nurses and midwives in these organisations keep up to date with regulatory and other professional issues, share good practice, share learning from incidents and events and enable the escalation of professional concerns.

Midwifery supervision

The Maternity Hand Held Record is now in use in all HSCTs in Northern Ireland. This award-winning joint work between the PHA and the DHSSPS shows midwifery supervision's involvement in multidisciplinary clinical governance and the enhancement of communication and evidence-based care in maternity services.

The LSA website, the use of lay representatives in the local supervising authority (LSA) audits and interview panels for trainee supervisors of midwives, plus the development and implementation of a regional annual review toolkit for midwives with web-based guidance and documentation are identified as good practice in Supervision, support and safety, the NMC's most recent analysis of supervision of midwives in the UK.

This year, the LSA worked with supervisors of midwives and the Northern Ireland Practice and Education Council to initiate the production of information and a webpage for midwives to clarify medicines management following the update of the midwives exemptions and the awaited, new UK-wide midwife supply order.

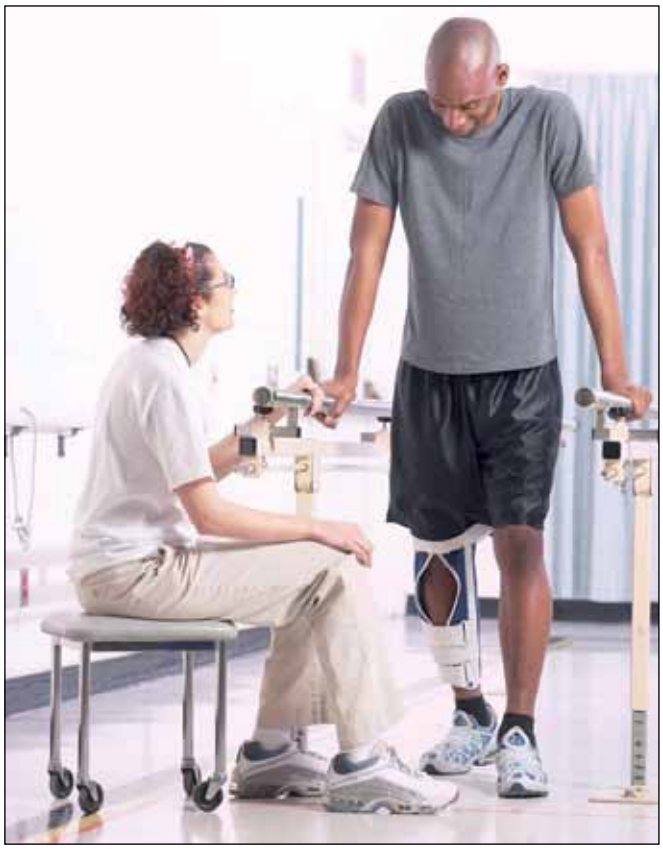
The new PHA/LSA supervision stakeholder group includes the NMC and acts as a forum for sharing information and networking between the PHA, supervisors of midwives and the NMC.

The LSA has been involved in the maternity specification for the new stand-alone midwifery-led unit at Lagan Valley Hospital which opened in February 2011. In addition, a joint PHA, DHSSPS, Royal College of Midwives and Royal College of Obstetricians and Gynaecologists conference on 'Normalising Birth' took place at the end of March and will feed into the anticipated maternity service review consultation.

Allied Health Professionals

AHPs are regulated by the Health Professions Council (HPC). The HPC is in place to protect the public by maintaining a register of health professionals to meet their standards for training, professional skill, behaviour and health.

We have established an AHP forum to provide professional leadership to AHPs working in the PHA, Health and Social Care Board (HSCB) and Business Services Organisation (BSO). This forum will assist AHPs to fulfil their statutory requirements with the HPC.



Partnership

The PHA works with a wide range of organisations, patients, clients, service users and carers. These partners are key to our success and are considered valued colleagues. We are grateful for their support and guidance and hope these partnerships will become even stronger for the future.

Conclusion

The areas outlined above are only examples of Nursing and Allied Health Professionals Directorate activity in the last year; further information is available on the PHA website.

I would like to sincerely thank all the team who have worked tirelessly throughout the year and who have faced every challenge with professionalism and compassion.

My thanks to those involved in supporting our work during the last year, the staff of the health and social care service whether at the bedside or the board room, the staff of the voluntary and community sector and the patients and clients who guide our work.

The aim of the directorate is to promote a service centred on the person, the patient and the community and a service which is high quality delivered with care, compassion and respect for each individual.

Directors' report: Operations

Edmond McClean

The Operations Directorate of the PHA concerns processes, people and resources – all essential elements in developing a fit-for-purpose organisation that applies our skills and capabilities successfully, in partnership with others, to play a leading role in the health structures.

Performance management systems

During 2010/11 the PHA has continued to develop performance management systems to enable the organisation to effectively monitor progress in meeting ministerial and corporate targets and objectives.

During the year, particular emphasis was placed on the development of a corporate planning spreadsheet that has allowed the PHA to assess, in detail, how expenditure was allocated across localities, priority areas, key target groups and sectors.

It is intended to further develop these systems in 2011/12.

Training

The PHA has a statutory and mandatory responsibility to provide training and awareness for all staff in operational protocols and governance arrangements.

Training provided to staff this year included:

- governance, including incident reporting and risk management;
- corporate business (Standing Financial Instructions (SFIs) and Standing Orders);
- health and safety (including fire safety);
- Freedom of Information and records management;
- data protection and IT security;
- complaints and Person and Public Involvement (PPI);
- Equality.

Additionally, an IT training needs analysis was undertaken in 2010/11 to identify what support could be provided to staff to improve their IT skills. Based on the results of the needs analysis, the Beeches Management Centre was commissioned to provide bespoke training for staff in Microsoft Excel, Powerpoint and Access.

Working practices

As the new staffing structures are implemented, we are making every effort to ensure that efficient and effective working practices are introduced to maximise performance and reduce costs. The first steps in expanding the current video conferencing capacity are being implemented. Increased use of both video and teleconferencing equipment will enhance communication between staff in the various offices, reducing the need to travel and the associated loss of staff time and cost.

Staff who have regional posts or a role that involves considerable work outside of the office have been provided with the appropriate technical support to ensure that they can maximise their ability to communicate and work remotely from the office environment. In addition, desks have been provided in some locations that can be used by staff travelling between locations.

Joint working with local government

During 2010/11 we have been working to strengthen relationships with local government. We have developed joint working teams in seven cluster areas to test and refine the way in which we can work collaboratively to improve health and wellbeing and reduce health inequalities. This has included the establishment of the Belfast Health Development Unit, bringing together staff from the PHA, Belfast City Council and Belfast HSCT.

A Project Steering Group has been meeting since May 2009 to provide the strategic direction for the work. The group is chaired by the Director of Operations Edmond McClean and has the following membership:

- six local government Chief Executives representing the clusters outside of Belfast;
- Director of Health and Environmental Services, Belfast City Council;
- Director of Public Health, PHA;
- Assistant Director of Public Health, Health and Social Wellbeing Improvement, PHA;
- Director of Social Services, HSCB;
- two Local Commissioning Group Chairs;
- Director of NICVA;
- Chief Executive, Patient and Client Council;
- Chair, CDHN;
- Chief Environmental Health Officer, DHSSPS.

Joint actions have been delivered across Northern Ireland during 2010/11 and Action Plans for 2011/12 are in the process of being finalised.

The joint working teams are the foundation to effectively tackling health inequalities in our communities through shared priorities, plans, mindsets, community health profiles, evidence bases, governance/performance measurement arrangements and evaluation methods.

Regional funding authorisation processes

We have now established regional processes for ensuring funding provided to HSCTs and external organisations such as the community and voluntary sector is awarded on a consistent basis, based on standards of best practice.

These processes also ensure that robust monitoring and audit arrangements are now established to ensure funding is allocated appropriately and the expected health and wellbeing outcomes are delivered.

Accommodation

In an attempt to maximise efficiency, reduce costs and enhance operational capability, the Public Health Agency has continued to review accommodation arrangements inherited at the formation of the organisation. Staff from McBrien House and the Kelvin Building have been relocated to Linenhall Street and the management team are exploring options to identify the best accommodation solutions for the PHA in Belfast.

In Ballymena, Londonderry and Armagh, staff have implemented the recommendations from local reviews of office accommodation.

Staff workshop

In November 2010 a workshop was held for all staff working in the Public Health Agency. It provided an opportunity for staff to:

- reflect as an organisation on some of the achievements, learning and progress to date;
- find out more about areas of work which they may not necessarily have much contact with in their day-to-day work;
- discuss priorities for the next four years.

Ten 'explorer zones' were set up and staff were given the opportunity to attend a number of them to learn more about what happens in those areas of work.

The explorer zones included quality and safety; research and development; health protection, the European Centre for Connected Health (ECCH); health intelligence; and health protection.

The event also gave staff the opportunity to identify priorities, as they saw them, for the PHA over the next few years. This allowed staff to provide some first thoughts on issues which could be used to shape the organisation's four year corporate strategy.

Governance

During 2010/11, we appointed a number of key staff who will be instrumental in taking forward governance issues, including a Senior Operations Manager, a chief executive office and committee manager; and a Governance Manager.

A new risk management process and risk register was put in place, ensuring the management and

reporting of risk at both directorate and corporate level. The corporate risk register was brought on a regular basis to the AMT and the Governance and Audit Committee.

A suite of IT security policies were developed and implemented, building on the information governance policies already in place.

The initial Standing Orders were reviewed during the year and a revised set of Standing Orders meeting was approved by the Governance and Audit Committee and the PHA board in January 2011.

Controls Assurance Standards

During 2010/11 we systematically self-assessed our level of compliance with the applicable Controls Assurance Standards.

The levels of compliance achieved are outlined in the table below.

Standard	DHSSPS expected level of compliance	Level of compliance 2010–11	Audited by internal audit
Buildings, land, plant and non-medical equipment	70% - 99% (Substantive)	77% (Substantive)	–
Decontamination of medical devices	70% - 99% (Substantive)	N/A	–
Emergency planning	70% - 99% (Substantive)	77% (Substantive)	BSO IA
Environmental cleanliness	70% - 99% (Substantive)	N/A	–
Environment management	70% - 99% (Substantive)	73% (Substantive)	–
Financial management (Core Standard)	70% - 99% (Substantive)	83% (Substantive)	BSO IA
Fire safety	70% - 99% (Substantive)	83% (Substantive)	–
Fleet and transport management	70% - 99% (Substantive)	N/A	–
Food hygiene	70% - 99% (Substantive)	N/A	–
Governance (Core Standard)	70% - 99% (Substantive)	78% (Substantive)	BSO IA
Health and safety	70% - 99% (Substantive)	76% (Substantive)	–
Human resources	70% - 99% (Substantive)	81% (Substantive)	–

Infection control	70% - 99% (Substantive)	N/A	–
Information communication	70% - 99% (Substantive)	73% (Substantive)	–
Management of purchasing and supply	70% - 99% (Substantive)	77% (Substantive)	–
Medical devices and equipment management	70% - 99% (Substantive)	N/A	–
Medicines management	70% - 99% (Substantive)	N/A	–
Records management	70% - 99% (Substantive)	67% (Moderate)	
Research governance	70% - 99% (Substantive)	78% (Substantive)	–
Risk management (Core Standard) (Core Standard)	70% - 99% (Substantive)	73% (Substantive)	BSO IA
Security management	70% - 99% (Substantive)	80% (Substantive)	–
Waste management	70% - 99% (Substantive)	77% (Substantive)	–

Health intelligence

Responsibility for health intelligence also lies within the Operations Directorate. Health intelligence informs all our work.

The Health intelligence unit is staffed by people skilled in the analysis and interpretation of information; survey design and analysis; critical appraisal; evaluation techniques; and research.

The unit supports the PHA by:

- Identifying and disseminating what works in public health through evidence reviews and evaluations. Recent examples include evidence reviews of smoking interventions and teenage pregnancy, evaluations of suicide training programmes and the Lifeline helpline, and a project to maximise access to benefits for people.
- Identifying issues and getting the message across through supporting public information campaigns and evaluating their impact. Health intelligence has provided briefings on a range of topics including Traveller health, life expectancy and road traffic accidents, and provided the core tables for the *Director of Public Health Annual Report*.
- Working with partners inside and outside the PHA to develop and make available knowledge or information about public health issues.

Communications

The Operations Directorate is responsible for the PHA's external and internal communications. Accurate, relevant and accessible information is essential for both health improvement and health protection. We are committed to high standards in our communications practice.

A multidisciplinary team works to meet the communications requirements of the PHA. The team includes specialists in publications development, design, electronic communications, marketing, public relations, event management and corporate communications.

Publications development

The PHA develops and produces a wide range of publications, both electronic and print, to support and inform our work areas. This year we produced almost 200 titles, including resources to encourage childhood immunisation and information on hepatitis C for patients and clinicians. We also reprinted 40 core leaflets and 52 posters.

We developed and produced public information to support the change to the cervical cancer screening programme introduced this year. We also developed information for health professionals.

In response to seasonal flu, we developed a range of materials for pregnant women.

The first of a series of resources in support of the Healthy child, healthy future programme has been published and future resources are planned for both the public and professionals.

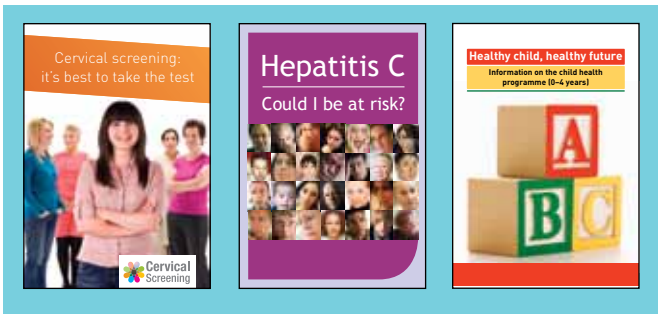
Healthcare associated infections (HCAI) materials were produced and supplied to nursing and residential homes, independent clinics, GP practices and dental surgeries.

We also produced a number of regular publications, including Transmit, produced monthly for the health protection team, and R&D Today, the journal of HSC R&D.

Design

Good design must be defined by appropriateness to audience and goals, and by its effectiveness. The PHA design team have continued to support the goals of the organisation by providing timely, well executed work over an expansive range of projects.

In the past 12 months we have been involved in moving forward the visual brand of the PHA across a body of corporate publications, including the Director of Public Health Annual Report 2010, alongside developing new work on themes such as



cervical and bowel cancer screening, and providing alternatives for focus group testing of public facing literature.

The most important thing about design is how it relates to people, and we look to carry the PHA message with clarity and originality.

We continue to be engaged in print specification and management, as well as working on annually updating and reprinting the PHA's catalogue of publications.

Electronic communications

We continue to prioritise electronic communications in all of our work. This year we maintained a variety of websites to support our public health work. These include Fluawareni.info, a new website developed to highlight important information during the flu season, want2stop.info, an existing website we updated substantially to support our latest smoking cessation campaign and enjoyhealthyeating.info, which was updated and improved in the light of user feedback.

We also developed and launched connect.publichealthagency.org, the new PHA staff intranet, and have been continually working to improve and redevelop the PHA corporate website.

Marketing

Adult smokers aged between 20–49 were the primary focus of the 'Things to do before you die'

public health information campaign.

The campaign was developed to motivate and encourage smokers to make a quit attempt by firstly focusing on why smokers should quit and secondly offering a range of options on how to quit.

The campaign ran from 6 January until 31 March 2011. It included television, radio, outdoor, washroom and online advertising.

The campaign was composed of two strands. One focused on why smokers should quit and reinforced the health risks and the consequences of smoking. This described how it feels to experience a smoking-related illness, not just for the smoker, but also the impact on their family.

For those who prefer help and support, the second strand of the campaign focused on how to quit. This part of the campaign highlighted the range of help available and reinforced the message that quitting is achievable with the right support and motivation.

Support highlighted in this part of the campaign included the smoking cessation services, GP/pharmacy support, helpline, the website want2stop.info and the Quit Kit.

The Quit Kit has been developed for smokers who want to quit on their own and opt to use 'cold turkey' as a quitting method. Uptake of the kit in England has been very good and the evaluation findings are very positive.

Other campaigns undertaken during the year focused on mental health and protecting yourself from the harmful effects of sunbeds.

Public relations

The public relations (PR) team was strengthened in 2010/11, and as a result the profile of the Public Health Agency was raised.

Colleagues from across the various directorates provided numerous opportunities to showcase our work in the media, and successful planned public relations activity increasingly communicated policy direction and health messages throughout the second part of 2010/2011.

Media coverage generated around 150 mentions in print and broadcast media throughout the winter months to December. This was enhanced with features on subjects such as bowel screening, smoking and organ donation.

Not all publicity is good, however, and the months from November to January provided challenges in managing the reputation of the Public Health Agency in the face of investigative reporting on issues such as overseas trips and challenges to the handling of seasonal flu – with swine flu hitting the headlines once again. The month of January saw the PR department handle over 120 media enquiries on flu over a three day period before moving to a series of weekly press briefings. The PHA featured in the media over 300 times in January with numerous articles and interviews provided on water shortage, suicide and seasonal flu.

To build capacity to respond to media requests a series of media training sessions were provided for key PHA subject spokespersons. This involved putting the subject experts through their paces in front of the cameras and microphones to ensure that clear messages were being delivered in a way that was appropriate for the intended audiences. A one day communications planning workshop was also held to enable key business areas to plan and prioritise the nature and timing of their communications.

A particularly challenging area of work is that of presenting the issue of suicide in the media. It is well recognised that inappropriate media reporting of suicide can have the effect of influencing the potential for 'clustering' or 'contagion'. A specific action under the DHSSPS Protect Life is to provide a facility for monitoring and reporting on inappropriate reporting of suicide and create awareness of good practice and the Samaritans/IAS Media Guidelines.

In November the contract with the Samaritans for a programme of work on media monitoring was agreed with the PHA. This has proved to be an invaluable resource in the PHA's work in supporting local communities where suicides are

causing concern. To complement this, members of the PR team have also worked directly on behalf of communities and bereaved families, often at short notice, to influence media reporting of these tragic circumstances.

2011 sees the Transplant Sport UK Transplant Games coming to Belfast. This brings with it a unique opportunity to promote the organ donor register and showcase transplant successes in the media. Coordination of this activity with the NHSBT, HSC Trusts and many voluntary organisations involved in organ donation and transplant is now underway with many testimonials taken forward by our media partners.

The PR function in the PHA is a dynamic and challenging one with planned activity only part of the daily challenge. The need for clear messaging on the PHA's preventative work will continue to be a priority.

Event management

We organised a number of conferences, seminars and training courses throughout the year. Most notable was the 'Focus on health inequalities', a month-long programme of events on the factors that influence individual and community health.

The programme included opportunities to consider work with young mothers; school children; on fuel poverty; sexual health; reducing the impact of poverty; suicide prevention; cross border road safety and health economics.

'Focus on health inequalities' not only highlighted the good work already underway with a range of partners from across health and social care, it also facilitated the sharing of best practice in tackling health inequalities.

Corporate communications

The responsibility for ensuring the flow of good internal communication throughout the organisation and the development of accessible and effective external communication channels, while aiming for the highest quality standards in communications practice, also lies within the Operations Directorate.


PHA
e-Bulletin
Public Health Agency
Physical activity: *It all adds up!*
Your activity record book

To assist the internal flow of information the communications team is responsible for the production and dissemination of a regular internal staff e-Bulletin that provides updates on key organisational issues and developments.

The launch of the first phase of the PHA's new staff intranet, Connect, took place during the year and is being built upon to ensure staff are kept up to date regarding organisational developments, important news and can access important staff and individual directorate and unit information.

To assist good communication between staff in each PHA area across Northern Ireland we have put in place a bi-monthly teleconference to exchange information on key work, support arrangements and health and safety issues.

The PHA has a key role in communicating important public health messages to a range of audiences. One of the main channels employed to ensure communication with these key external stakeholders and the public is the PHA's website, which has seen substantial work being undertaken towards the launch of the next phase of development.

The PHA is required to provide the DHSSPS with information on a regular basis that has been requested through official written and oral Assembly questions from Members. The PHA's corporate communications function has coordinated this important service with input from staff throughout the organisation.

Statement on Internal Control

The PHA Statement on Internal Control is available on request.

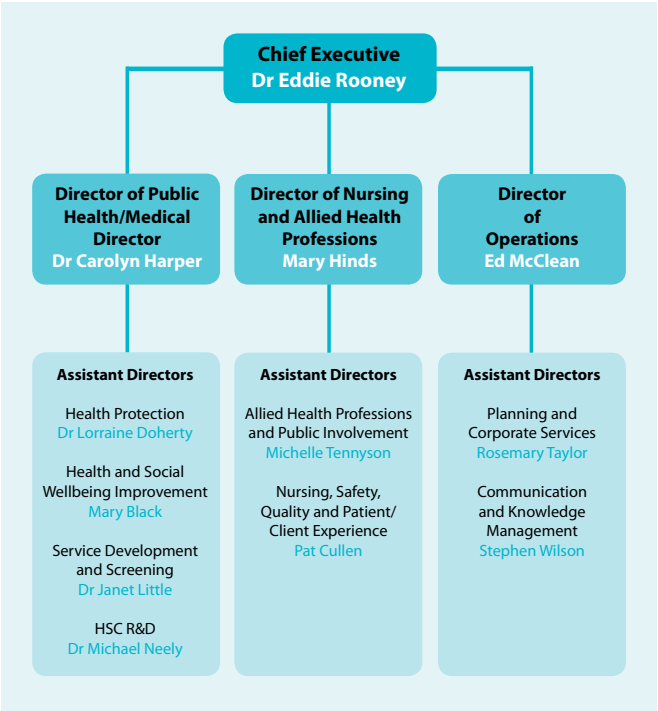
Management commentary

The PHA is an integral part of the HSC system, working with the HSCB, BSO and Patient and Client Council. It drives the public health and social wellbeing agenda, bringing together a wide range of functions to give a renewed, enhanced and sustained focus on health protection and improving health and wellbeing outcomes.

The PHA is a multidisciplinary, multi-professional body with a strong regional and local presence. It has four key functions:

- improvement of health and social wellbeing, including health inequalities;
- health protection;
- public health support to commissioning and policy development;
- HSC research and development.

The following diagram highlights the organisational structure down to tier three and details the main areas of activity with those.



Staffing structures

Over the year we have all but finalised the PHA staffing structures. Many staff have been slotted in to their positions in the new structure while

other positions have been advertised and recruited.

The completion of our final staffing structures is a pivotal aspect of our organisational development

Supporting and developing staff

We are committed to the continued professional development of our staff, and to maintaining a supportive and secure workplace.

In pursuit of this goal this year we have with our colleagues in BSO human resources and in consultation with staff and trade unions introduced a number of working policies and guides.

ICT polices we introduced include *Security, Equipment, Internet, Email and Use of Encrypted USB Devices.*

Other areas covered by new policies include a suite of *HR policies*; *Equality of Opportunity*; Health and Safety and *Fire Safety.*

Research and Health Intelligence Committee

We have prioritised the strengthening and refocusing of our research and health intelligence assets in order to:

- effectively harness health intelligence and research resources towards evidence based practice;
- create a deeper knowledge of the impacts of public health interventions;
- improve collaboration between stakeholders;
- enable the development of a learning organisation;
- ensure the transfer of knowledge into effective interventions with measurable outcomes at the population level.

During the year we established a Research and Health Intelligence Committee to oversee the development of high quality, applied public health research and intelligence and ensure that it underpins the breadth of our programmes of work.

The main functions of the Committee are:

- overseeing the performance of HSC R&D Division in relation to its agreed annual business plan and management of the HSC R&D Fund;
- identifying and agreeing a forward programme of research for the PHA, informed by the *PHA Corporate Plan*, business plans and priority areas;
- enhancing the information base of the PHA and wider HSC through the development of an appropriate knowledge management system;
- ensuring that the PHA incorporates robust policy/service evaluation across its various areas of operation;
- providing a leadership role for the emerging Northern Ireland Public Health Research Network (NIPHRN) embracing the wider public health community, nationally and on the island.

Personal and Public Involvement

The PHA is responsible for the HSC Personal and Public Involvement (PPI) agenda and ensuring that it is fully integrated into our way of working.

PPI is about people and communities influencing the planning, commissioning and delivery of health and social care services.

It means actively engaging with those who use our services and with the public. PPI is now a legislative requirement and has a number of Priorities for Action (PfA) targets associated with it.

In partnership with the HSCB, we have developed a draft PPI strategy. The strategy will guide each organisation in implementing PPI.

We have also established a regional PPI forum. This forum has membership from all HSC organisations, service users, carers and the community and voluntary sector.

PPI terms of reference have been developed and the group have met three times and established a number of sub-groups.

Training aimed at promoting and equipping staff with the knowledge and skills to facilitate and support meaningful and effective participation of children and young people has been piloted by the PHA.

The PHA has secured resources from the DHSSPS to promote and advance PPI across the HSC. Evaluations of these initiatives will be carried out in early 2011/12.

Finally, we have organised for staff across the PHA, HSCB and BSO to have deaf awareness training and plan to extend this in the near future to sight awareness training. We hope that this will enhance our relationships with the public.

Safety and quality

The PHA has the regional lead for safety and quality, crucial issues for patients, clients and their families.

In partnership with the HSCB, we developed and helped implement the policy and procedure for the reporting, management and review of serious adverse incidents (SAIs).

In partnership with HSCTs we are currently developing key performance indicators across a range of areas. It is hoped this will improve the quality of care provided to patients and clients within the health and social care system.

The PHA is working to explore and better illustrate the vital contribution of specialist nurses within Northern Ireland and are working with colleagues and HSCTs to develop a series of benchmarks for staffing levels within HSCTs.

Allied health professionals (AHPs) in Northern Ireland are required to assess and to begin to treat people within nine weeks. In order to do this we have had to pay particular attention to the reform and modernisation of the AHP services.

This means that we have led a process with the five HSCTs to standardise care pathways, clinical caseloads and to outline what we can expect from our teams in terms of level of care.

To support this work we completed a comparative analysis of AHP workforce levels in Northern Ireland compared with England, Scotland and Wales.

Patient experience

The PHA leads and chairs the regional steering group for implementing the DHSSPS patient experience standards.

We developed arrangements testing methodologies to support the implementation of the patient experience standards, including obtaining user feedback, observations of clinical practice, seeking feedback from staff and the development and implementation of an organisational audit.

We also invested in the use of software to gain real time information from patients on their experience within our services, and agreed the regional workplan for patient experience for 2011/12.

Equality scheme, audit of inequalities and action plan

In line with Equality Commission guidance, the Public Health Agency carried out an audit of inequalities to inform the development of an action plan.

In order to identify inequalities relating to the specific functions of the PHA and discuss what actions could be developed to address these, a total of eight workshops were convened – one with each of the Assistant Directors and their teams. This covered the following divisions:

- Service development and screening
- Health protection
- Health improvement
- Research and development
- Nursing and quality
- Allied health professionals and Personal and Public Involvement
- Communications and knowledge management
- Planning and corporate services.

The workshops were held between September and November 2010.

The PHA consulted on our draft equality scheme and action plan, based on the outcomes of the audit, from December 2010 to March 2011.

Accessible formats

The PHA continued to be actively represented on the regional accessible formats steering group. The overall purpose of the group is to support individuals in making informed choices about their health and social care through the provision of accessible information. This relates to written information in the first instance, provided by health and social care as well as public safety organisations, and different ways of making its content accessible.

During the year, a stakeholder workshop was convened with the aim to begin a dialogue with key people working with voluntary sector groups about accessible formats for information materials provided in health, social care and public safety.

The workshop followed three main purposes:

- to start exploring what issues stakeholders view as key for making information accessible to all;
- to find out how individuals may wish to be involved in work on accessible formats;
- to learn how best to reach out to service users with particular needs.

Discussion focused on four main target groups:

- black and minority ethnic people/those not fluent in English;

- people with a learning disability;
- older people;
- people with a sensory impairment.

Sick absence data

Based on the HSC formula for calculating absence levels the corporate absence level for the PHA for the period from 1 April 2010 – 31 March 2011 is 2.77%, which is 2.43% below the Priorities for Action target for absence, which is 5.2%.

During the above period there were 251 working days available (excluding bank holidays). The total number of working days available in this period was therefore 54,379.15.

There were1500.1 days lost due to sickness absence. This equates to 6.92 days lost per employee. This is 3.68 days less than the national average of 10.6 days per employee for the Health Sector (CIPD Absence Management Survey 2010). It is also 0.98 days less than the average days lost for an organisation of a similar size

Based on the above information, the cost of absence is £1,079 per employee per year. This is £217 more than the national average for public services of £862 per employee.

Information governance

During 2010/11 the PHA continued to fulfil our obligations under legislation such as the Freedom of Information Act, Data Protection Act and the Public Records Act. Changes to improve information security continued with the introduction of encrypted USB memory sticks and strict limitations placed on the use of removable media. Further mandatory training for all staff has been put in place to raise awareness of PHA policies and procedures.

There were no major data related incidents reported during the year.

Assembly questions

In the period 1 April 2010 to 31 March 2011 the PHA received and responded to a number of Assembly questions, correspondence, ministerial and research requests, as below:

Assembly questions	79
Correspondence requests	14
Ministerial requests	10
Research requests	5
Other correspondence from Ministerial offices	3

Complaints

The Public Health Agency received one complaint in 2009–2010. The complaint was resolved.

If you wish to make a formal complaint, please write to:

Mary Hinds
Director of Nursing and Allied Health Professionals
Public Health Agency
12–22 Linenhall Street
Belfast BT2 8BS

Preparation of accounts

The PHA has prepared a set of accounts for the year ended 31 March 2011 in accordance with the relevant legislative requirements.

Summary financial statements are included in the 'Operating and financial review' section of this report.

The continuing work of the Public Health Agency

This Annual Report has so far focused on our work and achievements during the 2010/11 financial year. No less important are the challenges that will face us in 2011/12.

The PHA recognises the difficult financial context within which the Northern Ireland Executive has had to set the budget for the period 2011/12–2014/15, but these financial difficulties do not lessen the need for the PHA's work to protect and improve health. In fact under such circumstances our work is even more crucial.

Northern Ireland experiences some of the greatest levels of health inequality in the UK. The PHA is concerned that the combined effect of the cuts proposed by individual government departments will be on those most likely to experience already poor levels of health and wellbeing.

Any reduction in the level of expenditure being invested by the PHA to help reduce levels of ill-health will only reinforce and increase levels of inequality in our population.

Public health programmes are highly cost-effective. Any reduction or delay in those programmes would therefore cost Northern Ireland more in the short, medium and long term, not just in health and social care, but also and particularly in education, the criminal justice system and the overall economy.

The economic case for increasing the level of investment in tackling health inequalities is well evidenced. If no action is taken, the scale of investment required to meet future needs will be unsustainable and treatment and care services will not be able to cope.In the coming financial year the PHA will seek to protect, as far as it can, the services that are being delivered by partners in the community and voluntary sectors. We will continue to explore more efficient ways of working as an organisation and with partners where appropriate.

If we are to ensure a healthier future for the people of Northern Ireland, it is essential that there is a greater shift to investment in preventive services. This will enable the adoption of models of service that will keep people healthier for longer. It will also require strong political and professional leadership to ensure that the changes required in professional practice and how local services are delivered are not unnecessarily hampered and prevented from being implemented.

Remuneration report for the year ended 31 March 2011

Scope of the report

Article 242B and schedule 7A of the Companies (NI) Order 1986, as interpreted for the public sector, requires HSC bodies to prepare a remuneration report containing information about directors' remuneration. The remuneration report summarises the remuneration policy of the PHA and particularly its application in connection with senior executives. The report also describes how the PHA applies the principles of good corporate governance in relation to senior managers' remuneration in accordance with HSS (SM) 3/2001 issued by the DHSSPS.

Remuneration committee

The board of the PHA, as set out in its standing orders, has delegated certain functions to the remuneration committee. The membership of this committee is as follows:

Members

Mary McMahon (Chair)

Dr Jeremy Harbison

Miriam Karp

Cllr Cathal Mullaghan

During the 2010–2011 year the committee met on one occasion to agree its terms of reference.

Remuneration policy

1. The membership of the remuneration committee for the PHA consists of the Chair and at least two of its non-executives.

2. The policy on remuneration of the PHA senior executives for current and future financial years is the application of terms and conditions of employment as provided and determined by the DHSSPS.

3. Performance of senior executives is assessed using a performance management system that comprises individual appraisal and review. Their performance is then considered by the remuneration committee and judgements are made to their banding in line with the departmental contract against the achievement of regional organisation and personal objectives.

4. The relevant importance of the appropriate proportion of remuneration is set by the DHSSPS under the performance management arrangements for senior executives.

5. In relation to the policy on duration of contracts, all contracts of senior executives in the PHA are permanent and contain a notice period of three months.

Service contracts

Senior executives in the year 2010–2011 were on DHSSPS senior executive contracts, which are detailed and contained within the circular HSS (SM) 2/2001.

Directors

Dr Eddie Rooney	Chief Executive, appointed 01 April 2009.
Dr Carolyn Harper	Director of Public Health/Medical Director, appointed 01 April 2009.
Edmond McClean	Director of Operations, appointed 01 April 2009.
Mary Hinds	Director of Nursing and Allied Health Professionals, appointed 18 May 2009.

Non-executive directors

The Non-executive directors were appointed for a period of four years, with effect from 1 April 2009.

Chair	**Mary McMahon**
Non-executive director	**Julie Erskine**
Non-executive director	**Dr Jeremy Harbison**
Non-executive director	**Miriam Karp**
Non-executive director	**Thomas Mahaffy**
Non-executive director	**Councillor Cathal Mullaghan**
Non-executive director	**Councillor Stephen Nicholl**
Non-executive director	**Ronnie Orr**

No other persons served at board director level during 2010–2011.

A notice period of three months is provided by either party except in the event of dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Retirement age

Throughout 2010/11 employees were required to retire at age 65 although employees could have asked to work beyond this age in accordance with Equality (Age) Regulations (NI). Since 6 April 2011 the default retirement age has been abolished.

Premature retirement costs

Section 16 of the Agenda for Change Terms and Conditions Handbook issued on 14 February 2007 under cover of the Department's Guidance Circular HSS AfC (4) 2007 sets out the arrangements for early retirement on the grounds of redundancy and in the interest of this service. Further circulars have been issued by the Department of Health Social Services AfC (6) 2007 and HSS AfC (5) 2008 set out changes to the timescale of the operation of the transitional protection under these arrangements.

Under the terms of section 16 of the Agenda for Change terms and conditions handbook individuals who were members of HPSS Superannuation Scheme prior to 1 October 2006, are over 50 years of age and have at least five years membership of HPSS superannuation scheme qualify for transitional protection. Staff who qualify for transitional protection are entitled to receive what they would have received by way of pension and redundancy payment had they taken redundancy retirement on 30 September 2006. This includes enhancement of up to 10 years additional service (reduced by the number of years between September 2006 and the actual date of retirement) and a lump sum redundancy payment of up to 30 weeks pay (reduced by 30% for each year of additional service over 6 2/3 years). Alternatively staff made redundant who are members of the HSS Pensions Scheme, have at least two years continuous service and two years qualifying membership and have reached the minimum age currently 50 years can opt to retire early without a reduction in their pension as a alternative to a lump sum redundancy payment of up to 24 months pay. In this case the cost of the early payment of pension is paid from the lump sum redundancy payment, however, if the redundancy payment is not sufficient to meet the early payment of pension cost the employer is required to meet the additional costs.

Salary (Table Audited)

Name	2010-11			2009-10		
	Salary £000s	Bonus / Performance pay £000	Benefits in Kind (Rounded to nearest £100)	Salary £000s	Bonus / Performance pay £000	Benefits in Kind (Rounded to nearest £100)
Non-Executive Members						
M McMahon	30 - 35	0	0	30 - 35	0	0
J Erskine	5 - 10	0	0	5 - 10	0	0
J Harbinson	5 - 10	0	0	5 - 10	0	0
M Karp	5 - 10	0	0	5 - 10	0	0
T Mahaffy	5 - 10	0	0	5 - 10	0	0
C Mullaghan	5 - 10	0	0	5 - 10	0	0
S Nicholl	5 - 10	0	0	5 - 10	0	0
R Orr	5 - 10	0	0	5 - 10	0	0
Executive Members						
E P Rooney	120-125	0	100	115-120	0	100
C Harper	130 -135	0	400	130-135	0	100
E McClean	80 - 85	0	300	75-80	0	0
M Hinds	100-105	0	600	85-90	0	0

Pensions (Table Audited)

Name	2010-11				
	Real increase in pension and related lump sum at age 60 £000s	Total accrued pension at age 60 and related lump sum £000s	CETV at 31/03/10 £000s	CETV at 31/03/11 £000s	Real increase in CETV £000s
E P Rooney	0-2.5 pension	0-5 pension	27	50	23
C Harper	5-7.5 pension 20-22.5 lump sum	25-30 pension 80-85 lump sum	358	427	68
E McClean	2.5-5 pension 7.5 - 10 lump sum	15-20 pension 55-60 lump sum	333	369	36
M Hinds	0-2.5 pension 2.5-5 lump sum	10-15 pension 35-40 lump sum	209	219	10

As Non-Executive members do not receive pension remuneration, there were no entries in respect of pensions for non-executive members. Cash equivalent Transfer Value (CETV) is the actuality assessed capital value of the pension scheme benefits accrued by a member of a particularly point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves the scheme or chooses to transfer their benefits accrued in their former scheme. The Pension figures showing relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSS Pension Scheme. They also include any additional pension benefits accrued to the member as a result of them purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines of framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase of accrued pension due to inflation, contributions paid by the employees (including the value of any benefits transfer from another pension scheme or arrangement) and uses column market valuation factors for the start and end of the period.

Signed

Chair
Date

Signed

Chief Executive
Date

Operating and financial review

Report from the Governance and Audit Committee

The Governance and Audit Committee (GAC) was established to give assurance to the PHA board, based on an independent and objective review, that effective risk management and internal control arrangements are in place for finance, corporate governance and related areas.

The GAC comprises four non-executive directors of the PHA: Mrs J Erskine (Chair); Mr R Orr; Mr T Mahaffy; and Cllr S Nicholl. During 2010/11 the membership was increased to include Mrs M Karp.

The committee is supported by: Mr E McClean, Director of Operations, PHA; Mr P Cummings, Director of Finance, HSCB; and Mrs C McKeown, Head of Internal Audit, BSO; and their respective staff.

Representatives of the Northern Ireland Audit Office and their contracted auditors (PricewaterhouseCoopers) attend as required.

The GAC decided at an early stage (in conjunction with the HSCB GAC) to recruit up to two independent lay advisors with expertise in finance and governance. Unfortunately this has not been successful, and alternative solutions are now being considered.

Meetings

The GAC met on the following dates during 2010/11:

- 1 June 2010
- 12 October 2010
- 10 January 2011
- 13 April 2011

Attendance

Member	Number of Meetings Attended
Mrs J Erskine (Chair)	4
Mr R Orr	3
Mr T Mahaffy	3
Cllr S Nicholl	4
Mrs M Karp (member from January 2011)	1

Activities

During 2010/11 the GAC:

- Considered the PHA final accounts, Statement on Internal Control and draft annual report and recommended their approval to the PHA board.
- Reviewed the External Auditor's Report to those charged with governance and management's response.
- Regularly considered and approved the PHA corporate risk register.
- Had oversight of the process for self-assessment of compliance with controls assurance standards.
- Agreed the mid-year assurance statement and recommended its approval to the board.
- Self-assessed the GAC against the NAO Audit Committee Self Assessment Checklist for submission to the DHSSPS.
- Approved a suite of IT Security policies.
- Regularly reviewed the Information Governance Action Plan progress report.
- Approved the internal audit workplan for 2010/11 and considered the reports on each piece of work.
- Received regular fraud liaison reports.
- Provided assurance to the board that the annual accounts would be prepared in accordance with the relevant statutory regulations.
- Considered and approved new standardised process and documentation for the award of funding to HSC and non-HSC organisations.
- Considered the revised PHA Standing Orders and recommended them to the PHA board for approval.
- Considered the revised PHA Standing Financial Instructions and recommended them to the PHA board for approval.
- Considered and approved PHA health and safety policies.

The chair of the GAC brings regular verbal and written reports to the PHA board; she also has regular meetings with the Chief Executive and PHA chair.

The GAC looks forward to continuing its work in 2011/12, building on relationships with executive directors, PHA officers, and internal and external auditors to ensure robust governance across the PHA.

J Erskine
Chair
Governance and Audit Committee

Summary financial statements

Overview

These accounts have been prepared in a form determined by the DHSSPS based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

This summary financial statement does not contain sufficient information for a full understanding of the activities and performance of the PHA. For further information, the full accounts (including the statement on internal control), Annual Report and Auditor's Report for the year ended 31 March 2011 should be consulted.

Copies of the full accounts are available from:

Director of Finance
Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 MARCH 2011

	2011 £000s	Restated 2010 £000s
Expenditure		
Staff costs	(12,580)	(12,988)
Depreciation	(58)	(52)
Other Expenditures	(33,519)	(30,194)
	(46,157)	(43,234)
Income		
Income from activities	636	0
Other Income	185	392
Transfers from reserves for donated property, plant, equipment & intangibles	0	0
Reimbursements receivable	0	0
	821	392
Net Expenditure	**(45,336)**	**(42,842)**
Revenue Resource Limits (RRLs) issued (to)		
Belfast HSC Trust	(9,183)	(9,795)
South Eastern HSC Trust	(1,902)	(1,448)
Southern HSC Trust	(3,918)	(6,824)
Northern HSC Trust	(4,943)	(3,923)
Western HSC Trust	(4,361)	(3,669)
NIAS HSC Trust	(5)	0
Total RRL issued	(24,312)	(25,659)
Total Commissioner resources utilised	(69,648)	(68,501)
Revenue Resource Limit (RRL) received from DHSSPS	69,712	68,679
Surplus / (deficit) against RRL	**64**	**178**

OTHER COMPREHENSIVE EXPENDITURE	2011 £000s	Restated 2010 £000s
Net gain/(loss) on revaluation of Property, Plant and Equipment	12	2
Net gain/(loss) on revaluation of Intangibles	(2)	0
Net gain/(loss) on revaluation of available for sales financial assets	0	0
TOTAL COMPREHENSIVE EXPENDITURE FOR THE YEAR ENDED 31 MARCH 2011	**(45,326)**	**(42,840)**

Revenue Resource Limit

Resulting from the introduction of the Non Departmental Public Body (NDPB) format of accounts, the Revenue Resource Limit (RRL) has been introduced as a means of setting a cash limit to the amount of funding to be drawn directly from the DHSSPS by the Trust in relation to the costs of providing services to Agency residents. This RRL mechanism replaced the Service and Budget Agreement previously in place.

The memorandum below expresses the PHA 'Net Expenditure Account' in a traditional income and expenditure format.

SUMMARY FINANCIAL INFORMATION FOR YEAR ENDED 31ST MARCH 2011

	2011 £'000	2010 (restated) £'000
Revenue Resource Limit (RRL) received from DHSSPS	69,712	68,679
Other Income	821	392
	70,533	69,071
Expenditure (including RRLs issued to Trusts)		
Staff Costs	(12,580)	(12,988)
Depreciation	(58)	(52)
Expenditure	(57,831)	(55,853)
	(70,469)	**(68,893)**
Surplus/(Deficit)	**64**	**178**

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	2011 £000s	Restated 2010 £000s	Restated 2009 £000s
Non Current Assets			
Property, Plant and Equipment	229	199	108
Intangible Assets	0	3	6
Financial Assets	0	0	0
Trade and other Receivables	0	0	0
Other Current Assets	0	0	0
Total Non Current Assets	229	202	114
Current Assets			
Assets classified as held for sale	0	0	0
Inventories	0	0	2
Trade and other Receivables	2,553	710	485
Other Current Assets	19	24	58
Financial Assets	0	0	0
Cash and cash equivalents	169	111	8,155
Total Current Assets	2,741	845	8,700
Total Assets	2,970	**1,047**	**8,814**
Current Liabilities			
Trade and other Payables	(10,927)	(16,754)	(11,931)
Other Liabilities	0	0	0
Total Current Liabilities	(10,927)	(16,754)	(11,931)
Non Current Assets plus/less Net Current Assets / Liabilities	**(7,957)**	**(15,707)**	**(3,117)**
Non Current liabilities			
Provisions	0	0	0
Other Payables → 1 yr	0	0	0
Financial Liabilities	0	0	0
Total Non Current Liabilities			
Assets less Liabilities	**(7,957)**	**(15,707)**	**(3,117)**
Taxpayers' equity			
Donated Asset Reserve	0	0	0
Revaluation Reserve	34	23	21
General Reserve	(7,991)	(15,730)	(3,138)
	(7,957)	**(15,707)**	**(3,117)**

Signed

Chair
Date

Signed

Chief Executive
Date

Management board

The Management board responsible for setting the direction of the PHA is made up of the following individuals:

Executive members:

Dr Eddie Rooney (Chief Executive)

Dr Carolyn Harper

Edmond McClean

Mary Hinds

Non-executive members:

Mary McMahon (Chairperson)

Julie Erskine

Dr Jeremy Harbison

Miriam Karp

Thomas Mahaffy

Cllr Cathal Mullaghan

Cllr Stephen Nicholl

Ronnie Orr

Equal opportunities

The PHA has in place an equal opportunities policy to promote and provide equality between persons of different genders, marital or family status, religious belief or political opinion, age, disability, race or ethnic origin, nationality or sexual orientation, between persons with a disability and persons without, between persons with dependents and persons without, between men and women generally, and irrespective of staff organisation membership. This policy applies to recruitment, promotion, training, transfer and other benefits and facilities.

Public Sector Payment Policy – Measure of Compliance

The Department requires that the PHA pays their non-HSC trade creditors in accordance with the CBI Prompt Payment Policy and Government Accounting Rules. The PHA's payment policy is consistent with the CBI prompt payment codes and Government Accounting rules and its measure of compliance is:

	2011 Number	2011 Value £'000	2010 Number *
Total bills paid	8,944	35,715	6,821
Total bills paid within 30 day target	8,477	33,734	6,371
% of bills paid within 30 day target	94.8%	94.5%	93.4%

*Comparative data by value is not available for 2010.

Related party transactions

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

Director's interests

Details of company directorships or other significant interests held by directors, where those directors are likely to do business, or are possibly seeking to do business with the PHA where this may conflict with their managerial responsibilities, are held on a central register. A copy is available from Edmond McClean, PHA Director of Operations.

Charitable donations

The PHA did not make any charitable donations during the financial year.

Post balance sheet events

There are no post balance sheet events that have a material impact on the accounts.

Audit services

The PHA's statutory audit was performed by PricewaterhouseCoopers on behalf of the Northern Ireland Audit Office. The audit fee for 2010–2011 was £17,713. An additional amount of £1,456 was paid to the Audit Office in respect of work carried out on the National Fraud Initiative. This is reflected in miscellaneous expenditure within note 4 of the Annual Accounts.

Statement on disclosure of audit information

All directors can confirm that they are not aware of any relevant audit information of which the PHA's auditors are unaware.

Staff Numbers

The average number of whole time equivalent persons employed during the year was:

	2011 Total	2011 Permanently employed staff	2011 Other Staff	2010 (restated) Total
Health Commissioning improvement and protection	242	185	57	247
Less staff on outward secondments (average)	3	3	0	6
Total (average) persons employed	239	182	57	241

Signed

Chair
Date

Signed

Chief Executive
Date

Statement of the Comptroller and Auditor General to the NI Assembly

I have examined the summary financial statement for the year ended 31 March 2011 set out on pages 31 to 34.

Respective responsibilities of the Public Health Agency, Chief Executive and Auditor

The Public Health Agency and Chief Executive are responsible for preparing the summary financial statement.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the full annual financial statements, and its compliance with the relevant requirements of the Health and Health and Social Care (Reform) Act (Northern Ireland) 2009, as amended, and Department of Health, Social Services and Public Safety directions made thereunder.

In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

Basis of audit opinions

I conducted my work in accordance with Bulletin 2008/03 'The auditors' statement on the summary financial statement in the United Kingdom' issued by the Auditing Practices Board. My report on the Public Health Agency full annual financial statements describes the basis of my audit opinions on those financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion, the summary financial statement is consistent with the full annual financial statements of the Public Health Agency for the year ended 31 March 2011and complies with the applicable requirements of the Health and Health and Social Care (Reform) Act (Northern Ireland) 2009, as amended, and Department of Health, Social Services and Public Safety directions made thereunder.

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU
27June 2011

Mary McMahon

1 Mary is the PHA's Chair and is a self-employed Social Policy Researcher. She was previously coordinator with the Belfast Traveller Support Group and is a member of Amnesty International (Mid-Down branch), the Committee on the Administration of Justice and also the United Nations Children's Fund (UNICEF). She is a Belfast Harbour Commissioner.

2 Dr Eddie Rooney

Dr Eddie Rooney is Chief Executive of the Public Health Agency. The Agency was established in 2009 to protect and improve health and social wellbeing and reduce health inequalities. Prior to joining the Public Health Agency, Dr Rooney served as Equality Director at the Office for the First Minister and Deputy First Minister and as Deputy Secretary at the Department of Education from 2004–08.

3 Dr Carolyn Harper

Dr Harper is the PHA's Director of Public Health and Medical Director. She was previously Deputy Chief Medical Officer in the DHSSPS. She trained in general practice before moving into public health and also worked as Director of Quality Improvement for the Quality Improvement Organisation in California.

4 Mary Hinds

Mary Hinds is the PHA's Director of Nursing and Allied Professionals. She was previously Director of the Royal College of Nursing (RCN) in Northern Ireland. Prior to joining the RCN, she was Director of Nursing at the Mater Hospital in Belfast.

5 Edmond McClean

Edmond McClean is the PHA's Director of Operations. He was previously lead Director supporting the initial development of Belfast and East LCGs. From 1997 to 2007 he was Director of Strategic Planning and Commissioning with the Northern Health and Social Services Board. This role also involved leading equality and human rights functions, Investing for Health and Northern Neighbourhoods Health Action Zones initiatives.

6 Paul Cummings

Paul Cummings is Director of Finance, HSCB, He has previously been a Director of Finance in the South Eastern, Mater and Ulster Community and Hospitals Trusts with over 25 years experience in Health and Social Care and was the national chair of the Healthcare Financial Management Association in 2002/03, continuing to be an active member. Paul, or a deputy, will attend all Agency board meetings and have attendance and speaking rights.

7 Julie Erskine

Julie Erskine is a member of the Northern Ireland Social Care Council, a member of the Northern Ireland Local Government Officers' Superannuation Committee and a member of the Audit Committee for the Northern Ireland Commissioner for Children and Young People. She has worked in the healthcare service industry for over 25 years and held the position of Operations Director and Support Services Director within a Belfast-based private healthcare company.

8 Dr Jeremy Harbison

Dr Harbison is a retired civil servant. He is a Pro Chancellor of the University of Ulster and a Trustee of the Community Foundation for Northern Ireland. He remains a Commissioner of the Northern Ireland Legal Services Commission.

9 Miriam Karp

Miriam Karp is a member of the Northern Ireland Social Care Council, a member of the Statutory Committee (Conduct committee) of the Northern Ireland Pharmaceutical Society, a member of the Exceptional Circumstances Body for School Transfer, a member of the Social Care Institute Of Excellence (SCIE) Partners' Council and a consultant for Arthritis Care UK and the National Cancer Screening Programme in Ireland.

10 Councillor Stephen Nicholl

Stephen Nicholl is a locally elected representative member of Antrim Borough Council. He is employed as a Policy Advisor to Jim Nicholson MEP and was previously Secretary and Project Manager for the New Lodge Duncairn Community Health Partnership.

11 Thomas Mahaffy

Thomas Mahaffy is employed by UNISON as a Policy Officer with responsibility for partnerships, equality, human rights and social policy issues within Northern Ireland. He is a board member of the Northern Ireland Anti-Poverty Network and Human Rights Consortium.

12 Ronnie Orr

Ronnie Orr worked with the Office of Social Services in DHSSPS until 2009, undertaking inspections and providing policy advice in relation to child care and criminal justice. He is currently a member of the Independent Monitoring Board for Hydebank Wood Prison and Young Offenders Centre.

Not pictured

Maeve Hully

Maeve Hully is Chief Executive of the Patient and Client Council. A representative from the PCC will attend all PHA board meetings.

Fionnuala McAndrew

Fionnuala McAndrew is Director of Social Care and Children, HSCB. Fionnuala, or a deputy, will attend all Agency board meetings and have attendance and speaking rights.

Councillor Cathal Mullaghan

Cathal Mullaghan is a locally-elected representative member of Belfast City Council. He has been a board member of Libraries NI from 1 August 2009. He also sits on the Northern Ireland Local Government Association (NILGA) Executive Commitee and on the NILGA Health and Environment sub-committee. He is a Belfast Harbour Commissioner.

HSC Public Health Agency

Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

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