PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2022

PUBLIC HEALTH AGENCY ANNUAL REPORT & ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2022

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

On 1 July 2022

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2021/22 in delivering our corporate priorities and highlights examples of work undertaken during this period. It shows how this work has contributed to meeting our wider objectives and fulfilling our statutory functions.

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

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

Other formats

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

Any enquiries regarding this document should be sent to us at:
Public Health Agency
12/22 Linenhall Street
Belfast
BT2 8BS

This publication is also available for download from our website at:
www.publichealth.hscni.net

ISBN: 978-1-874602-85-9

PUBLIC HEALTH AGENCY
ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2022

Getting in touch

Headquarters
4th floor
12–22 Linenhall Street
Belfast
BT2 8BS
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Northern Office
County Hall
182 Galgorm Road
Ballymena
BT42 1QB
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Southern Office
Tower Hill
Armagh
BT61 9DR
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Western Office
Gransha Park House
15 Gransha Park
Clooney Road
Londonderry
BT47 6FN
Tel: 0300 555 0114 (Local call rate and included within inclusive call packages)

Normal business hours:
9.00am–5.00pm Monday–Friday

Contents

PERFORMANCE REPORT

Performance Overview

The purpose of the Performance Overview is to provide a brief summary of the role, purpose, activities and values of the PHA.

The Public Health Agency – our role, purpose and activities

The Public Health Agency (PHA) is the statutory body responsible for improving and protecting the health of our population and an integral part of the Health and Social Care (HSC) system, working closely with the Health and Social Care Board (HSCB), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO) and the Patient Client Council (PCC).

Central to our main responsibilities is working in close partnership with individuals, groups and organisations from all sectors – community, voluntary and statutory.

The PHA was set up with the explicit agenda to:

- protect public health;
- improve the health and social wellbeing of people in Northern Ireland;
- work to reduce health inequalities between people in Northern Ireland; and
- work with the HSCB, providing professional input to the commissioning of health and social care services.

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

During 2021/22, the PHA continued to work and be guided by our purpose, vision and values, as set out in our Corporate Plan 2017 – 2021, which was rolled forward

into 2021/22 as advised by the Department of Health (DoH); however our focus was on responding to the challenges of COVID-19.

Our purpose

- to protect and improve the health and social wellbeing of our population and reduce health inequalities through strong partnerships with individuals, communities and other key public, private and voluntary organisations.

Our vision

- all people and communities are enabled and supported in achieving their full health and wellbeing potential, and inequalities in health are reduced.

Our values

- we put individuals and communities at the heart of everything we do in improving their health and social wellbeing and reducing health inequalities;
- we act with openness and honesty and treat all with dignity, respect and compassion as we conduct our business;
- we work in partnership with individuals, communities and other public, private, community and voluntary organisations to improve the quality of life of those we serve;
- we listen to and involve individuals and communities;
- we value, develop and empower our staff and strive for excellence and innovation; and
- we are evidence-led and outcomes-focused.

HSC values

In addition we subscribe to the values and associated behaviours that all staff working within Health and Social Care (HSC) are expected to display at all times.

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

Chair's Foreword

On behalf of the Board I would like to pay tribute to the staff of the Public Health Agency for their unswerving and diligent response to a second year of the COVID-19 pandemic. Staff have also worked tirelessly in order to restore those services which either had to be reduced or paused at the height of the pandemic.

I am delighted that in this year the PHA was able to appoint a permanent Chief Executive. Aidan Dawson took up his post on 1 July 2021. Prior to his appointment, Aidan held a range of director positions in Health and Social Care Trusts in Northern Ireland, as well as having served in the voluntary sector.

I would like to thank Olive Macleod OBE who undertook the role of Interim Chief Executive at the commencement of the pandemic. She oversaw the establishment of the contact tracing service and ensured that the PHA acted promptly to reduce the major health threats caused by the virus and its variants.

I also wish to express my immense appreciation to the Department of Health and in particular to Professor Sir Michael McBride for steadfast leadership during the last two years. In the birthday honours list of 2021, Professor McBride's contribution was fittingly recognised with a knighthood.

The Department of Health and the PHA are now in the process of designing and implementing a new operating model. This new model will both refresh and reshape the PHA in order to address effectively the public health needs of the people of Northern Ireland into the next decade and beyond.

The PHA is keen to ensure the appointment of individuals from a broad range of disciplines to become public health consultants. The Board continues to review its committee structure and looks forward to contributing to this new model in every way possible.

I wish to record the contribution of two local councillors who served on the Board of the PHA for almost 10 years. Alderman Paul Porter and Alderman William Ashe MBE brought great understanding and knowledge of community issues to our deliberations in the boardroom.

We were delighted in October 2021 to welcome two new local government appointees to the Board in Councillor Robert Irvine from Fermanagh and Omagh District Council and Alderman Phillip Brett from Antrim and Newtownabbey Borough Council.

Alderman Brett previously served on the Board of the Northern Ireland Housing Executive and Councillor Irvine presently serves on the Board of the Northern Ireland Fire and Rescue Service.

In addition Mrs Anne Henderson OBE has been appointed as non-executive director with financial experience. Mrs Henderson is a former Chair of the Parades Commission for Northern Ireland and a former Vice Chair of the Board of the Northern Ireland Housing Executive.

I want to record appreciation and thanks to members of the Board, both executive and non-executive, who went above and beyond the call of duty in a particularly demanding year.

We look forward in the coming year to ensure refreshed clarity of focus for the objectives of the PHA, not just in the immediate years but for the decade ahead.

Andrew Dougal OBE
Chair of the Board
Public Health Agency for Northern Ireland

Chief Executive's Report

The past year has proven to be extremely demanding as we continued to face the challenges of the coronavirus pandemic while trying to get on with normal business as much as possible.

PHA staff met those challenges head-on, delivering solutions that have made a difference while continuing to work to improve the general health and wellbeing of our communities.

Since joining the PHA, I have been tremendously impressed with the resolve and professionalism of PHA staff, working as a team with drive and determination. Our people have not been found wanting, and have continually risen to whatever has been asked of them.

The organisation has had to be agile and adapted quickly to the emergence of new COVID-19 variants and peaks in case numbers. We increased our staff complement at the height of the pandemic, and evolved new services including enhancements to the Contact Tracing Service to meet the significant rise in COVID-19 cases. Growing the organisation in such a short timescale has been demanding, especially in the middle of a pandemic when many staff have been working remotely. I am immensely proud of the effort that has been put into adapting how we work quickly and effectively. This has resulted in lives being saved.

Adversity brings with it opportunity and one of the most significant developments has been the targeted use of data science, information and analytics. We have taken significant strides forward in developing leading edge real-time information streams which underpin our surveillance and analytics systems, relying on greater automation than at any time previously. This work has helped target our interventions during the pandemic, and the learning we have taken from it will be of significant benefit in how we do things in future.

Genomic sequencing and behavioural science capacity has become further established within Northern Ireland, and through partnerships with academia, tech, HSC and other partners, we have brought a targeted focus underpinning the pandemic response.

Vaccination has played a major role in the battle against coronavirus, and the roll-out of new vaccines across society formed the biggest breakthrough in this pandemic. The PHA has, together with the wider HSC family, played a key role in achieving approximately 90% uptake amongst the adult population – in line with other regions across these islands. Of course this, and the general actions which people have taken to help protect themselves and others throughout the pandemic, is testament to the responsibility and responsiveness that the public has shown in taking on board the significant and often fast-moving messaging as evidence emerged and responses were developed.

In 2022, responsibility for coordination of the COVID-19 vaccination programme is moving to the PHA, which will again require a new level of focus to ensure that we have the capacity available to deliver it as part of our existing vaccination programmes.

The annual report provides a snapshot across a range of work undertaken during the year, with a particular focus on the management of COVID-19. The Department of Health advised that our corporate strategy would be rolled over for 2021/22, and our business plan for 2021/22 acknowledged that while the focus of the programme would be the COVID-19 response, where possible we would hope to return to non-COVID business as soon as possible.

However, the emergence of the Delta and latterly Omicron variants has resulted in PHA staff at various stages during the year stepping in to provide additional sustained support to Health Protection and contact tracing functions. This has had an impact on the delivery of some key objectives, but notwithstanding good progress has been achieved. Work has also continued across our areas of responsibility including health improvement, screening, Nursing and Allied Health Professionals, quality and safety, and Research & Development.

Change has been a constant feature over the past two years and will undoubtedly continue as the pandemic transitions into an endemic state in the future.

Looking ahead, we can envisage a period of major strategic change in health, beginning with the closure of our commissioning partner the HSCB and its transfer of

functions into the Department of Health in the form of a new Strategic Planning and Performance Group. This will be closely followed by the roll-out of a new integrated care planning system that will help to ensure that the people's health needs are best met through a population health planning approach, including prevention and early intervention.

We currently have a unique 'reset' opportunity and to this end the PHA, together with the Department of Health, have commenced a review process which will bring forward plans for taking on board the hard-earned learning from the last two years while ensuring that the PHA is best placed to lead on the response to the key strategic challenges locally, nationally and internationally in the months and years ahead.

While we work our way through the future stages of the pandemic, there will be new public health challenges that we need to be ready to face. For example, we already know there are significant health inequalities experienced by people living in the most deprived areas compared with those in the least deprived, leading to ill-health and earlier death. The cost-of-living crisis, with increased costs for food, fuel and other necessities, could exacerbate this further and have a real detrimental impact on health and wellbeing, so we need to be creative, collaborative and effective in how we work to reduce this within a public health context.

We have gone through an unprecedented couple of years which impacted on all of our lives – no one has been untouched by this pandemic. As we emerge and look to the future, the hard work of our staff and the learning we have taken from our experiences will enable the PHA to move forward even more effectively in helping to protect and improve people's health and wellbeing.

Aidan Dawson
Chief Executive
Public Health Agency

Performance Analysis

The PHA *Annual Business Plan 2021–2022* sets out the key actions for the year commencing 1 April 2021 and ending 31 March 2022 to meet ministerial priorities and deliver on outcomes set out in the Corporate Plan for 2017/21 which was rolled forward to 2021/22 at the request of the Department of Health due to the backdrop of the ongoing COVID-19 response. Staff across the PHA, as well as Board members, were engaged with, and contributed to, the content of the plan.

The plan was also developed in alignment with the *Draft Programme for Government 2016–2021*, *Making Life Better 2012–2023*, *Health and Wellbeing 2026: Delivering Together* and the evolving community planning arrangements.

A key element identified at the time of developing the Annual Business Plan was the overriding priority of focusing on the ongoing COVID-19 pandemic and ensuring that key interventions needed to contain and manage the virus, such as testing, contact tracing, surveillance, roll out of the vaccination programme and public behaviour messaging were effectively implemented, whilst also endeavouring to balance 'business as usual' as far as possible. In the context of guidance from the Department of Health, the *Annual Business Plan 2021–2022* contains 53 targets to take forward the five agreed key outcome themes:

1) COVID-19 Response;
2) Health Protection;
3) Health Improvement;
4) Shaping future health; and
5) Our organisation works effectively.

Progress is reported to the PHA Board through quarterly progress reports. Performance against these targets has been of a high standard.

The figures in the following table set out the position at 31 March 2022.

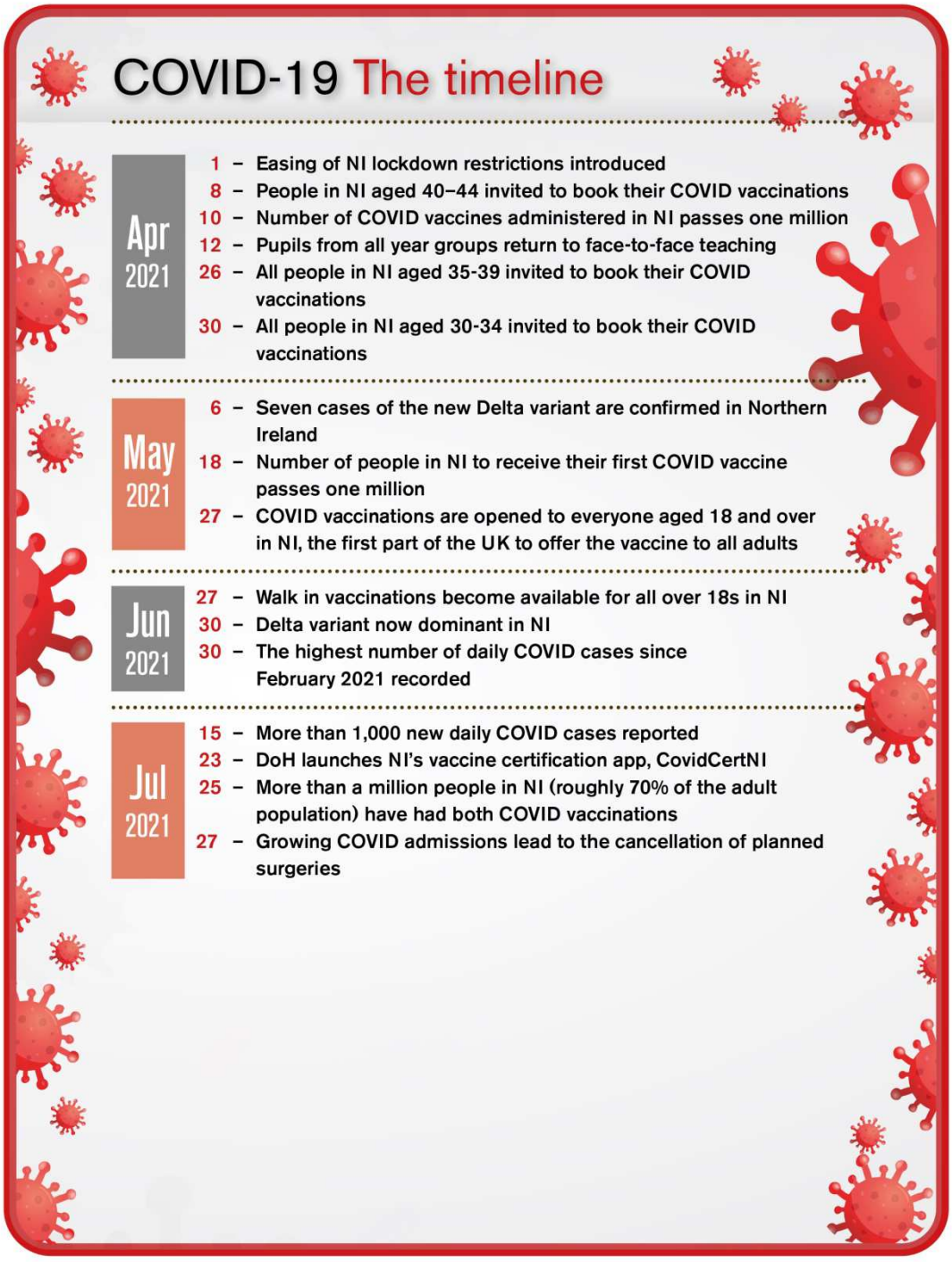
Green	On target	44
Amber	Slight delay	9
Red	Significant delay / will not be completed	0
TOTAL		**53**

The following pages highlight some of the key actions taken forward during 2021/22. They reflect work across all of the PHA Directorates and functional areas. It should be noted however, that as we had to flexibly refocus our activities during 2021/22 to respond to the COVID-19 pandemic with staff redeployments, a lot of work commenced throughout the year has had to be paused for periods of time.

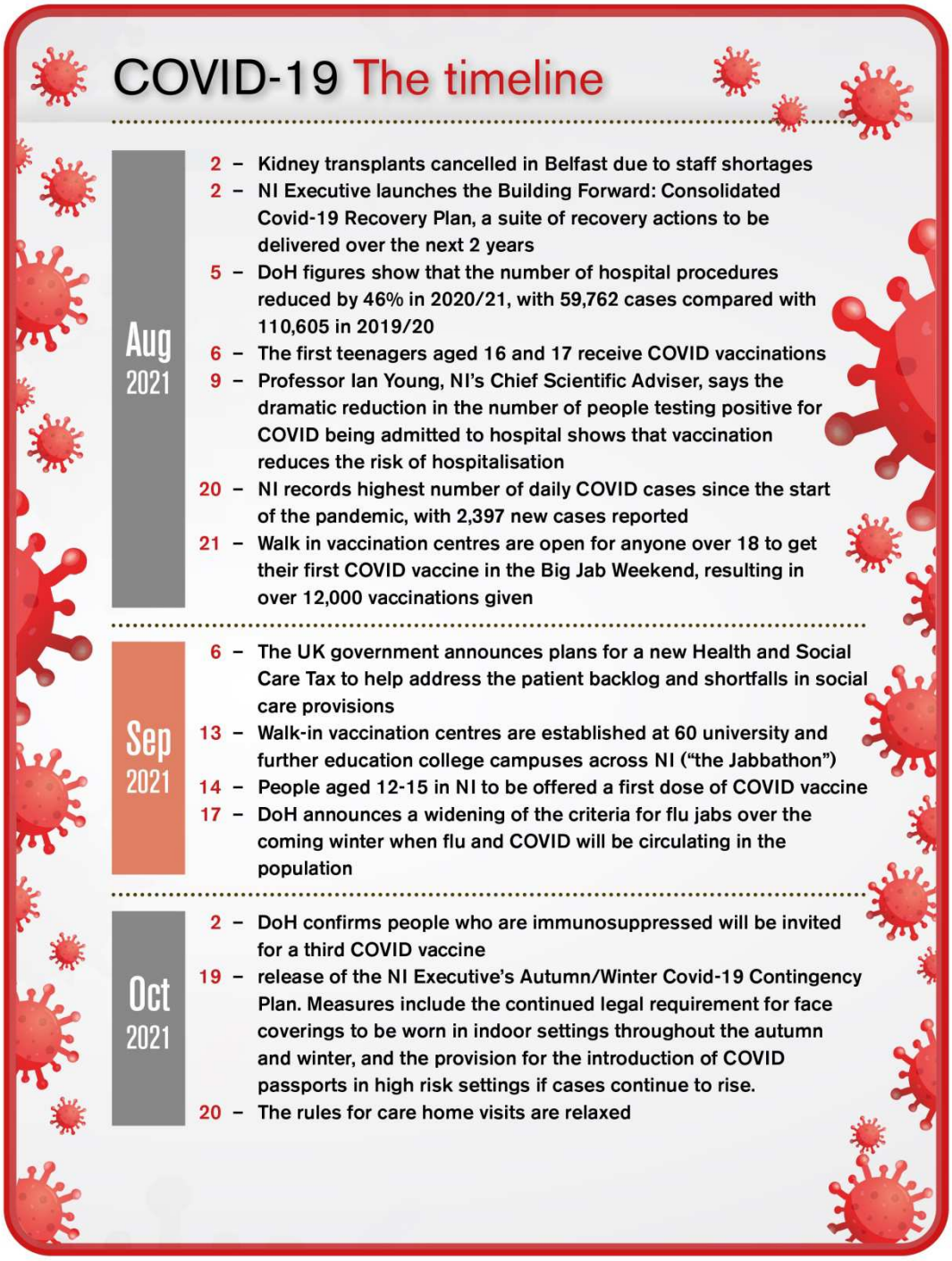
COVID-19 Timeline

A brief timeline for some of the key events that have marked the pandemic to the end of March 2022 is illustrated in the following timeline.

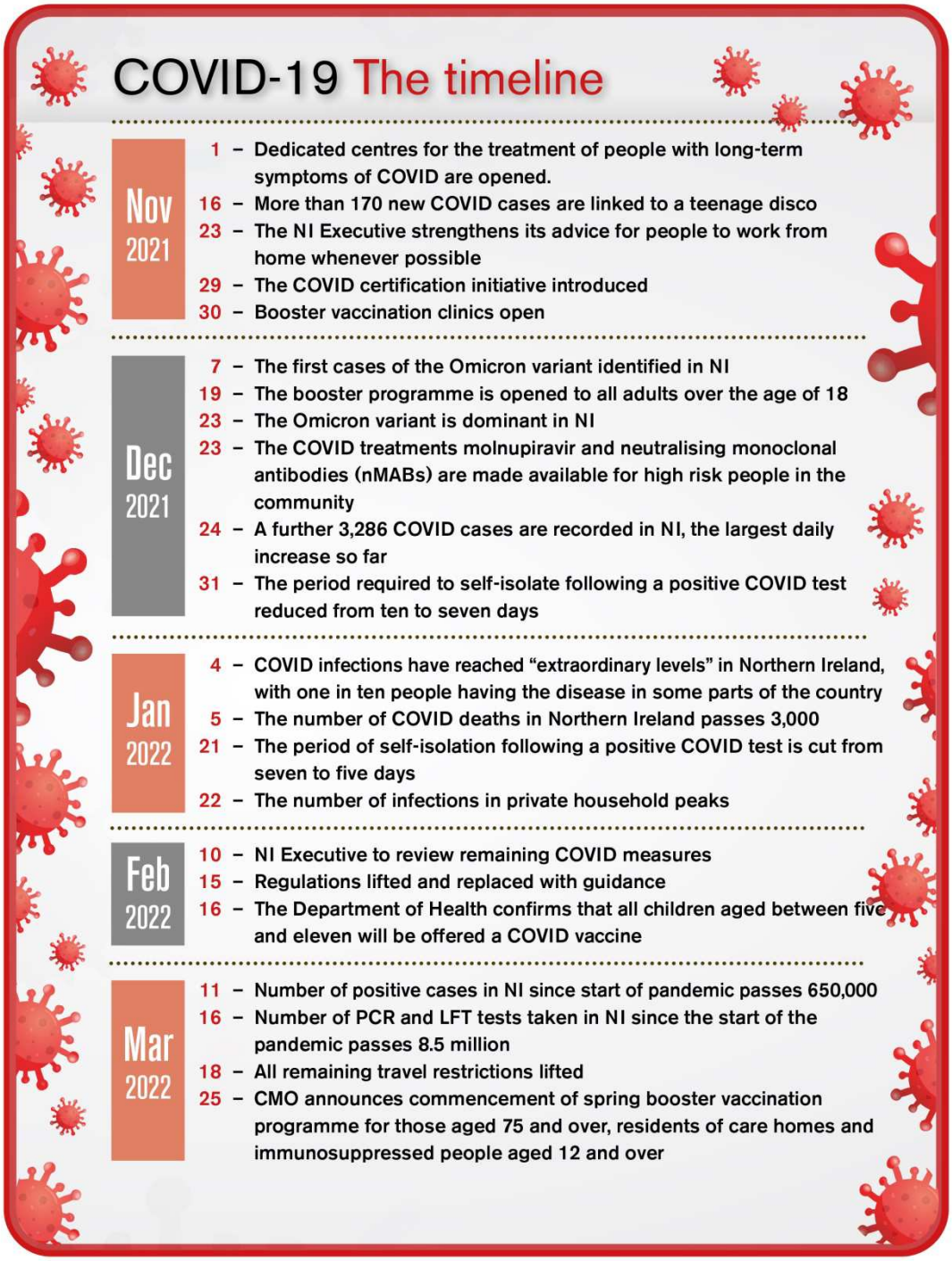
COVID-19 timeline - April to July 2021.



COVID-19 timeline - August to October 2021.



COVID-19 timeline - November 2021 to March 2022.



The Public Health Agency response to COVID-19

As Northern Ireland entered the second year of the COVID-19 pandemic, it was evident that the demands facing the PHA were set to continue and would require an even greater level of dedicated professional resources.

The logistical challenges in rolling out a new and complex vaccination programme across the population while continuing to respond to the unpredictable trajectory of emerging variants of concern would demand an unprecedented level of synergy across the HSC family, in partnership with all aspects of society in Northern Ireland. Central to this was the role, support and work of the PHA.

This report describes some of the work undertaken by the PHA during 2021/22, providing an insight into the breadth of the PHA response across directorates and functions.

These areas include:

- The role of health protection in the response to COVID-19;
- Development of the Northern Ireland Contact Tracing Service;
- Support for the education sector;
- Supporting the care home sector;
- Infection prevention and control during the pandemic;
- Collaborative approach to surge management;
- The Research and Development response to COVID-19;
- Vaccination programmes;
- The impact of COVID-19 on screening services;
- Health and wellbeing improvement initiatives;
- Supporting mental health and emotional wellbeing during COVID-19;
- The key role of communication during a pandemic;
- Planning and operational response; and
- Health & Social Care Quality Improvement (HSCQI) response to the pandemic.

The role of PHA Health Protection in the response to COVID-19

The PHA Health Protection directorate has continued to provide sustained and intensive leadership, intelligence and health protection expertise during 2021/22, in addition to delivering essential ongoing acute response and proactive health protection programmes.

Over 38,000 enquiries regarding COVID-19 have been managed through the PHA Health Protection Acute Response Service, which is responsible for investigating and managing clusters and outbreaks of infectious disease.

The service operates 24 hours a day, seven days a week and has provided the professional lead for a large number of multi-disciplinary incident control teams for the management of outbreaks in a range of settings including churches, care homes, schools and colleges, workplaces, and health care settings.

The service works in close partnership with HSC Trusts, Local Councils, the Health and Safety Executive and the Education Authority to prevent and bring outbreaks under control and has continued to collaborate fully with colleagues from UK and Republic of Ireland to share learning, assess evidence and influence policy.

The PHA has produced and contributed to the development of guidance and policies in relation to COVID-19 across many different settings, including for the general public, vulnerable people, care homes, hospitals, funeral directors and schools. A dedicated guidance cell was established to respond to queries about application of COVID-19 guidance, and has managed almost 1,000 enquiries to date.

During spring and summer 2021, a further wave of infection with the more transmissible and more severe Delta variant was managed. Initial steps included mandatory ten days hotel quarantine for returnees from ‘red list’ countries and mass testing of residents in targeted areas to find and isolate cases. Incident management teams were held to control outbreaks, and to reduce onward transmission.

There was a further surge of infection when schools went back after the summer holidays, and the PHA worked closely with schools and the Education Authority to support them in managing cases and clusters. This included the production of a suite of letters, guidance and information resources for schools, parents and children.

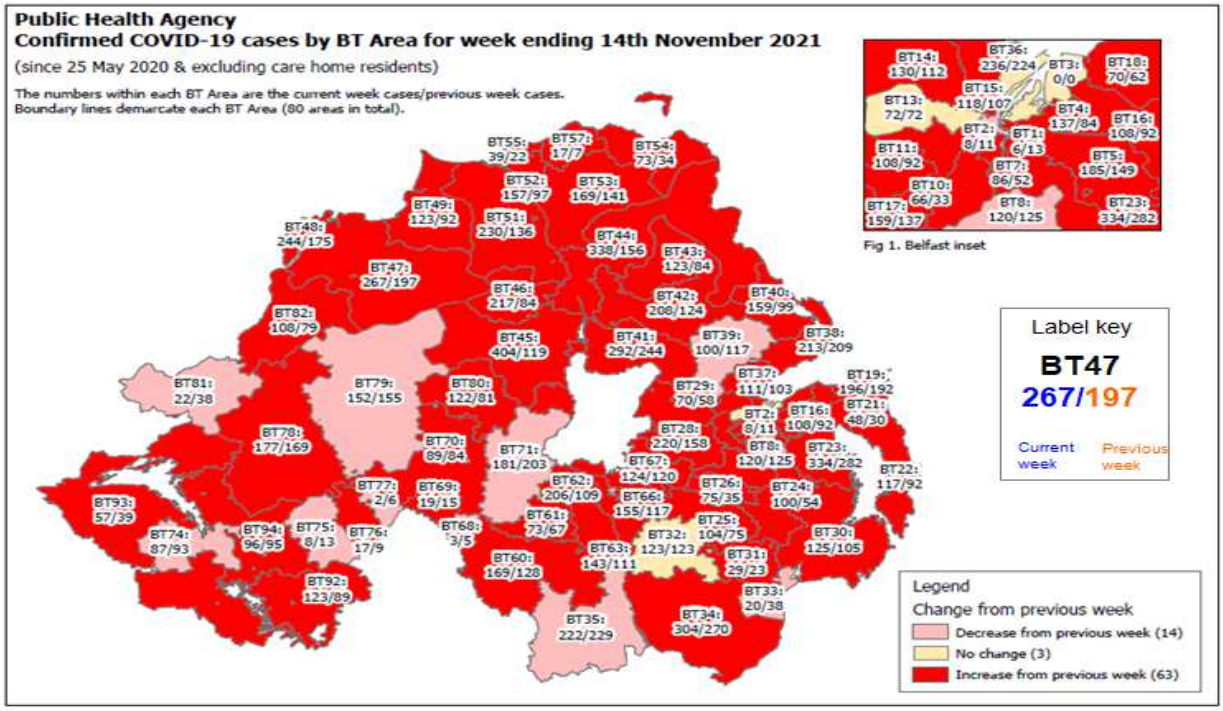
In November 2021, the PHA stood up a response to the emerging Omicron variant first identified in South Africa. This included liaising directly with the National Institute for Communicable Diseases in South Africa to obtain real time information to inform our risk assessment and planning. Rapid work was undertaken to characterise the risk from this new variant in terms of transmissibility, growth advantage, immune escape and severity. Staff from across the PHA were mobilised to assist with the operational Health Protection response, and in particular to support care homes during the peak.

The Omicron variant posed particular challenges in health care and residential care settings in terms of health care acquired infections due to its increased transmissibility, and also the reduced staffing levels they were experiencing at the time. As well as providing guidance and advice to manage the outbreaks, the PHA also assessed if there were any broader issues of concern, for example with staffing or PPE, and escalated these appropriately.

Critical to the PHA response has been the further evolution of our systematic surveillance systems. Surveillance is the continuous process of collection, analysis and interpretation of data related to communicable disease and environmental hazards. To target interventions to prevent and control outbreaks, the health protection surveillance team draw from a range of information sources including laboratories, hospitals, GPs, HSC Trusts, UKHSA and lighthouse laboratories. Waste water surveillance has been used to analyse the trajectory of COVID-19, identify the burden of disease and which age groups and geographical areas are most affected. Outputs are used to inform public health decision making, and policy.

A bi-weekly early warning report has continued to be produced, identifying geographical areas of concern within Northern Ireland where increased resources and testing need to be directed.

Confirmed COVID-19 cases by postcode area (week ending 14 November 2021)



Source: Virology Database

COVID-19 case rates and proportion positive by Local Government District (7-day rolling average, week ending 9 January 2022)

COVID-19 case rates per 100,000 population, by Local Government District (7-day rolling average)

Local Government District (LGD)	Population (2019 Mid-Year)	15/11/2021-21/11/2021	22/11/2021-28/11/2021	29/11/2021-05/12/2021	06/12/2021-12/12/2021	13/12/2021-19/12/2021	20/12/2021-26/12/2021	27/12/2021-02/01/2022	03/01/2022-09/01/2022
Antrim and Newtownabbey	143,504	96.36	94.87	103.73	102.73	103.43	188.15	346.83	189.34
Ards and North Down	161,725	84.09	84.89	93.37	100.08	119.25	183.65	289.47	145.75
Armagh, Banbridge and Craigavon	216,205	73.54	75.85	90.59	83.92	114.71	158.65	341.67	216.73
Belfast	343,542	77.80	74.89	81.92	74.85	105.66	200.47	367.89	209.17
Causeway Coast and Glens	144,838	107.31	91.14	84.33	75.36	79.89	144.69	354.48	176.75
Derry and Strabane	151,284	66.95	65.91	74.41	81.59	113.79	243.44	674.70	325.12
Fermanagh and Omagh	117,397	77.76	71.92	80.80	75.20	100.15	189.71	538.22	272.82
Lisburn and Castlereagh	146,002	88.94	84.64	100.59	89.92	114.97	204.89	316.63	159.88
Mid and East Antrim	139,274	100.42	92.93	90.37	84.93	82.67	132.83	270.89	169.86
Mid Ulster	148,528	112.73	94.16	93.67	70.60	95.03	160.43	416.76	258.73
Newry, Mourne and Down	181,368	81.21	94.13	119.41	108.07	102.95	185.02	436.52	248.27
Northern Ireland	1,893,667	86.45	83.53	91.96	85.74	104.45	183.60	392.21	216.20

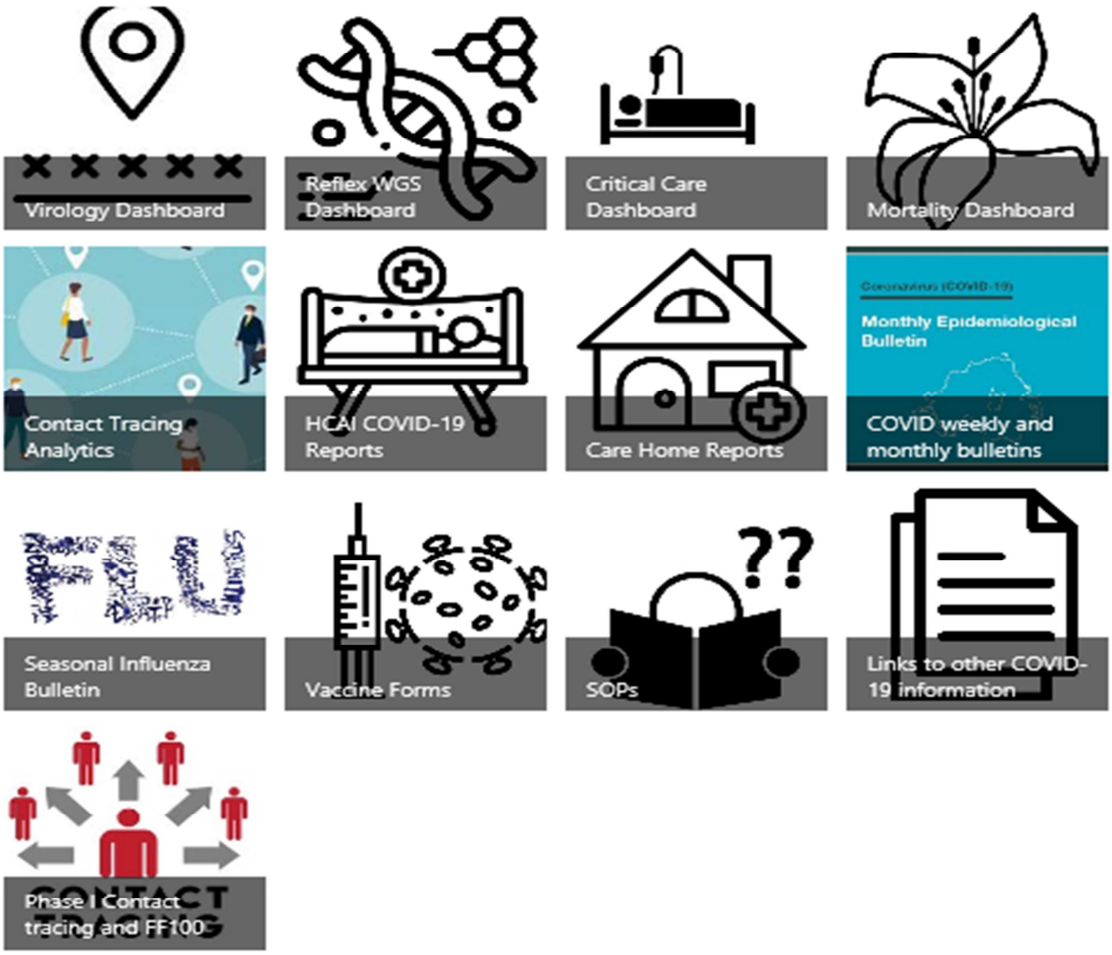
COVID-19 proportion positive, by Local Government District (7-day rolling average)

Local Government District (LGD)	Population (2019 Mid-Year)	15/11/2021-21/11/2021	22/11/2021-28/11/2021	29/11/2021-05/12/2021	06/12/2021-12/12/2021	13/12/2021-19/12/2021	20/12/2021-26/12/2021	27/12/2021-02/01/2022	03/01/2022-09/01/2022
Antrim and Newtownabbey	143,504	21.3	21.9	20.8	21.3	20.3	31.3	48.3	41.2
Ards and North Down	161,725	21.4	20.6	21.1	20.8	21.0	30.6	45.8	35.3
Armagh, Banbridge and Craigavon	216,205	22.1	20.9	21.4	21.4	23.0	33.8	52.2	46.6
Belfast	343,542	20.1	19.5	18.7	18.4	21.4	33.3	49.4	40.8
Causeway Coast and Glens	144,838	23.7	22.9	21.9	19.7	20.8	33.3	50.4	39.8
Derry and Strabane	151,284	20.4	19.7	20.3	20.0	23.4	37.6	55.9	45.7
Fermanagh and Omagh	117,397	20.6	20.7	20.9	20.2	21.3	35.4	55.5	45.5
Lisburn and Castlereagh	146,002	19.2	19.9	21.1	19.1	19.6	30.2	44.9	38.2
Mid and East Antrim	139,274	23.0	20.9	21.1	20.4	19.5	29.7	46.4	39.4
Mid Ulster	148,528	25.0	25.0	22.5	21.1	23.6	35.7	55.5	47.9
Newry, Mourne and Down	181,368	20.6	21.7	22.4	22.0	21.2	33.9	52.2	47.4
Northern Ireland	1,893,667	21.4	21.0	20.9	20.2	21.4	33.2	51.0	42.9

Source: Virology database.

COVID-19 internal dashboard

During 2021/22 a series of additional refinements have been made to the COVID-19 internal dashboard, including information on virology, testing, trends, mortality and Whole Genome Sequencing (WGS). Weekly reports on COVID-19 and care homes were produced for the public.



Source: Virology database.

WGS results have been used to monitor emerging new variants of 'concern' or 'under investigation' and were key in the management of the Delta and Omicron waves in 2021. The WGS team within Health Protection Surveillance collaborate with colleagues in UKHSA (formerly PHE), Republic of Ireland, Queens University Belfast, HSC laboratories, the Regional Virology Laboratory (RVL) and COVID-19 Genomics UK Consortium (COG-UK). Weekly Variants and Mutations (VAM) profiles and WGS epidemiological reports were produced to support this work. A

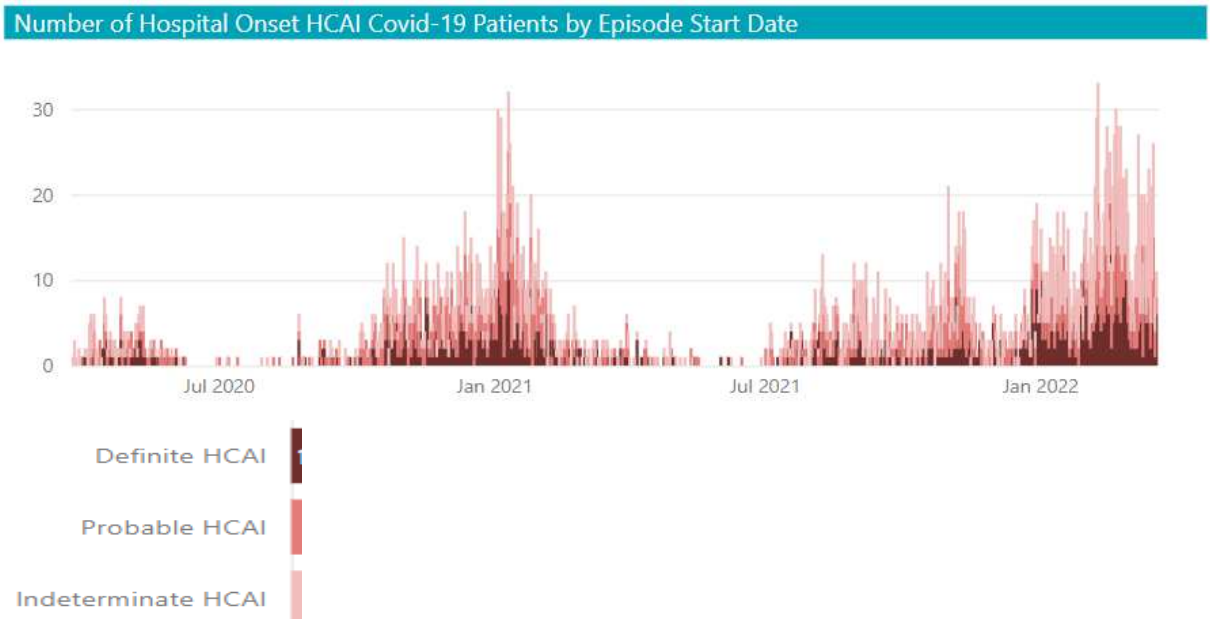
pathogen genomics service development group was convened in October 2021 to develop the genomics service within Northern Ireland and to expand to other pathogen in the future.

Dedicated surveillance systems are in place to monitor COVID-19 in high risk populations and settings. For example, care home surveillance identifies outbreaks in care homes and helps target the advice and support given.

The hospital acquired COVID-19 infection dashboard has provided information on COVID-19 infections in patients who have been admitted to hospital in Northern Ireland. This information is updated on a daily basis and can be broken down by HSC Trust, hospital and individual ward level. This enables the PHA and HSC Trusts to quickly identify health care associated infections (HCAIs) and outbreaks, ensuring early investigation and intervention to help to prevent further spread of COVID-19 in the hospital setting. The dashboard also enables monitoring of trends in infection and mortality associated with hospital acquired COVID-19.

PHA health protection staff are represented on national groups to ensure that standardised definitions and methodology are used to categorise hospital acquired COVID-19 infections to enable comparison with other UK nations. Over the course of the year the PHA has also continued to monitor other healthcare associated infections including *S. aureus* bacteraemias, *C. difficile* infection, Gram negative bloodstream infections and multi-drug resistant organisms throughout the pandemic.

Hospital Acquired COVID-19 cases in all HSC Trusts: March 2020- March 2022 (extracted from Hospital Acquired COVID-19 Dashboard 22/03/22

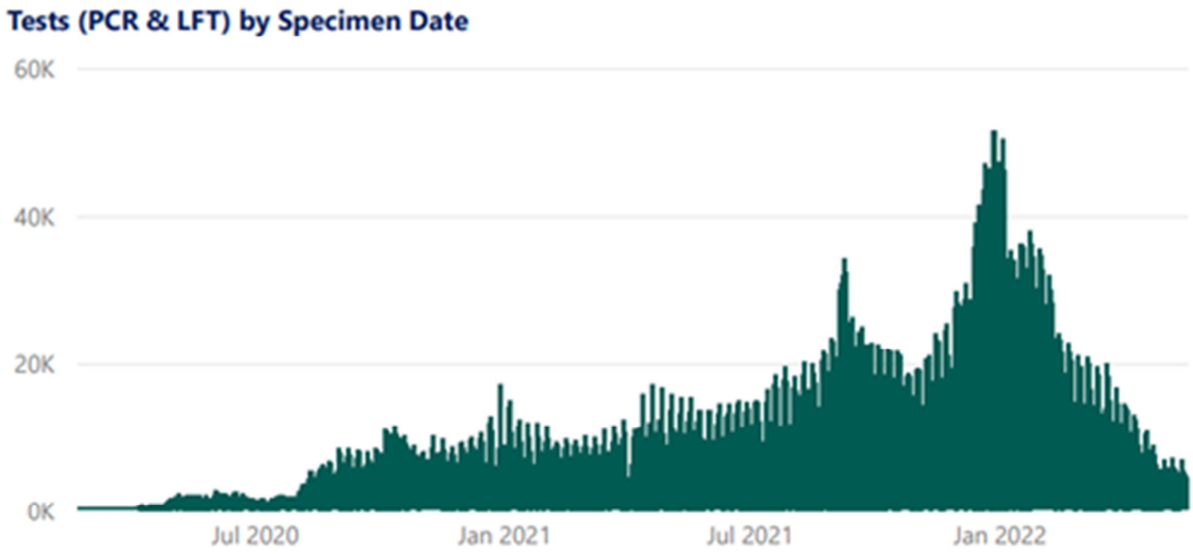


From August 2021, the PHA has led on the roll out of COVID-19 vaccination for all children and young people (including those at risk) and is currently leading on the vaccination of all over fives. Final preparations are in place for the roll out of the 'Spring booster', which will be delivered during April and May 2022.

A PHA Low Uptake Group was set up during the year to identify and implement targeted interventions to support fair access and fair opportunity for everyone to receive their vaccine and thus contribute to increasing overall population vaccine coverage. An online toolkit for professionals and wider community groups has been developed to use when trying to target areas of low vaccine uptake. This contains a number of examples of good practice from across Northern Ireland, as well as practical guides and patient testimonials.

Testing for COVID-19

The first positive COVID-19 case in Northern Ireland was tested on 26 February 2020. In total, at the time of reporting (30 March 2022), a cumulative number of 5,702,409 COVID-19 PCR tests had been completed in Northern Ireland, and 3,012,210 lateral flow device (LFD) tests had been reported.



Tests (PCR and LFD) by specimen date, 23 February 2020 - 30 March 2022. Source: Department of Health: COVID-19 Daily Dashboard.

The testing programme has evolved in the course of the pandemic to include a variety of technologies. During 2021/22 the PHA testing team has continued to work with colleagues across the region, including local test site partners, the Northern Ireland Expert Advisory Group for COVID-19 testing and the Northern Ireland Pathology Network, to develop the testing programme and ensure that it is delivered to a high standard. Staff have linked closely with colleagues working on the testing programmes in England, Scotland and Wales to share knowledge and resources.

Pillar 1

Pillar 1 tests are those conducted within the Health and Social Care system. Initially this was only through laboratory-based PCR testing but in the course of the pandemic there has been an expansion in the number of technologies available. All HSC Trusts are able to provide COVID-19 testing to their patients and staff. In addition to standard PCR tests, there are now further laboratory-based tests with

shorter turnaround times and point of care tests which can be done without the sample being transferred to a laboratory. These quicker tests allow for rapid decision making in the healthcare system.

Pillar 2 PCR testing

Members of the public are able to access community testing by PCR through Pillar 2 testing sites. For example, during the last quarter of 2021/22 there were up to five 'drive through' regional test sites and nine 'walk through' local test sites in Northern Ireland, accompanied by a fleet of mobile testing units. These mobile units are temporary sites that can be set up quickly in response to local demand. Home testing kits are also available. Information on the Pillar 2 PCR testing sites is available on the PHA website.

Lateral flow device (LFD) testing

In the course of the last year, there has been significant expansion in LFD testing in Northern Ireland. These rapid tests allow asymptomatic individuals to test at home, with a result available within 30 minutes. Around one third of those with COVID-19 can have no symptoms, so taking a LFD test can identify the virus and help individuals to take appropriate steps to stop the spread of the virus to others.

Members of the public are able to order LFD tests online for home delivery or can collect them at local collection sites, including pharmacies. In addition, LFDs are available for staff in a variety of settings, including workforces, health and social care settings and care homes. In schools, all pupils in years 8-14 and all staff were offered LFDs.

Loop-mediated isothermal amplification (LAMP) testing

In 2021, the PHA worked with the Education Authority and Queen's University Belfast to introduce a programme of LAMP testing for pupils and staff at special schools in Northern Ireland. LAMP is a saliva-based test and was felt to be easier than nose and throat swab LFD testing for some children who attend special schools.

The LAMP testing programme now uses a second laboratory, based at Ulster University, in addition to Queen's University Belfast. The testing has been made available to some staff in HSC Trusts as an alternative to LFDs.

Contact Tracing Centre (CTC)

The PHA Contact Tracing Service continued work in 2021/22. While the successful introduction of the COVID-19 vaccine meant less severe disease in many people; the delta and omicron variants were much more transmissible and led to much higher numbers of cases than in previous waves.

The PHA responded to this increased demand not only by increasing the headcount of our workforce at pace, but also by introducing a different model of working. We introduced a Tracing Technician role to trace non-complex cases which were triaged by the senior team.

This also allowed us to focus effort on increasing the uptake of the Digital Self Trace platform which increased to around 30% at the peak of the delta wave. We refined the tracing script in response to each wave in order to ensure that the public health interventions for close contacts were timely.

The return of schools and colleges in September 2021 coincided with the peak of the delta wave. This caused a much higher workload for school leadership teams who had been supporting contact tracing by identifying in-school contacts. The definition of a school-aged contact was then revised in line with practice across the UK, and the PHA undertook the entire process. In parallel we worked closely with colleagues in the Education Authority to support the establishment of a helpdesk where they were the first point of contact for mainstream schools and PHA contact channels remained open for support for special schools.

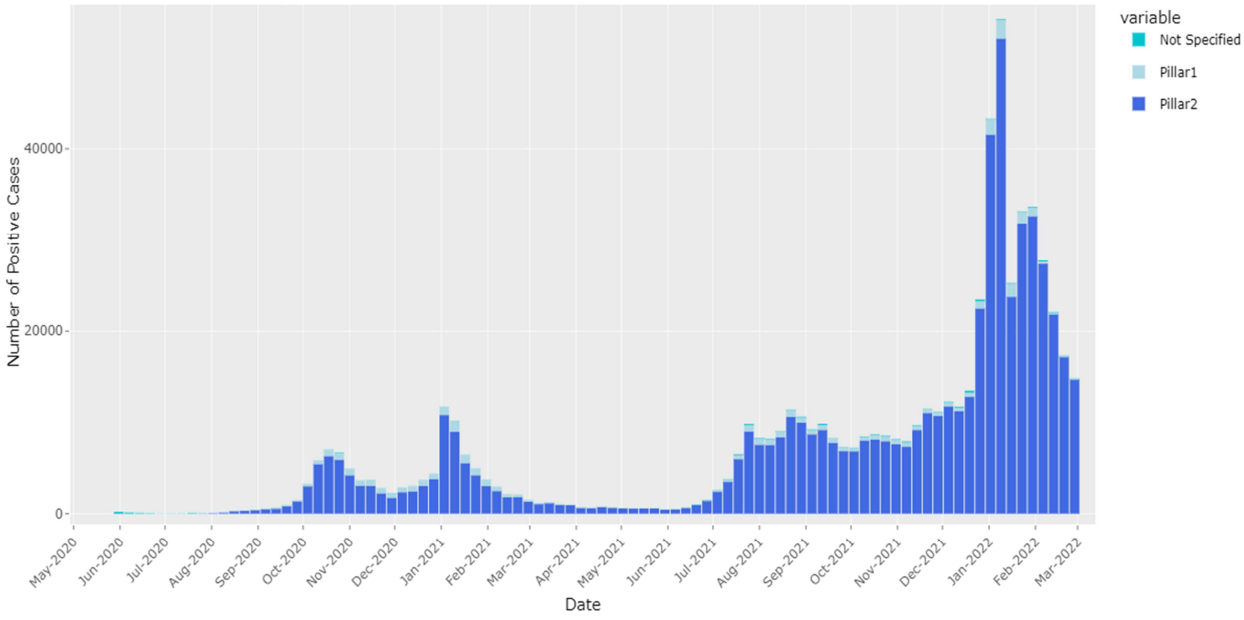
In order to provide resilience for the Contact Tracing Service we continued to train staff from the wider PHA who were able to support during the delta and omicron waves when case numbers reached previously unseen levels.

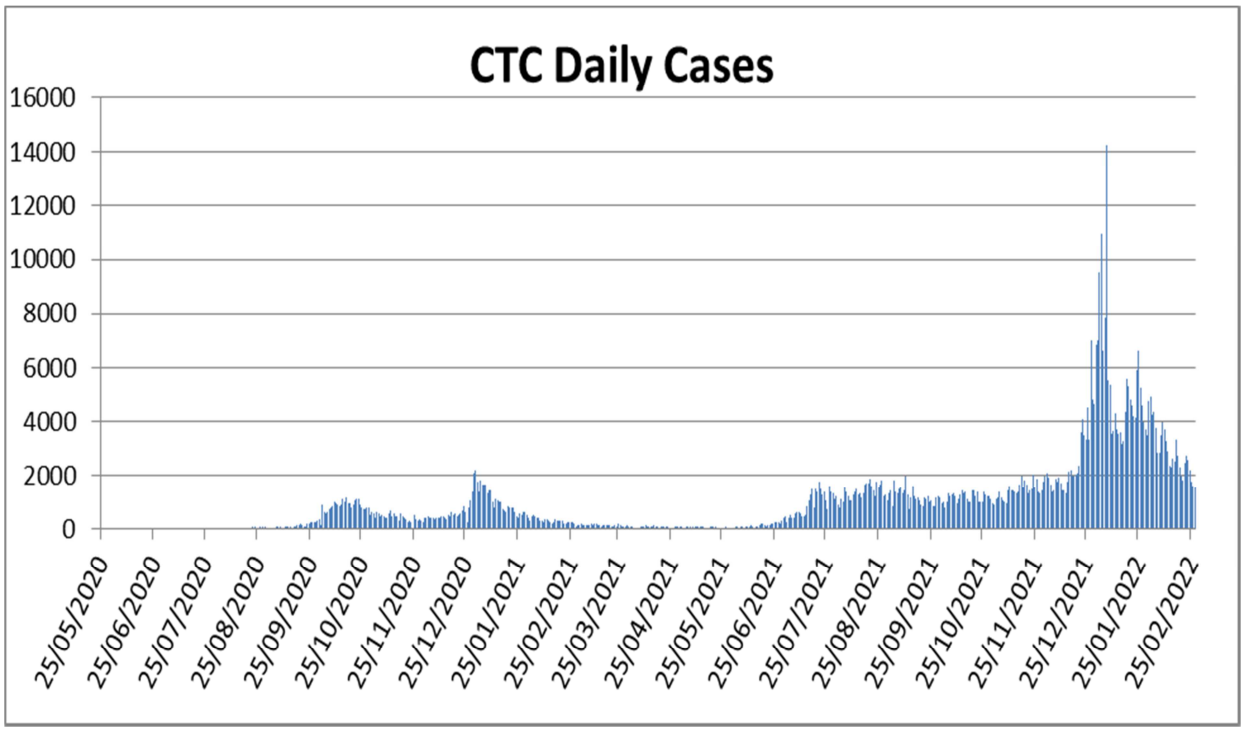
Throughout the year, the PHA responded to various changes in policy and operations including for returning travellers, isolation periods and close contacts. We supported the investigation of clusters, outbreaks and new variants. We provided vital information through our analytics strands that influenced modelling and

decisions on societal restrictions. The PHA continued to perform well even when case numbers exceeded all expectations. We are incredibly proud of our achievements this year and the people who made them happen.

The following charts illustrate the levels of contract tracing cases over the period May 2020 to March 2022.

CTC Cases per week





COVID-19 Vaccination Programme

Under the direction of the Department of Health, the COVID-19 vaccination programme has been successfully rolled-out in Northern Ireland, with over 3.7 million doses given to date (achieving 88.38% uptake of first doses in those over the age of 12).

The PHA has been instrumental in supporting the delivery of this programme with strategic involvement from the outset, through the provision of a public communication strategy, developing resources to enhance the campaign, producing PGDs to facilitate vaccine administration, and providing expert advice to healthcare professionals and the general public. The programme has substantially reduced the risk from severe COVID-19 and is estimated to have prevented between 23.7 and 24.1 million infections and between 119,500 and 126,800 deaths in the UK to date.

In advance of the transition of the COVID-19 vaccination programme to the PHA, the children's and young people vaccination programme has been guided by the PHA immunisation team. In conjunction with paediatricians and Child Health Heads of Services, the PHA worked to identify cohorts of children requiring vaccination. Children were issued letters inviting them to bespoke clinics arranged by each HSC Trust. The PHA communications team also worked to produce children-specific information leaflets for parents. While overall uptake was low (approximately 35% of the estimated cohort), the child health teams were able to deliver vaccines to CEV children under very short timescales with most HSC Trusts offering clinics within three weeks of the announcement in July despite challenges such as venue and staff availability.

In September 2021, the programme was extended to all 12 to 15 year olds. Historically, immunisation programmes in school settings have been successful, with Northern Ireland achieving excellent uptake rates for other teenage immunisations such as HPV and School Leaver's Booster. With this model in mind, the PHA Immunisation Team worked with HSC Trust school nursing teams to administer the COVID-19 vaccine. With the assistance of the Education Authority, the programme

was rolled-out through schools and vaccination was offered to all eligible post-primary school children in Northern Ireland by the end of January 2022.

Surveillance of the COVID-19 vaccination programmes has been enhanced via a new digital analytics platform, the Vaccine Management System (VMS). This functions as a clinical information system to capture vaccine administration at the point of care and also permits multi-layered interrogation of the data. It is used to generate dashboards to display vaccination uptake rates and identify locations which may require additional resource or an increase in the accessibility and convenience of vaccination availability.

These dashboards have been used to re-invigorate COVID-19 vaccine low uptake groups. This is a cross-directorate taskforce convened within the PHA to target interventions within communities and enable fair access and opportunity for individuals to receive the COVID-19 vaccination. An action plan has been agreed to focus the efforts of all stakeholders within the low uptake groups, and a digital toolkit created which offers a collection of resources to support the development of targeted initiatives.

The whole scale provision of this vaccination at a population level has had an impact on other vaccine programmes. In addition to monitoring and responding to the anti-vax protests associated with this vaccination and in particular the schools programme, there has been ongoing efforts across health and social care to make provision for all other vaccines. Despite this, there has been a significant reduction in uptake of other vaccines including HPV, childhood vaccine programmes, school leaver's vaccines and the shingles vaccine programme.

As the COVID-19 vaccination programme becomes embedded into routine healthcare practice and transfers to a business as usual model, there is a planned transition of the adult vaccination programme to the PHA. The investment and leadership demanded of this extensive programme has been reviewed and will require additional staffing resource, a review of current processes and pathways in addition to new ways of working across the Health Protection Directorate and the PHA.

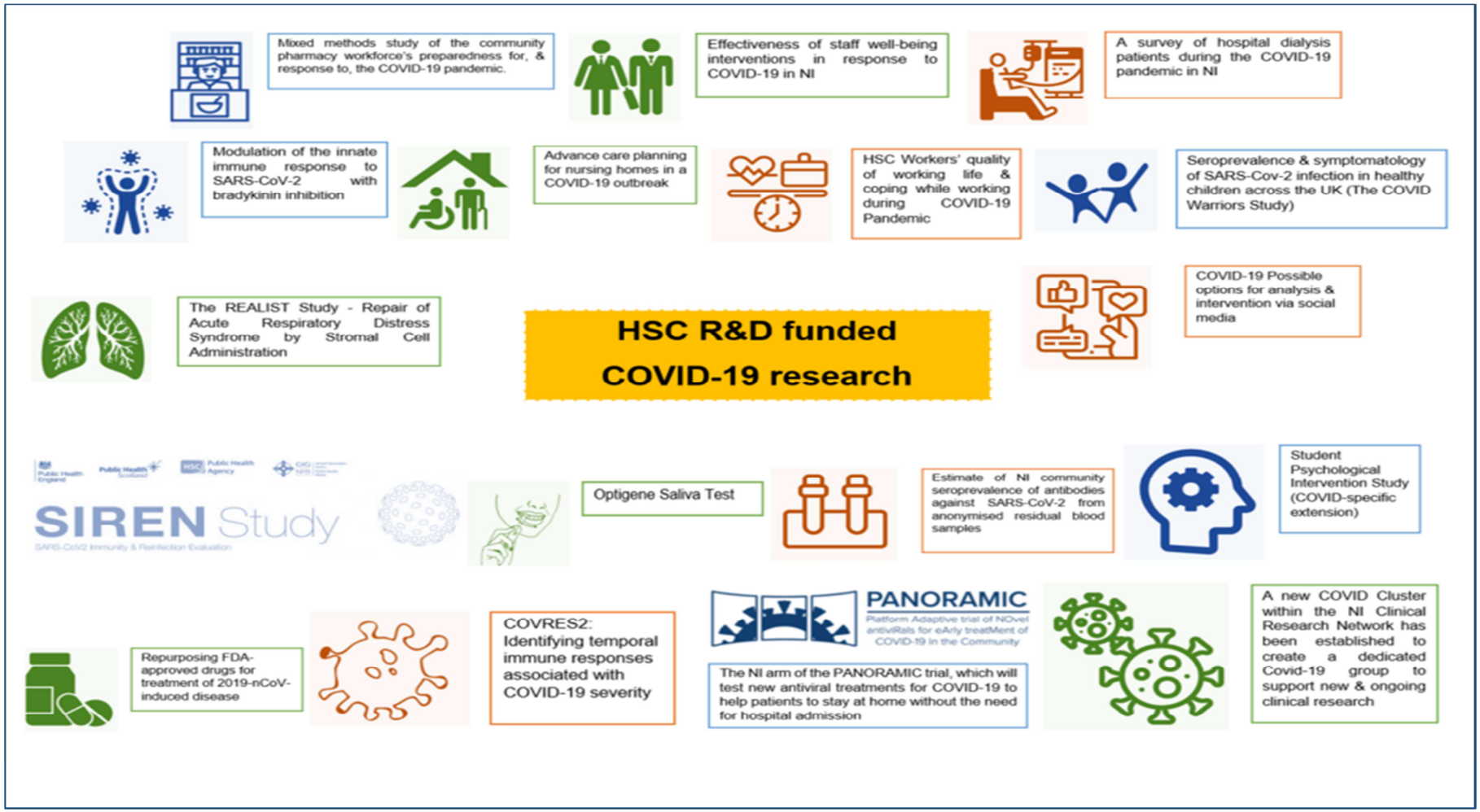
HSC Research and Development

There have been many direct and indirect impacts of the COVID-19 pandemic on health and wellbeing, often exacerbating existing health inequalities.

The last 24 months have made patients, practitioners, policy makers and the public more aware of the importance of research. They have seen how the development of vaccines and diagnostic tests and the identification of treatments that both work, and don't work, for COVID-19 has relied on research, in particular clinical trials. Research conducted during the pandemic has made an immense positive impact on so many people's lives and offers us all hope for the future.

The PHA Health and Social Care Research and Development Division (HSC R&D) has been at the forefront of the coordination, administration, support and funding of the HSC research ecosystem in Northern Ireland, in particular clinical trials infrastructure (see footnote page 30), to effectively manage the COVID-19 pandemic and ensure we save lives, protect our HSC services and rebuild services to ensure the health and wellbeing needs of society are effectively addressed. Almost 30,000 participants from Northern Ireland including staff, patients, carers, students, children and the wider public have now been recruited to participate in COVID-19 research.

As society seeks to look beyond the pandemic, HSC R&D Division is acutely aware that the recent priority focus on COVID-19 research, the re-direction of research resources to the care of COVID-19 patients and the impact of measures to contain the spread of COVID-19 has had negative effects for other areas of research. Many studies were slowed or paused, while others have been abandoned and some that were due to start are still pending. We now need to seize the opportunity to re-invigorate research in NI and build on the successes seen with COVID-19 to re-start and grow research activity across all areas of health and social care. Clinical research has been critical to the treatment of citizens during the pandemic and is even more crucial for our recovery. We need to move forward with research, setting an agenda that focuses on and is responsive to the most pressing health and social care needs of our society.


Mixed methods study of the community pharmacy workforce's preparedness for, & response to, the COVID-19 pandemic.
Effectiveness of staff well-being interventions in response to COVID-19 in NI
A survey of hospital dialysis patients during the COVID-19 pandemic in NI
Modulation of the innate immune response to SARS-CoV-2 with bradykinin inhibition
Advance care planning for nursing homes in a COVID-19 outbreak
HSC Workers' quality of working life & coping while working during COVID-19 Pandemic
Seroprevalence & symptomatology of SARS-Cov-2 infection in healthy children across the UK (The COVID Warriors Study)
The REALIST Study - Repair of Acute Respiratory Distress Syndrome by Stromal Cell Administration
HSC R&D funded COVID-19 research
COVID-19 Possible options for analysis & intervention via social media
SIREN Study
Optigene Saliva Test
Estimate of NI community seroprevalence of antibodies against SARS-CoV-2 from anonymised residual blood samples
Student Psychological Intervention Study (COVID-specific extension)
Repurposing FDA-approved drugs for treatment of 2019-nCoV-induced disease
COVRES2: Identifying temporal immune responses associated with COVID-19 severity
PANORAMIC
Platform Adaptive trial of NOvel antiviRals for eArly treatMent of COVID-19 in the Community
The NI arm of the PANORAMIC trial, which will test new antiviral treatments for COVID-19 to help patients to stay at home without the need for hospital admission
A new COVID Cluster within the NI Clinical Research Network has been established to create a dedicated Covid-19 group to support new & ongoing clinical research

In addition to core R&D business, the Division was on call to support cross-agency activities, such as providing a Scientific and Technical Cell during the acute phase of the pandemic, re-deploying team members to support the contact tracing centre, and leading on activities in partnership with other government and academic institutions.

These included:

- coordinating a local antibody serology study in partnership with the universities and DAERA colleagues, which fed into the pandemic modelling group;
- supporting the roll-out of the UK-wide COVID-19 infection survey in Northern Ireland in partnership with the UK Office of Life Sciences, Department of Health and Northern Ireland Statistics and Research Agency;
- convening a Behaviour Change Group, drawing stakeholders from across government and academic sectors to provide insights to various Departmental and Executive groups; and
- contributing to the creation of a UK-wide research participant registry of volunteers willing to take part in vaccine trials and other research with colleagues from the Department of Health and Social Care, the National Institute of Health Research and our counterparts from Chief Scientist Office in Scotland and Health and Care Research Wales.

We are most grateful to all our partner organisations with whom we were able to play our part in a highly effective response to the COVID-19 crisis.

**The clinical trials infrastructure refers to the necessary resources (human capital, financial support, patient participants, information systems, regulatory pathways, and institutional commitment) and the manner in which they are organised and brought together to conduct a clinical trial.*

Infection Prevention and Control

During the year the PHA-led Infection prevention and control (IPC) Cell has continued to be an important forum for ensuring regional consistency of IPC practices across Northern Ireland and also for providing advice and guidance for organisations such as the Department of Education and care home providers. The PHA also has representatives on the National IPC Cell which ensures Northern Ireland input and influence to national guidance including the development in year of *'Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022'* within Northern Ireland.

The COVID-19 pandemic has highlighted the importance of IPC and therefore the PHA has commissioned work to develop a Regional IPC Framework and a Managed Care Network. This framework will be an excellent opportunity to shape IPC practice across the HSC, improve standardisation and build capacity of IPC Teams. We also aim to establish a Managed Care Network and this will replace the current Regional IPC Cell.

During the year, effective regional cluster and outbreak management has been undertaken by PHA Health Protection and HSC Trust IPC Teams with support from the IPC Cell. The IPC Cell has recently developed a standard operating procedure (SOP) to support Care Homes with the management of outbreaks. This outlines the actions required to be taken and will streamline the process avoiding duplication.

Health Intelligence

COVID-19 prompted a step change in the demand for population health intelligence to inform the public, media, policymakers, health service planners and researchers.

Healthcare data were used to manage the direct care and contact tracing of patients, to measure the incidence and severity of COVID-19, to improve healthcare safety, to project the course of the epidemic and to address health inequalities.

The scale and pace of this data has continued during 2021/22 requiring adoption of new approaches towards work-flow, data architecture, storage, analysis and dissemination. We have used cloud-based architecture, scheduled reports, deployed dashboards and leveraged each-others' knowledge by sharing code in an internally-hosted GitHub. We now have integrated health surveillance across routine datasets, including genomic data, following our participation in the COG-UK programme.

PHA Analysts have over the course of the year been able to provide evidence about public knowledge, attitudes and behaviours associated with getting the COVID-19 vaccination, COVID-19 vaccine effectiveness and how mental health and social factors may influence the equity of vaccine coverage (through work undertaken through the BSO Honest Broker Service).

Direct public engagement about the use of health data was undertaken by the Northern Ireland Trusted Research Environment, supported by Health Data Research UK. The PHA participated in the HDR-funded Data and Connectivity Vaccines Pharmacovigilance research study and CO-CONNECT project, which both featured exemplary personal and public involvement and engagement (PPIE).

Our ability to deliver population-level health insights at scale and speed has been greatly enhanced.

Population Screening Programmes

Very high risk breast screening, newborn bloodspot, newborn hearing and screening for infections in pregnant women have continued uninterrupted throughout the pandemic. All staff involved in these programmes should be commended for ensuring that these critical services continued to be delivered to high standards and in a timely way during challenging times.

A number of the population screening programmes were temporarily paused during the first wave of the COVID-19 pandemic in 2020, so efforts in 2021/22 have focused on recovering these services and addressing the resulting backlogs in invites. As each programme is delivered in a different way, they have each faced different challenges in this rebuild process.

The Breast Screening Programme has taken significant steps to recovering the round length of screening (the time between screening invites). While the standard is that women should be offered screening every 36 months, this had stretched to 40 months by October 2020. Through the provision of additional screening clinics, both in hours and out of hours, within mobile and static sites, as well as the engagement of Action Cancer to provide an additional 2,000 appointments during 2021/22, by the end of March 2022 appointments were being offered to women just 5 weeks over their due invite date.

The Cervical Screening Programme has found it more difficult to recover backlogs due to continued pressures in primary care, laboratories and colposcopy services. The programme continues to operate with a 5 month delay in invitations and we will continue to keep this under close review exploring any possible opportunities to address and improve this position.

The Aortic Aneurysm Screening Programme, aimed at men aged 65, has taken some time to re-establish access to all their screening sites and has been working through the cohort of men who were due for screening in 2020/21. By the end of March 2022, 97% of the 2020/21 cohort were invited for screening and it is intended that the remaining will be invited by the end of June 2022. Invitations to men within

the 2021/22 cohort commenced in January 2022 and PHA continues to work with the Belfast Trust to explore options for further expanding the capacity of the service to reduce these backlogs.

The Diabetic Eye Screening Programme moved rapidly to a new model of providing services at a smaller number of fixed sites rather than at individual GP practices. As capacity has been limited due to constraints such as social distancing and infection control requirements, a two year screening interval was also introduced for those at lower risk of sight threatening retinopathy. The programme has worked extremely hard over the last 18 months to screen as many participants as possible, and continues to identify and secure new screening venues across Northern Ireland to support ongoing recovery and modernisation of the programme.

The Bowel Cancer Screening Programme introduced a new test for screening in January 2021, Faecal Immunochemical Testing (FIT). One of the key benefits of FIT is that it is an easier test kit to complete and studies elsewhere had demonstrated that moving to FIT had increased participation in screening. After one year of FIT in Northern Ireland, and despite the ongoing challenges of the pandemic, provisional data suggests that we are in fact seeing improvements in screening uptake, which is to be welcomed and will ultimately result in more cancers being identified and treated at an early stage. The programme continues to operate with backlogs in invites as a result of the pause in 2020. These are being reduced in a managed way, with the anticipation that the programme will be fully restored by autumn 2022.

The pandemic has also created opportunities to show flexibility and to explore and trial new ways of working. A long term project with the Women's Resource and Development Agency (WRDA) to promote informed choice in cancer screening moved from face to face sessions with community groups to a virtually delivered service. This ensured that this important work to promote participation in cancer screening continued successively during the pandemic. As we now move once again to in person meetings, the mode of delivery is shifting back again. This hybrid model of service delivery is now likely to continue into the future to better meet the needs of the target population.

Allied Health Professionals (AHP)

Development of Post-COVID syndrome services

During the year PHA AHP and Nursing teams worked in collaboration with HSCB colleagues to lead the development and implementation of services to support patients suffering the longer terms effects of COVID-19 (post COVID syndrome). This ensured the appropriate allocation of AHPs and nurses in the primary care-facing multi-disciplinary clinics, bespoke pulmonary rehabilitation services and post-ICU follow up clinics. Services are now available regionally.

AHP Non-medical prescribing (NMP) education and training resources

Education and training resources are now available to support the ongoing continued professional development of our AHPs involved in the management of medications. This was identified as a gap through the Regional AHP NMP forum. Online mandatory training was developed in partnership with the Clinical Education Centre and will be available to support over 1,300 AHPs. The PHA has worked with colleagues in the DoH and Northern Ireland Centre for Pharmacy Learning and Development (NICPLD) to secure access to NICPLD resources for the 200 AHP independent and supplementary prescribers. This will ensure NMP AHPs are able to maintain their competencies through ongoing continued professional development.

Promoting health and wellbeing of residents in care homes

PHA AHP and Nursing teams established and led a regional Extension for Community Healthcare Outcomes (ECHO) with care home activity coordinators to promote meaningful activity and social interaction in their work with residents. These ECHO sessions allow sharing of information, advice and resources and provide an opportunity for activity coordinators to meet regionally. In year sessions have included the themes of meaningful activity in care homes; bringing music activities to people living in care home settings; Christmas activities; intergenerational activity ideas; Montessori approach for ageing and dementia; and healthy ageing and physical activity awareness.

Engagement in meaningful activity was also promoted by developing, in partnership with occupational therapy and care home partners, a resource to support care home

staff to promote meaningful activity. This resource is aimed at care home staff and provides helpful tips and advice on the importance of promoting activity and selecting suitable activities.

AHPs in public health

The Northern Ireland AHP Public Health Group, led by the PHA, is responsible for progressing the goals of the UK AHP Public Health Strategic Framework 2019-2024. Over the course of the last 12 months the group has focused on key areas of the UK AHP Public Health Strategic Framework to highlight and strengthen the impact of AHPs in Northern Ireland. This includes population health, preventing and reducing health inequalities, raising awareness both among AHPs and throughout the HSC of the public health role of AHPs and highlighting the impact of AHP interventions on population health and health inequalities. We also established communication networks and accessibility to resources to support AHPs in developing their public health roles and sharing best practice, representing AHPs in wider HSC staff health and wellbeing initiatives.

Partnering with People – Delivering on Personal and Public Involvement (PPI) and Patient Client Experience (PCE)

The PHA has continued to support cultural change within the HSC so that the active involvement of and partnership working with people with lived and living experience becomes the norm. In 2021/22 the PPI team focused on building understanding, skills, knowledge and expertise in involvement, co-production and partnership working with HSC staff, service users and carers.

Some 200+ participants have now undertaken the Leading in Partnership programme. A number of staff were also facilitated to achieve their Certificate of Professional Development or Advanced Practitioners Certificate in Involvement and our webinar series had almost 1,000 people engaged. This is key in helping to build capacity to effect real change through meaningful involvement leading to improvements in quality, safety and efficiency.

In 2021/22 there was growing commitment to embedding PCE methodologies into care homes in Northern Ireland, reaching out to residents, relatives and staff. This included leading in collaboration with the Patient Client Council on an online survey to inform the Executive Plan for Visiting in Care Homes. Over 1,400 returns were analysed and provided valuable insight into how to improve the experience for residents, relatives and staff. This approach ensured the PHA *Guidance on Visiting in Care Homes* was person-centred and offered a balance to deliver a safe and meaningful plan. The work in care homes continues to grow with development of a Snapshot survey and the implementation of the Online User Feedback Service (OUFS) across the care home sector to support the voice of residents and families.

In 2021/22 Public Health Agency continued to lead on the implementation of the OUFS, Care Opinion, across the whole of the HSC. There are currently over 5,000 stories collated through the service and over 150 changes recorded as informed by the stories. This service delivers a two way feedback mechanism between the author and the service and the PHA have supported thematic analysis of key areas including vaccinations, primary care, general surgery, children and young people and maternity and neonatal, to ensure the voices impact decisions at a strategic level.

Health Improvement

Health Improvement has developed a 'Recovery Plan' focused on short term actions (2021/22), medium term (2022-25) and long term (2025+).

The Recovery Plan is presented using a theory of change approach. The plan sets out a series of outcomes we have achieved over the 2021/22 financial year and those we are planning for the next four years, including whom we need to work with and the actions we will undertake to meet the desired outcomes.

Central to implementation of the Recovery Plan this year was the need to adjust and maintain health improvement services within the context of COVID-19 and to enhance cross agency and external partnership working.

Progress against the desired outcomes of the Recovery Plan has been strong. However, our ability to deliver at the anticipated pace and scale across all 20 thematic areas has been adversely impacted over the last few months by public health guidance/regulations and redeployment of 70% of staff. Some of the highlights across the four pillars of the plan for 2021/22 financial year are:

1. **STRATEGY** - Influence and align the policy of others to address health inequalities and the wider determinants of heath:
    - influence the tender process for rural support networks from the Department for the Agriculture, Environment and Rural Affairs to include health inequalities;
    - the submission of a collective response to the Mental Health Strategy 2021-2031 and a response to the Crisis Services Review; and
    - implementation of Nutritional Standards across healthcare settings.

2. **SYSTEM** - Enhance multi-disciplinary working across our organisation and towards a wider health and care system:
    - establishment of a new internal team PHA Strategic Team for Mental and Emotional Wellbeing and Suicide Prevention and commitment from local

PLIGS and Drug and Alcohol Coordination Teams to work on common mental health, suicide prevention and drug and alcohol issues.

3. **INFRASTRUCTURE** - Work in partnership to plan and deliver for the places and communities we live in, and with:

- preparatory work with Department of Health, PHA, Environmental Health and local Council representatives regarding enforcement for new legislation relating to smoking in cars with minors and age sales of electronic cigarettes. Tobacco Control Officers (funded by PHA) to have joint enforcement duties alongside the Police Service of Northern Ireland.

4. **PEOPLE** - Deliver evidence based services:

- Northern Ireland is the only part of the UK to maintain both Needle and Syringe Exchange Service and Take Home Naloxone services throughout the pandemic; and
- all PHA mental health, emotional wellbeing and suicide prevention services and training programmes have been maintained and enhanced where needed throughout the last year, making adaptations to manage COVID restrictions / guidance where necessary. Services moved on-line and via telephone, with face to face services been maintained where necessary (within COVID guidelines). This includes regional services such as Lifeline and the Self Harm Intervention Programme (SHIP). Lifeline received 33,979 calls and SHIP provided support for almost 3,000 individuals and carers /families.

This is only a snapshot of outcomes identified by staff leads across health improvement for the 2021/22 Recovery Plan. A schematic of the theory of change model is provided in the table overleaf.

Kings Fund Population Health Model	Health Improvement (HI) Recovery Plan Strategic Pillars	HI Recovery Plan Strategic priorities *(conditions to be met)*	Making Life Better Themes	PHA Corporate Outcomes	Societal outcomes (PfG)
The wider determinates of health	**Strategy (policy)**	Influence and align the **policy** of others to address health inequalities	• Give Every Child the Best Start • Equipped Throughout Life • Creating the Conditions • Develop Collaboration	• All children and young people have the best start in life. • All older adults are enabled to live healthier and more fulfilling lives. • All individuals and communities are equipped and enabled to live long healthy lives. • All health and wellbeing services should be safe and high quality. • Our organisation works effectively.	• Our children and young people have the best start in life • We have an equal and inclusive society where everyone is valued and treated with respect • We all enjoy long, healthy, active lives • Everyone can reach their potential • We have a caring society that supports people throughout their lives • People want to live, work and visit here.
An integrated health and care system	**System** ***(process)***	Enhance **multi-disciplinary working** across the organisation Strengthen **collaboration and integration** within the health and social care system	• Empower Healthy Living • Develop Collaboration		
The places and communities we live in, and with	**Infrastructure (communities)**	Work in **partnership** to plan and deliver Build **capacity** for public health	• Equipped Throughout Life • Empower Communities • Develop Collaboration		
Our health behaviours and lifestyles	**People (individuals)**	Raise **awareness** of services and support available Deliver **evidence based** services Improve **health literacy** to reduce inequalities	• Give Every Child the Best Start • Equipped Throughout Life • Empower Healthy Living • Develop Collaboration		

Safety, Quality and Experience Nursing Team

During the year the PHA Safety, Quality and Experience Nursing Team has led on several key pieces of work in supporting frontline staff in the prevention and management of pressure ulcer prevention through the Regional Pressure Ulcer Prevention Group. Through the group the PHA provides advice and support, and shares learning across the HSC.

Annual Quality Report

In line with the implementation of the *Quality 2020 Strategy*, the PHA and HSCB have continued to produce an *Annual Quality Report* to showcase work that improves the quality, safety and effectiveness of health and social care services.

The report was developed to cover a range of topics and focuses on areas of work which firstly transform the culture of our organisation. It highlights the PHA/HSCB safety and quality governance structures and describes how we have worked to create a learning culture and continue to seek new ways to improve how we learn from errors.

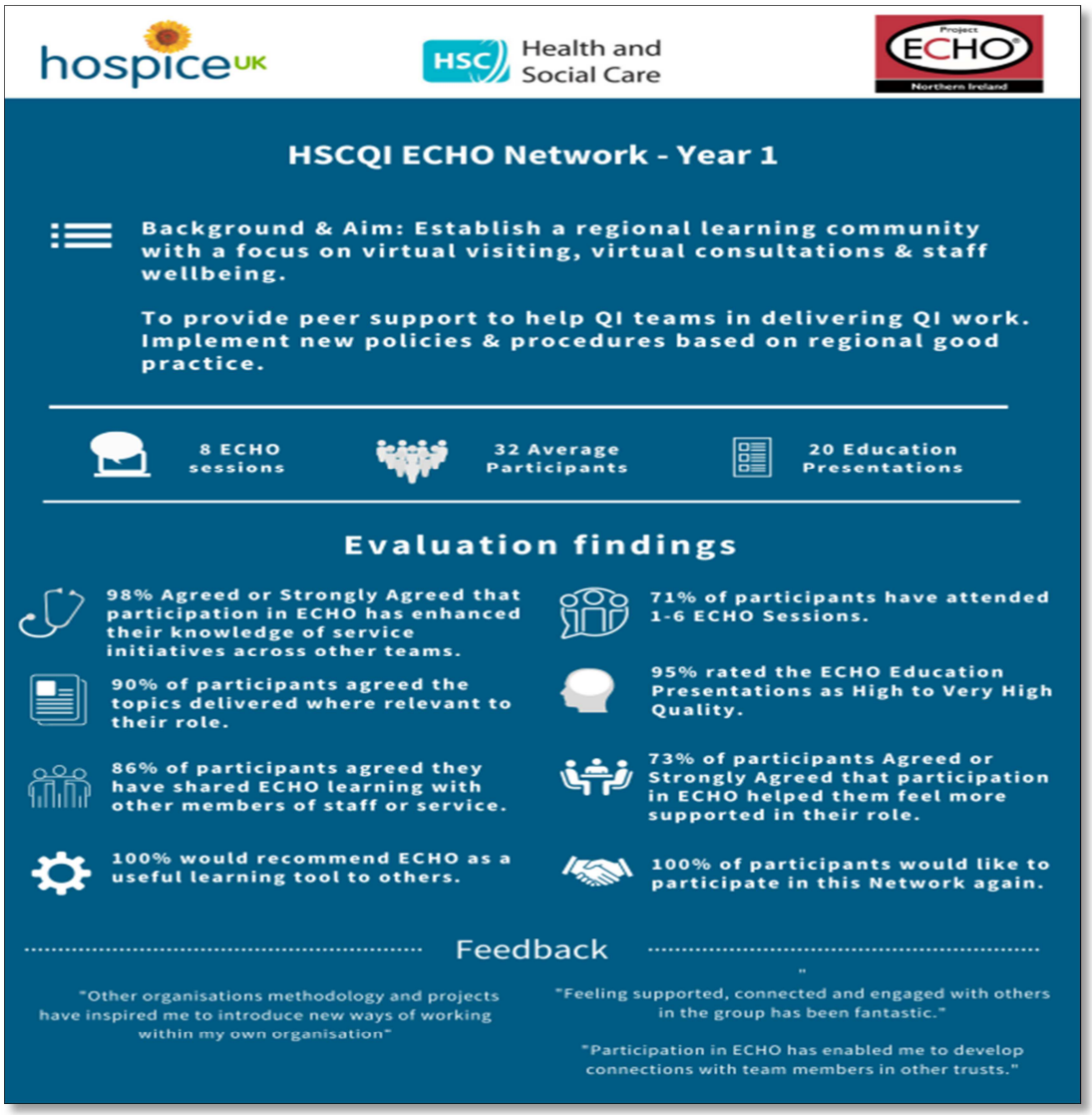
On World Quality Day in November 2021 the report was launched alongside other HSC Annual Quality Reports. Launching the reports on World Quality Day enabled the PHA/HSCB and other HSC organisations to reinforce the importance of reviewing our work through an 'improving quality' lens; and it enabled us to highlight the HSC system-wide approach to improving the quality of health and social care.

Health and Social Care Quality Improvement (HSCQI)

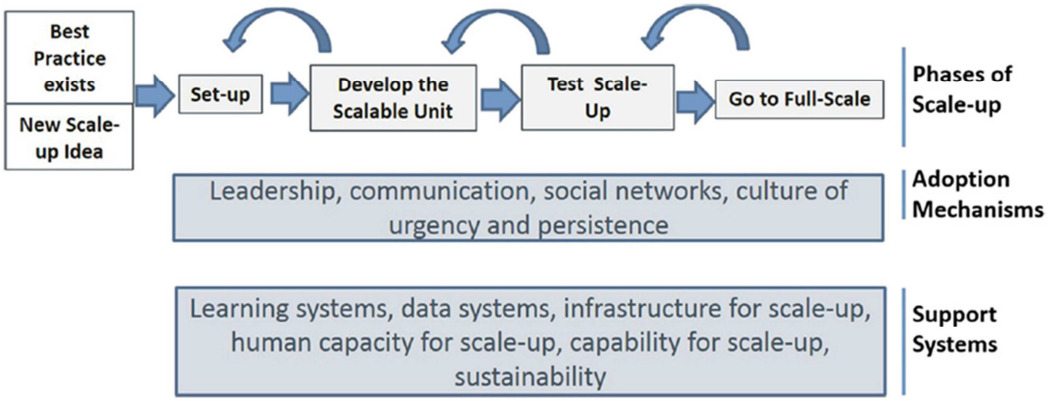
HSCQI Regional Learning System

A key priority for HSCQI in 2021/22 was to make further progress on the establishment a HSC Regional Learning System. This built on the 90 day learning cycle approach undertaken in 2020/21 which identified three key themes, namely, Staff Psychological Wellbeing, Virtual Visiting and Virtual Consultations.

HSCQI continued in partnership with the regional Extension for Community Healthcare Outcomes (ECHO) project team to support shared learning with a focus on data and evidence for improvement through monthly learning sessions. The evaluation summary of these is outlined below:



Further engagement across the HSCQI network continued throughout 2021/22. Informed by these discussions the HSCQI Hub team conducted a literature review focused on learning systems to identify a robust scale and spread framework. The IHI Framework for Going to Full Scale (below) was proposed and subsequently endorsed by the HSCQI Leads and the HSCQI Leadership Alliance.



IHI Framework for going to Full Scale

QI Capability

HSCQI have completed a scoping exercise with HSC Trusts to identify staff that have completed level 3 Quality Improvement programmes (aligned with the Q2020 Attributes Framework). Between January and March 2022 HSCQI extended this scoping exercise across all PHA Directorates to obtain baseline data which will support future planning of quality improvement training and activity in the PHA.

In addition the HSCQI Hub team have explored options to facilitate the delivery of level 4 quality improvement training for Boards. This training will be focused on the leadership behaviours and approaches necessary to build safety cultures and learning systems.

Communications during the pandemic

Communicating effectively is a core foundation of public health in any context but in a pandemic it is particularly vital to ensure that information is shared at the right time to the right audience and in the most appropriate format so that the population is able to understand, accept and adhere to critical public health guidance.

In facing the many challenges presenting throughout 2021/22, the PHA's Communications team has continued to work proactively with internal and external stakeholders to deliver a sustained and agile multi-channel programme of communications across all aspects of pandemic management.

Team members have been embedded in strategic planning and delivery of all elements of the Test, Trace and Protect programme, leading communication for the testing programme in Northern Ireland and promoting and explaining the role of the Contact Tracing Service. This also included targeted communications to increase uptake of testing in local communities as new variants emerged as well as use of apps and digital self-trace to support contact tracing.

Throughout the year a significant volume of communications activity was undertaken to inform, advise and influence behaviour change with key target audiences. This was done through the creation and delivery of multi-channel communications, including proactive issuing of news releases, handling extensive media enquiries, an ongoing programme of mass media advertising campaigns, multiple publications including alternative formats - easy read, braille, ISl/BSL, translations and online information, and developing graphics and video content for the agency's social media channels – Facebook (currently around a quarter of a million followers), Twitter (currently over 32,000 followers) and Instagram (currently over 12,000 followers).

In the case of the COVID-19 vaccination programme, a diverse programme of sustained communications was essential in informing and encouraging uptake, particularly when the programme was extended out to the under-50s and younger audiences. Against a crowded communications backdrop characterised by a

significant scale of misinformed claims and counter claims the PHA has sought to achieve cut through of its messaging by focusing on the available evidence base and promotion of authoritative commentary from leading health experts at all times.

During the year it was a priority for the team to ensure that other significant public health messaging (non-COVID-19) was advanced. We successfully delivered a sustained programme of proactive messaging on a broad range of public health portfolios across directorate areas, helping to ensure that people continued to be empowered and informed around looking after their health and wellbeing.

A total of six Living Well campaigns were delivered in over 500 community pharmacies. The campaigns included: know your limits (alcohol); be cancer aware; boost your immunity - flu and booster vaccination; healthier choices (weight control).

FAST stroke symptom awareness and portion control/healthy weight campaign were also delivered. PHA communications also lead in raising awareness and encouraging support for preventing smoking in cars and the use of nicotine inhalation products in accordance with regulations introduced February 2022.

Finally, the PHA Communications programme has over the past 10 years successfully increased awareness of and support for Organ Donation in Northern Ireland. The passage of legislation by the Northern Ireland Assembly (Final Stage on 8 February 2022) and subsequent Royal Assent on 30 March 2022, which will introduce a new Opt Out system was widely welcomed across Northern Ireland and reflects positively on the role played by the PHA Communications and Knowledge Management team throughout.

New Planning Model and Population Health Planning Framework

During 2021/22, the PHA has further developed a framework for population health planning. The framework aims to provide a practical guide of principles and actions to enable the shift towards and consistent implementation of population health planning. It draws on existing literature, frameworks and Northern Ireland's experience so far and is intended as a practical guide to embarking on population health planning.

Population health has been a key strategic direction in Northern Ireland for many years as set out in the *Programme for Government*, *Making Life Better Public Health Framework* and *Delivering Together Strategy*. These documents advocate for, and recognise that, in order to have a real and lasting positive impact on improving the health and wellbeing of and reducing inequalities in the communities we serve we must consider:

- the impact of and need to address health inequalities;
- the impact of the wider determinants and where we live;
- the need for collaboration and for whole system approaches; and
- the need for shared longer term outcomes.

It is extensively documented that a shift towards population health requires collaboration and coordinated efforts across a range of sectors and wider communities. This also means that accountability for population health is spread widely across sectors, organisations and communities and is not concentrated in single organisations or within the boundaries of traditional health care services.

The New Planning Model for HSC is being developed with this in mind and is focused on population health planning, the need for collaboration and a whole system approach.

Northern Ireland has many, if not all, of the required building blocks for a successful shift towards a collaborative population health planning approach. The challenge lies

in how we build on and join these strategies and building blocks together alongside evidence-based initiatives to create a systematic approach to improving population health within and across our communities.

Mental Health, Emotional Wellbeing and Suicide Prevention Strategic Planning Team

In July 2021, the Agency Management Team agreed the development of a Strategic Planning Team (SPT) for Mental Health, Emotional Wellbeing and Suicide Prevention, following submission of a joint paper from the Operations, Nursing and AHP and Public Health Directorates.

The team, comprised of representatives from across the organisation, will work together to collaboratively plan and deliver PHA priorities and functions relating to mental health, emotional wellbeing and suicide prevention and will develop a shared, collaborative, outcomes-based planning and performance framework that sets out the PHA's role and priorities and a clear action plan.

Mental health, emotional wellbeing and suicide prevention are key priority areas and a major focus for the PHA. As focus turns to post-COVID-19 rebuild and recovery and to the preparations for implementation of a new planning model; as well as the development and publication of a number of strategies including a new Mental Health Strategy; it is important that the organisation has in place a connected approach across the organisation on how it plans and implements actions to effectively address these issues in relation to mental health, emotional wellbeing and suicide prevention.

Such a collaborative planning structure will enable the organisation to work closely together across teams and create a more aligned approach through shared priorities for mental health, emotional wellbeing and suicide prevention; combine resources effectively and demonstrate impact and outcomes in relation to achieving Corporate Strategy goals and objectives; and also show how it is contributing to delivering on the higher level outcomes set by the Northern Ireland Executive in its *Programme for Government*.

The aim of the team, as well as being a pilot for future SPTs, is to consider how PHA can work in a more connected way, harnessing skills, experience and knowledge from across the organisation and to enable more effective delivery of functions,

facilitate stronger links with other key strategic and thematic policy areas and demonstrate corporate agreement of decisions and actions. This approach also ensures organisational flexibility and corporate oversight through cross-directorate planning and delivery and will help PHA to react to external influences, prepare to support the new planning system and also to adapt to any new PHA structure and future while continuing to deliver on key functions, duties and responsibilities.

Planning and Operational Services

During 2021/22, Planning and Operational Services continued to provide essential support to enable the Contact Tracing Service to operate effectively. It also provided information governance expertise in assessing data protection issues linked to the sharing of personal information and the operation of digital platforms such as the vaccine management system.

Surge planning work undertaken in early 2021/22 identified the need to hugely expand the Contact Tracing Service workforce to meet forecast levels of infection. In response, in June 2021, Operations staff worked to ensure that the capacity in the existing Contact Tracing Centre was maximised and also prepared additional satellite offices for Contact Tracing Service staff to work from Belfast, Armagh and Londonderry. This was part of a phased expansion plan that was developed. Additional ICT resources were procured and delivered and workstations for the Contact Tracing Service established on the 3rd and 4th Floors of Linenhall Street as well as in the Towerhill and Gransha offices.

The establishment of the Belfast office also allowed the organisation to pilot a new model of contact tracing using Band 4 staff. This model has been operating since August 2021 and has been highly effective in providing additional capacity to meet the significant levels of demand for contact tracing experienced since late June 2021. The temporary development of other satellite offices facilitated the training and redeployment of core PHA staff as well as providing increased flexibility for existing Contact Tracing Service staff.

In addition to managing the expansion of the operational infrastructure for the Contact Tracing Service, Operations also led on the development of the business case for the Contact Tracing Service to ensure that the necessary funding was secured to support the scale and model of service required to meet changing demand throughout the year.

During 2021/22, there continued to be a large focus on providing information governance input to support the response to COVID-19. Information governance

support to the testing service continued during the year to support colleagues expand and develop the testing programme.

Also during the year the PHA become joint data controller with the Health and Social Care Board (HSCB), which became the Strategic Planning and Performance Group (SPPG) from 1 April 2022, for the personal data held by the COVID-19 and Flu Vaccine Management System (VMS). There was a large information governance input required to ensure the necessary arrangements were in place for managing all personal data in line with the UK *Data Protection Act 2018* and UK *General Data Protection Regulation* (GDPR).

PHA has also worked along with the Department of Health (DoH) and the HSCB on the development and delivery of the COVID Certification Service (CCS) and are Joint Data Controllers with DoH, and HSCB up to its migration to the DoH on 1 April 2022, for the personal information processed in the CCS and mobile App. The CCS solution provides citizens with an easily accessible, streamlined process for obtaining a certificate for use when providing evidence of their COVID-19 status when required.

In all instances where personal information is collected and processed, the necessary Privacy Notices and Data Protection Impact Assessments (DPIAs), as required, were in place. Additionally, where sharing of information occurs, the necessary Data Access Agreements/Data Sharing Agreements are in place.

Freedom of Information requests continue to rise significantly. There have been a large number of COVID-19 related Freedom of Information requests submitted this year, along with a range of other non-COVID-19 requests. More detail on this is provided in the section on Information Requests on page 62 of this document. These continue to be managed in line with the *Freedom of Information Act 2000*.

Forward Look 2022/23

Looking ahead to 2022/23, the PHA can be expected to continue to focus a significant element of our resources on addressing the ongoing COVID-19 pandemic

and ensure that key interventions to contain and manage the virus, such as further roll out of the vaccination programme, targeted COVID-19 testing, contact tracing, surveillance and public behaviour messaging are deployed in a proportionate and effective way and in line with emergent policy decisions.

While the PHA will continue to prioritise all actions necessary to effectively manage the COVID-19 pandemic it is important that in 2022/23 the PHA also focuses as much as possible on returning to 'business as usual' and addressing our wider corporate priorities, such as health inequalities, which have been further exacerbated during the pandemic.

Significantly, 2022/23 will see several strategic changes within the planning and delivery of Health and Social Care across Northern Ireland. From April 2022 the Health and Social Care Board has been replaced by a new Strategic Performance Planning Group (SPPG) under the direction of the DoH. New arrangements for the planning and commissioning of services will be stood up during the course of the year as a new Area Based Integrated Planning system is rolled out. The PHA will be required to engage fully to ensure we successfully optimise the potential for population health outcomes to be realised in partnership with the wider HSC and other key bodies.

At the same time there is also a need to plan how the PHA as the strategic lead for public health in Northern Ireland needs to change, taking on board the learning from the pandemic response to date and developments across health and social care and wider society, so that we ensure we have the appropriate skills, knowledge and expertise to best address the significant public health challenges facing Northern Ireland both now and in the future. To that end resource will be focused on supporting the PHA/DoH review of our operating model and structures that commenced in the final quarter of 2021/22.

FINANCIAL PERFORMANCE REPORT

The HSCB Director of Finance supports the PHA in the delivery of its core functions, including Financial Planning, Financial Governance, Financial Management and Financial Accounting services.

Financial Planning

At the outset of 2021/22 it was clear that the financial impact of the response to the COVID-19 pandemic would continue to necessitate agility in managing the resources available to the PHA. The variability of the required response of the changing landscape during COVID-19 and its impact on PHA's core business activities was closely monitored to the opening financial plan assumptions.

Looking forward into 2022/23, the ongoing response to managing the COVID-19 pandemic, inescapable cost pressures, rebuilding costs, inflation and the 2022/23 budget settlement requires the whole HSC system to continue to work closely together to ensure that resources are prioritised and sound financial management continues.

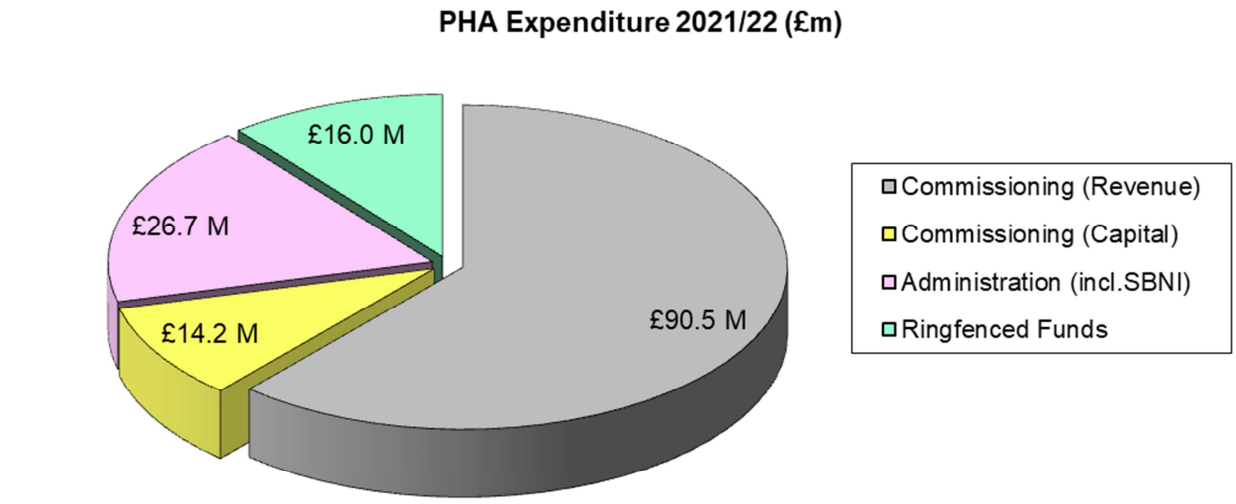
PHA Financial Management and Stability

The PHA received a revenue resource budget £134m in 2021/22, along with income from other sources of £4m and a further £14m capital funding was allocated to PHA in the year.

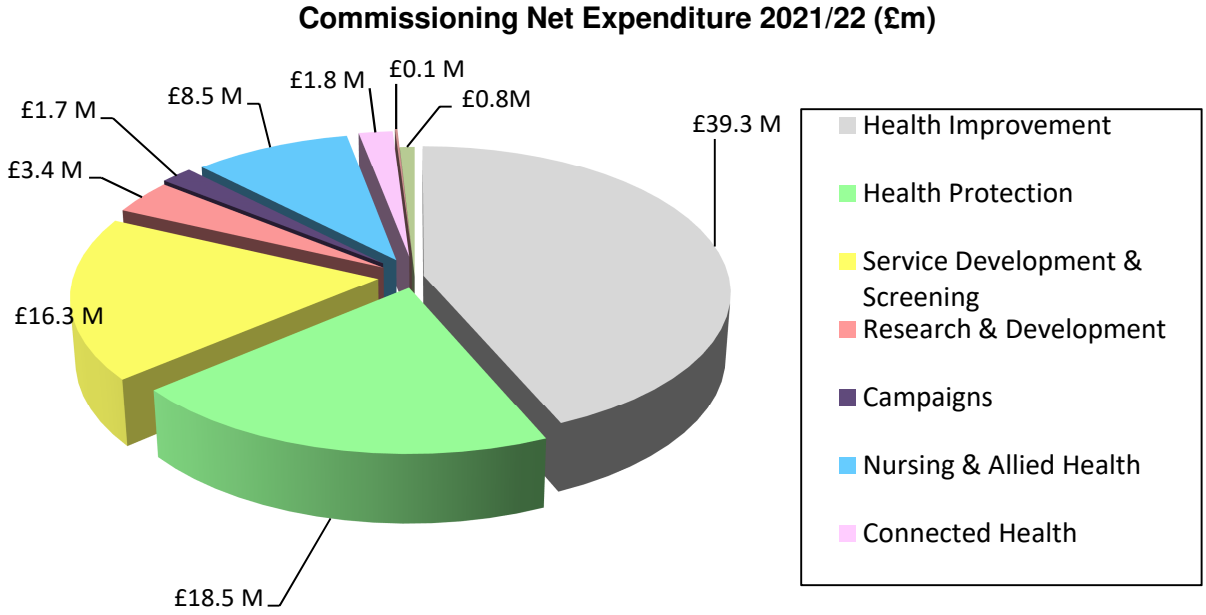
The financial statements presented in this Annual Report and Accounts highlight that PHA successfully delivered its breakeven duty with a small revenue surplus of £94k being reported. This was achieved by significant and diligent efforts on the part of PHA budget holders supported by the Finance Directorate (HSCB), in managing the wide range of slippage and pressures across both Programme and Management and Administration budgets set in the backdrop of the COVID-19 response.

The following charts highlight how the PHA's revenue funds have been utilised during 2021/22.

a. PHA Net Expenditure by Area 2021/22



b. Programme Expenditure by Budget Area 2021/22

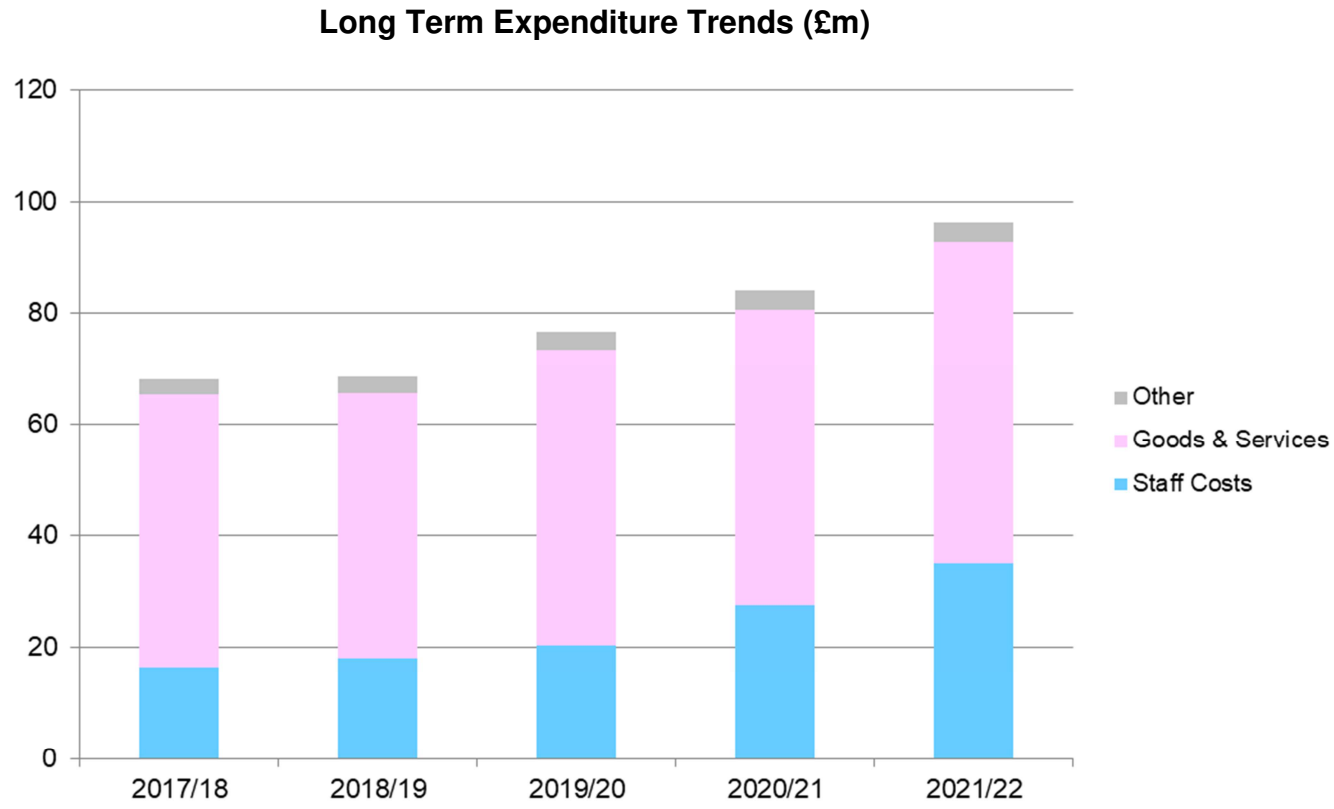


COVID-19 Allocations and Expenditure

During 2021/22, specific ring-fenced allocations earmarked for COVID-19 were allocated to the PHA from DoH. These allocations totalled £13.6m which allowed the PHA to support the region in its response to the pandemic. This included initiatives such as the operation of the regional Contact Tracing Centre, enhancing the level of staffing within Infection Prevention and Control Nursing and in Health Protection to provide ongoing support and guidance across the region and to increase the level of flu vaccinations available to the public.

Long Term Expenditure Trends

The following chart highlights how the main categories of expenditure within the Statement of Comprehensive Net Expenditure (SoCNE) have moved over the last 5 years. This relates to the revenue expenditure of the PHA.



Note: 'Other' includes establishment and premises expenditure and other items such as depreciation.

The impact of the additional expenditure in respect of the PHA's COVID-19 response is largely illustrated by the increase in expenditure levels from 2020/21 2021/22.

Prompt Payment Performance

a) Public Sector Payment Policy - Measure of Compliance

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

	2022 Number	2022 Value £000s	2021 Number	2021 Value £000s
Total bills paid	7,090	£72,467	5,764	£59,103
Total bills paid within 30 day target or under agreed payment terms	6,992	£68,086	5,433	£58,173
% of bills paid within 30 day target or under agreed payment terms	**98.6%**	**94.0%**	**94.3%**	**98.4%**
Total bills paid within 10 day target	6,215	£58,902	4,836	£55,986
% of bills paid within 10 day target	**87.7%**	**81.3%**	**83.9%**	**94.7%**

The PHA performed well above the 95% target for payments within 30 days, at 98.6% (2020/21, 94.3%) and has performed well above the 70% target of payments within 10 days, at 87.7% (2021/22, 83.9%).

b) The Late Payment of Commercial Debts Regulations 2002

The PHA paid no late payment fees in 2021/22 (£nil for 2020/21).

Sustainability – Environmental, Social and Community Issues

The Northern Ireland Executive Sustainable Development Strategy *Everyone's Involved* was published in May 2010, setting out a vision for a peaceful, fair, prosperous and sustainable society. The strategy is based on the following principles:

- Living within environmental limits;
- Ensuring a strong, healthy and just society;
- Achieving a sustainable economy;
- Promoting good governance;
- Using sound science responsibly; and
- Promoting opportunity and innovation.

The PHA is committed to the principles of sustainable development and endeavours to integrate these principles into our daily activities. We seek to increase awareness of sustainable development within the PHA generally and to ensure that wherever possible our overall business activities support the achievement of sustainable development objectives.

To meet these objectives we will encourage energy and resource efficiency in all our offices through:

- Working with landlords to maximise energy efficiency where possible;
- reminding staff to turn of lights, computers and other electrical equipment when not in use;
- where possible reducing the amount of printing; and
- as and when appropriate disseminate sustainable development best practice guidelines to staff.

To use our natural resources responsibly, through:

- using recycled materials where possible; and
- promoting recycling of appropriate waste.

To reduce our carbon footprint through how we work, in particular through:

- promoting the use of tele-conferencing and video-conferencing to reduce travel;
- supporting the use of travel smart schemes to promote the use of public transport; and
- supporting the cycle to work scheme.

Equality and Diversity

During 2021/22 the PHA completed the Five Year Review of Equality Scheme. The review drew on what members of Tapestry, the disability network for staff working in the PHA and its 10 regional HSC partner organisations, had to say about barriers they still face. It also involved input from a range of teams across the organisation. A number of commitments have been made as a result of the review for the next five years of Equality Scheme delivery.

Facilitated by the BSO Equality Unit (who provide support to us on equality matters) we hold two Disability Awareness Days every year. A major achievement has been the rise in the number of participants of the days. Two days were delivered during the year: on Dementia (in December 2021) and on Attention Deficit Hyperactivity Disorder (in February 2022). The days included a live online session with an expert in the field (a health or social care professional or an individual with lived experience of the condition). The ensuing discussion on both days showed a keen interest from staff who are carers of a person with a disability. Sessions are recorded and then made available on the Tapestry website. This has ensured that staff can access the session at a time convenient to them.

Rural Needs Act

The purpose of the Act is to ensure that public authorities have ‘due regard’ to the social and economic needs of people in rural areas and to provide a mechanism for

ensuring greater transparency in relation to how public authorities consider rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services. The Act seeks to help deliver fairer and more equitable treatment for people in rural areas which will deliver better outcomes and make rural communities more sustainable. The Rural Needs Act has been embedded into the PHA's processes; the completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project.

The PHA has carried out a number of Rural Needs Impact Assessments for the period 1 April 2021 to 31 March 2022, as part of designing public services. Details are included in the table below.

Description of the activity undertaken by the public authority which is subject to section 1(1) of the Rural Needs Act (NI) 2016[1].	*The rural policy area(s) which the activity relates to[2].*	*Describe how the public authority has had due regard to rural needs when developing, adopting, implementing or revising the policy, strategy or plan or when designing or delivering the public service[3].*
Bereaved by suicide project: Facilitation of support networks for people bereaved by suicide and their role in influencing policy and service delivery	Broadband or Mobile Communications in Rural Areas Health of Social Care Services in Rural Areas	The Bereaved by suicide co-ordination, development and facilitation project is not a service for individuals. It is a project that supports individuals bereaved by suicide to influence policy and service delivery. The project will encourage participation through bereavement groups and local protect life implementation groups which have representation from Rural Networks and Rural Support. • There are no costs to participate in the project. • Those that wish to participate can do so in person, by phone or by electronic means. Stakeholder involvement has been undertaken as part of the review of the project. This was carried out via an online electronic survey in line with COVID regulations and included identification of gaps and barriers in relation to the current service model. Of the 26 responses, only one comment was made in relation to the need to strengthen links in some rural areas. The PHA has also carried out a wider involvement process to determine how the Protect Life 2 Strategy actions, for which the PHA is

		responsible, can be delivered. Through this process the following issues around rural service provision were identified; • Barriers around digital access must be considered e.g. digital poverty, many do not have digital skills, smart phones or good internet connection in rural areas; conversely digital services were also highlighted as a means of helping people in rural communities to be reached with a blended approach and cross departmental working highlighted as a means of addressing barriers. • Stakeholders outlined a number of user groups who require support accessing services which included rural dwellers. Additional requirements will be included within the project to ensure direct connection with Rural Networks to raise awareness of the project and to encourage participation from rural communities. Publication in relation to the project will be promoted to groups currently funded by the PHA which include rural networks and community and voluntary organisations located within rural communities.
Early intervention Support Service (EISS) – Regional Family Support Service across Northern Ireland	Health and Social Care Services in Rural Areas Deprivation in Rural Areas	The aim of EISS is to deliver and coordinate personalised evidence based early intervention for children, young people and their families to support families when problems first emerge before the need for statutory involvement. As part of the development of EISS comprehensive stakeholder engagement was undertaken facilitated through the Children's and Young People's Strategic Partnership Outcomes Groups and Locality Planning Groups in collaboration with the Directors of Social Services within each health and social care trust locality. A lack of service provision and difficulty accessing services due to transport issues were identified in a number of rural areas. The locations and geographic spread for each EISS was agreed based on local need, emerging need and gaps in service provision. It was clear from the strategies, ongoing monitoring Information, evaluations and stakeholder involvement there is a need to continue to offer the EISS to children, young people and families in both rural and urban communities. Provider

		organisations will be required to deliver EISS within the geographic areas identified with the aim of ensuring that children, young people and families in both urban and rural areas are supported to access the service. Providers will be required to provide links with Family Support Hubs, other community and voluntary services and others working in related areas such as drugs and alcohol, mental health etc. to ensure families have the ongoing support when their engagement with EISS is completed. Travel to rural areas in winter months and during inclement weather can on occasions cause some difficulties. Throughout the COVID-19 pandemic EISS have adapted ways of delivering the service as face to face visits were not possible for a prolonged period of time. All EISS have the necessary technology to offer the EISS using a blended approach of face to face visits and virtual sessions on Zoom or Microsoft Teams. Virtual sessions will continue to be used to offer support to families on occasions when home visiting cannot be offered as an option.
Maintaining the integrity and functionality of the National Breast Screening system in Northern Ireland	Health and Social Care Services in Rural Areas	The following issues were considered in relation to the social and economic needs of people in rural areas: **Accessibility of healthcare services** – the project will have neither a positive or negative impact on the accessibility of healthcare services. No change to the current service configuration is planned. **Employment, training and commuting** – No change to current staffing of Breast Screening Units is planned. No change to the location of Breast Screening Units is planned. Opportunities for appropriate training in the new system will be offered to all staff at their normal place of work, so no additional travel needed. All Breast Screening Units are represented in the project management structure and will contribute to the project implementation plan.

Complaints

The PHA received 60 complaints in 2021/22, 25 of these were related to COVID-19 testing and 11 to the Contact Tracing service. Critically appraising complaints is important and strict procedures are followed. If needed, staff take action to ensure any lessons learned are embedded in practice to prevent recurrences. Learning is also shared to enable others to embed this learning into their area of work.

Information Requests

Between 1 April 2021 and 31 March 2022 the following requests were made and responded to:

- 200 Freedom of Information Requests; and
- 7 Subject Access Requests.

During the COVID-19 pandemic the PHA received a significant increase in the number of Freedom of Information requests from the public. For comparison, in our 2019/20 and 2020/21 Annual Reports, we reported receipt of 44 and 144 Freedom of Information requests respectively, compared to the 200 requests reported in 2021/22. The majority of the Freedom of Information requests in 2021/22 related to COVID-19 (71%) but an increase in non COVID-19 related requests was also noted.

One personal data incident was reported to the Information Commissioner's Office, in conjunction with other HSC Organisations, during 2021/22 (27 July 2021) and concerned the NI COVID Certification Service (CCS). Immediate steps were taken to stop the incident, an investigation was completed and measures were taken to prevent a repeat of the error. A further incident concerning payroll data processed by the BSO Payroll Service Centre (PSC) during 2021/22 has been identified during the first weeks of April 2022. The incident was reported to the Information Commissioners Officer and an investigation was undertaken. The ICO notified BSO in May 2022 that no further action is necessary by the ICO on this occasion.

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

- Performance Overview.
- Performance Analysis.

Aidan Dawson
Chief Executive

Date: 16th June 2022

ACCOUNTABILITY REPORT

Non-Executive Directors' Report

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

The Board is comprised of a Chair, 7 non-executive Directors, the Chief Executive and 3 Executive Directors. One other PHA Director and 2 HSCB Directors are in attendance at Board meetings. The Department of Health appoints the Non-Executive Directors, with the approval of the Minister of Health. The Non-Executive Directors are:

- Mr Andrew Dougal, OBE (Chair);
- Alderman Phillip Brett;
- Mr John Patrick Clayton;
- Ms Anne Henderson OBE;
- Councillor Robert Irvine;
- Ms Deepa Mann-Kler;
- Professor Nichola Rooney; and
- Mr Joseph Stewart, OBE

The year 2021/22 continued to be a year of particular challenges, as the PHA refocused its work, prioritising the response to COVID-19. In following the guidance provided by the NI Executive together with the need for social distancing, the majority of staff continued to work from home for much of the year. Reflecting all of this, business continuity arrangements were followed and the PHA Board also had to adapt.

The Board and its committees have continued to hold regular meetings during the year, with these mostly being delivered by Zoom. During 2021/22 the Board held 11 meetings, but also held a number of workshops.

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

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

CORPORATE GOVERNANCE REPORT

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

Directors' Report

PHA 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 at www.publichealth.hscni.net.

Andrew Dougal OBE

Andrew Dougal took up the position as Chair of the PHA on 1 June 2015. Health and social care has been experiencing much change since that time. The functions of the Health and Social Care Board will migrate to the Department of Health on 1st of April 2022. He was previously Chief Executive of Northern Ireland Chest Heart and Stroke from 1983 and prior to that worked for 10 years in education.

He is an alumnus of the Salzburg seminar on philanthropy and non-profit organisations. He participated in the Duke of Edinburgh work study conference and in the Northern Ireland leadership challenge programme. He was awarded a Paul Dudley White fellowship to the American heart association.

Over the past 35 years he has been a Non-Executive Director of organisations spanning the private, public and voluntary sectors. He is a former Trustee and

Chair of the HR Committee of the UK Health Forum, a former Trustee and Treasurer of the World Heart Federation, and a former Chair of the Chartered Institute of Personnel and Development in Northern Ireland. He is also a member of the Ulster Orchestra Foundation Board.

Aidan Dawson

Aidan was appointed Chief Executive of the Public Health Agency on 1 July 2021. He comes with a career spanning over 30 years working in the Health Service and 3rd sector.

In 2016 Aidan was appointed as the Director of Specialist Hospitals & Women's Health in Belfast Health and Social Care Trust. He was responsible for a diverse range of services including Royal Belfast Hospital for Sick children, Maternity Services, Gynecology Services, ENT, Trauma and Orthopaedics, Neuro Rehabilitation, Sexual and Reproductive health, Regional Disablement Services and the Dental Hospital.

In April 2019 he also assumed responsibility for Mental Health Services for adults and children across the Trust on an interim basis. In 2020 the Mental Health role expanded to include the Mental Health Capacity Act Compliance.

Prior to this role Aidan was the Co-Director in the Trust for Trauma, Orthopaedics, and Rehabilitation Services. His career has included roles working with The British Red Cross and Disability Action.

Olive Macleod OBE

Olive joined PHA as Interim Chief Executive in March 2020 and retired in June 2021. She was previously Chief Executive of RQIA for four years.

Olive qualified as a registered nurse from St Vincent's Hospital, Dublin, and a registered midwife from Lanarkshire

School of Midwifery, Scotland. She spent 14 years in Canada working at Mount Sinai Hospital Toronto and Kingston General Hospital as an obstetric nurse, lead nurse and clinical educator.

In 1997 she joined the Mater Hospital, Belfast, as a staff midwife and worked in a number of roles including Assistant Director of Nursing at the hospital. From 2007, Olive was the Co-Director of Nursing in the Belfast Health and Social Care Trust, with responsibility for governance, performance and standards, before moving to the Northern Health and Social Care Trust as Executive Director of Nursing and User Experience. Olive was awarded an OBE in 2018, in recognition of her services to nursing.

Rodney Morton

Rodney Morton took up post as Director of Nursing and Allied Health Professions in January 2020. Previously Rodney held the position of Deputy Chief Nursing Officer with the Department of Health. Rodney was responsible for co-leading the development of a 10-15 year road map for Nursing and Midwifery in Northern Ireland, along with providing professional advice on mental health, learning disability and older people nursing services. In addition, Rodney held policy responsibility for Personal, Public, Involvement, and led the development of a new Co-Production Framework for the Northern Ireland Health and Social Care Sector.

Rodney has over 34 years' experience in a range of practice, managerial and leadership roles in CAMHS, Autism, Adult Mental Health, Addictions, Psychological Therapies, Older People, Public Mental Health and Primary Care Services. Rodney also led the development of the Regional 'You in Mind' Mental Health Care Pathways Programme, Regional Mental Health and Psychological Therapies Training Programme for Northern Ireland. Rodney is also an improvement science enthusiast and has been promoting and building quality Improvement capability across the Nursing and AHP Services.

Dr Aideen Keaney

Aideen is the Director of the Northern Ireland Health and Social Care Quality Improvement and Innovation (HSCQI) Network. HSCQI as an entity was launched by the Department of Health in April 2019 and is aligned with the NI HSC strategies Q2020 and Health and Well Being 2026: Delivering Together.

Aideen is a graduate of Queens University Belfast Medical School and is a Fellow of the College of Anaesthetists (RCSI) Dublin. Aideen also holds a Post Graduate Diploma in Healthcare Risk Management and Quality from University College Dublin.

Aideen completed her Anaesthesia training on the Northern Ireland Anaesthesia Training Scheme, also completing Clinical Fellowships in Dublin, Glasgow, London and Melbourne.

Aideen is a Scottish Patient Safety Programme Fellow, a Health Foundation Generation Q Fellow and has a Masters in Leadership and Quality Improvement (with Distinction) from Ashridge Executive Education, Hult International Business School.Aideen has worked as a Consultant in Paediatric Anaesthesia and Paediatric Intensive Care for over 14 years during which time she held a number of Medical Leadership roles namely Clinical Governance Lead, Clinical Lead for Patient Safety and Quality Improvement and Clinical Director.

Since taking up her post Aideen has been leading on the further design, development and growth of HSCQI with a particular focus on supporting the HSC system to share learning and identify and scale up best practice.

Dr Stephen Bergin

Dr Stephen Bergin is the Interim Director of Public Health.

Dr Bergin graduated in Medicine from QUB in 1990. After a period of post-graduate general medical training, he trained in Public Health, between 1993-1998, in the N.E. England public health training scheme. In 1998, he was appointed to the post of consultant in public health medicine with the former Southern Health and Social Board. He continued service in this position, with RPA, from 2009 until 2017. In November 2017, he commenced duties as Assistant Director of Public Health, initially within the Service Development division of the directorate, before taking up responsibility for the Population Screening division in February 2018.

In December 2019, he commenced duties as Deputy Director of Public Health. He assumed the role of interim Director of Public Health in November 2020. He has been on the GMC specialist register (public health) since 1998.

Dr Brid Farrell has also supported the PHA in a temporary capacity as Director of Public Health for periods during 2021/22.

Dr Brid Farrell

Dr Brid Farrell has been Deputy Director of Public Health since 2021. She qualified in medicine in 1982 and pursued a career in general practice in Canada, Ireland and N Ireland until 1990. She has worked in Public Health since 1990, and has a particular interest in service development, Diabetes and Stroke. Since 2020 she has led on COVID testing in N Ireland and co-ordinating the COVID response in PHA.

Stephen Wilson

Stephen Wilson was appointed as Interim Director of Operations in December 2020 having previously worked since 2009 as Assistant Director (Operations) with responsibility for leading Communications and Health Intelligence.

Stephen has extensive experience across a wide range of disciplines including strategic planning, operational management, communications, policy development and project management. His qualifications include a B.Sc (Hons), M.Sc (Management) and post-grad in Corporate Governance.

Following graduation Stephen worked in local government in Scotland leading on competitive tendering programmes before returning to Northern Ireland to work with the Sports Council for Northern Ireland and more recently the Health Promotion Agency where he worked as Senior Planning Manager and subsequently as Interim Director of Corporate Services until transferring in 2009 to the PHA under the Review of Public Administration.

Alderman Billy Ashe MBE

Alderman Billy Ashe MBE served as a member of the PHA Board from February 2012 to July 2021.

Billy has been an Elected member of firstly, Carrickfergus Borough Council since 1997, having served as Mayor twice, and then Mid and East Antrim Borough Council, following its formation after the review of Public Administration in 2015, where he was the first Mayor of the newly formed Borough.

Billy has extensive experience in the community and voluntary sector, having served as Chair of an Urban Farm project for those with learning difficulties and as

Coordinator of a Community Umbrella Project. He currently provides advice, coaching and mentoring to community projects and individuals.

Alderman Phillip Brett

Alderman Phillip Brett entered Local Government in 2013, becoming the youngest Councillor to ever serve on Newtownabbey Borough Council.

Following the reorganisation of Local Government in 2014, he has served as Group Leader of the Democratic Unionist party on Antrim and Newtownabbey Borough Council.

He has worked for the Democratic Unionist Party in both Belfast and London. He is a former Board Member of the Northern Ireland Housing Executive.

John Patrick Clayton

John Patrick is Policy Officer of the trade union, Unison. He was appointed to the trade union member post on the PHA Board.

He is a qualified barrister who has practised both at the Northern Ireland Bar and at the Bar in the Republic of Ireland.

John Patrick is a member of the Northern Ireland Committee of the Irish Congress of Trade Unions. In 2020 he joined the Executive of the voluntary organisation NIACRO.

Anne Henderson OBE

Anne Henderson commenced her career in the private sector, in the accountancy firms KPMG and BDO Stoy Hayward, and in the international media company Time Warner Inc. where she was based in London and Los Angeles.

She has extensive public sector experience, including as vice-chair and acting Chair of the Northern Ireland Housing Executive, where she worked for 17 years.

Anne chaired the Parades Commission for Northern Ireland for 7 years, until 2020. She has held Board positions in the International Fund for Ireland and its associated venture capital companies, and is a former member of the audit committee of Queens' University Belfast.

Councillor Robert Irvine

Councillor Robert Irvine lives in County Fermanagh and has been a partner in R.J. Irvine, a quantity surveying and project management consultancy firm, since 1982. He has been an elected local District Councillor since 2001 and currently sits as a member of Fermanagh and Omagh District Council. In his role as a Councillor, he sits on various committees, notably the Planning Committee and the Local Development Plan Steering Group of which he has been chair since 2015.

In the recent past he has been a member of the Western Local Commissioning Group, a committee of the Health and Social Care Board, the Western Education & Library Board and several school and college Boards of Governors. He currently is a Board member of the Northern Ireland Fire and Rescue Service.

Deepa Mann-Kler

Deepa Mann-Kler is Chief Executive of Neon; Visiting Professor in Immersive Futures at Ulster University in Northern Ireland; and an experienced public, private and charity sector Chair and Non-Executive Director, having served on 10 Boards across the UK over the past fifteen years. As a TEDx speaker and thought leader she regularly keynotes on the intersection of digital transformation, technical innovation, inclusion, ethics, bias, data, AI and creativity.

Alderman Paul Porter

Alderman Paul Porter served as a member of the PHA Board from November 2011 to July 2021. Paul has served as a Councillor from 2001 and was elected to the new Lisburn and Castlereagh City Council. Over the past 19 years he has worked closely with community and voluntary organisations delivering major projects ranging from early intervention, youth programmes and special needs provision. During this time he has helped secure major capital investment for several community centres in the wider Lisburn area.

Professor Nichola Rooney

Nichola is a consultant clinical psychologist and former Head of Psychological Services at the Belfast Health and Social Care Trust. She is senior professional adviser in psychology to the RQIA and associate consultant to the HSC Leadership Centre. Nichola is a former member of the judicial appointments Commission for Northern Ireland and currently chairs the Board of the Children's Heartbeat Trust. The current chair of the BPS Division of Clinical Psychology NI, she holds the position of honorary professor at QUB

School of Psychology.

Joseph Stewart OBE

Joseph has held a number of Board level positions in the public and private sectors in Northern Ireland having retired in 2016 as Director of Human Resources from PSNI, a post which he held from the inception of the service in 2001.

A graduate of Law from Queen's University, Belfast, Joseph was a Director of the Engineering Employers Federation until 1990 and a Director in Harland and Wolff between 1990 and 1995. He was Vice Chairman of the Police Authority from 1989 to 1994 and Chief Executive from 1995 to 2001.

Joe is Chair of the Governance and Audit Committee of the Agency and in February 2021 was appointed Non-Executive Director and Chair of the Audit Risk and Assurance Committee of the Livestock and Meat Commission Northern Ireland. Joseph received an OBE in the Queen's Birthday Honours list in 1994.

Tracey McCaig

Tracey McCaig has been appointed Interim Director of Finance for the PHA on 15 February 2021. Prior to this appointment Tracey held the post of Assistant Director of Finance in the Northern Health and Social Care Trust from May 2017. During her 33 year career in Health and Social Care finance, Tracey, who is a Chartered Management accountant, has headed up a number senior finance roles across the HSC, ranging from internal audit to head accountant roles in the NI Ambulance Service, Health and Social Care Board and Public Health Agency.

Tracey has a proven track record in team leadership, quality improvement, financial governance and multi-disciplinary HSC team working to effect change and improvement in HSC services.

Brendan Whittle

Brendan Whittle was appointed as HSCB Director of Social Care and Children and Executive Director of Social Work in April 2021.

Previously Brendan has held senior positions in the HSC, including as a Director at South Eastern HSC Trust between 2012 and 2019. He initially served as Director of Adult Services and Prison Healthcare and subsequently as Director of Children's Services & Executive Director of Social work. Most recently, Brendan has been Deputy Director of Social Care and Children at HSCB since 2019.

Brendan qualified as a Social Worker in London, working in East London initially before moving to Northern Ireland in 1992. He has a wealth of experience in Health and Social Care across a range of areas including Children's Services, Hospital Social Work, Disability services, Older People and Mental Health services.

During this time Brendan has maintained his professional development achieving both the MSc in Advanced Social Work and the Northern Ireland Leadership and Strategic Award in Social Work.

Related party transactions

The PHA is an arm's length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts. During the year, none of the Board members, members of the key management staff or other related parties have undertaken any material transactions with the PHA.

Register of Directors' interests

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

Audit Services

The PHA's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2022 was £24,000.

Statement on Disclosure of Information

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

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

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

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

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

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

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Aidan Dawson as the Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the regularity and

propriety of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PHA's assets, are set out in the formal letter of appointment of the Accounting Officer issued by the Department of Health, Chapter 3 of Managing Public Money Northern Ireland (MPMNI) and the HM Treasury Handbook: Regularity and Propriety.

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

GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

As Accounting Officer, I exercise my responsibility by ensuring that an adequate system for the identification, assessment and management of risk is in place. I have in place a range of organisational controls, commensurate with officers' current assessment of risk, designed to ensure the efficient and effective discharge of PHA business in accordance with the law and Departmental direction. Every effort is made to ensure that the objectives of the PHA are pursued in accordance with the recognised and accepted standards of public administration.

A range of processes and systems (including Service Level Agreements (SLAs), representation on PHA Board, Governance and Audit Committee and regular formal meetings between senior officers) are in place to support the close working between the PHA and its partner organisations, primarily the Health and Social Care Board (HSCB) and the Business Services Organisation (BSO), as they provide essential services to the PHA (including the finance function) and in taking forward the health and wellbeing agenda.

Systems are also in place to support the inter-relationship between the PHA and the DoH, through regular meetings and by submitting regular reports.

2. Compliance with Corporate Governance Best Practice

The Board of the PHA applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The

Board of the PHA does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by internal and external audits and through the operation of the Governance and Audit Committee, with regular reports to the PHA Board.

The PHA Board has also completed a self-assessment against the DoH Arm's Length Bodies (ALB) Board Self-Assessment Toolkit. Overall this shows that the PHA Board functions well, and identifies progress from the previous year. An action plan has been developed to take forward further improvements.

Arrangements are in place for an annual declaration of interests by all PHA Board Members and staff; the register is publically available on the PHA website. Members are also required to declare any potential conflict of interests at Board or committee meetings, and withdraw from the meeting while the item is being discussed and voted on.

3. Governance Framework

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

- PHA Board;
- Governance and Audit Committee; and
- Remuneration and Terms of Service Committee.

The PHA Board is comprised of a Non-Executive Chair, seven Non-Executive members, the Chief Executive and four Executive Directors.

During 2021/22, the PHA Board met on eleven occasions. The PHA Board meets regularly, usually monthly, with the exception of July. The Board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are

in place to appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. All Board meetings were quorate.

PHA Board Meeting Attendance Register 2021/22

Name	Meetings Attended	Meetings Contracted to attend
Mr Andrew Dougal (Chair)	**11**	**11**
Mrs Olive MacLeod*	**3**	**3**
Mr Aidan Dawson*	**7**	**7**
Mr Stephen Wilson*	**11**	**11**
Dr Stephen Bergin*	**7**	**8**
Dr Brid Farrell *	**2**	**3**
Mr Rodney Morton*	**7**	**11**
Dr Aideen Keaney**	**6**	**11**
Alderman Billy Ashe***	**3**	**3**
Alderman Phillip Brett***	**5**	**6**
Mr John Patrick Clayton***	**10**	**11**
Ms Anne Henderson***	**6**	**6**
Councillor Robert Irvine***	**5**	**6**
Ms Deepa Mann-Kler***	**10**	**11**
Alderman Paul Porter***	**2**	**3**
Professor Nichola Rooney***	**8**	**11**
Mr Joseph Stewart***	**10**	**11**
Mrs Tracey McCaig****	**10**	**11**
Mr Brendan Whittle****	**6**	**11**

*Executive Director ** Director *** Non-Executive Director ****HSCB Director in attendance

The Governance and Audit Committee's (GAC) purpose is to give an assurance to the PHA Board and Accounting Officer on the adequacy and effectiveness of the PHA's system of internal control. The GAC has an integrated governance role encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by risk management systems. The GAC meets at least quarterly and currently comprises of four Non-Executive Directors and is supported by the PHA's Interim Director of Operations and the HSCB's Director of Finance. Representatives from Internal and External Audit are also in attendance. During 2021/22 the GAC met on five occasions and all meetings were quorate.

The Remuneration and Terms of Service Committee advises the PHA Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets at least once every 6 months. During 2021/22, the Committee met on two occasions and the meetings were quorate.

4. Framework for Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The PHA *Corporate Plan 2017 – 2021*, setting out the PHA purpose, vision, values and strategic outcomes, was approved by the PHA Board on 20 April 2017 and by the DoH on 26 May 2017. This was rolled forward into 2021/22 as advised by the Department of Health (DoH), in line with governance processes required during the COVID-19 pandemic. The Annual Business Plan 2021/22, which sets out the actions to be taken forward in the PHA Corporate Plan, taking account of DoH

guidance and priorities, was approved by the PHA Board on 17 June 2021. Both documents were developed with input from the PHA Board and staff from all Directorates and engagement with external stakeholders.

The PHA's Risk Management Strategy and Policy explicitly outlines the PHA risk management process which is a 5 stage approach – risk identification, risk assessment, risk appetite, addressing risk and recording and reviewing risk, as follows:

Stage 1 - Risk Identification

Risks are identified in a number of ways and at all levels within the organisation corporately, by Directorate and by individual staff members. Risks can present as external factors which impact on the organisation but which the organisation may have limited control over or operational which concern the service provided and the resources/processes available and utilised. Within the organisation risk identification is related to the organisation's objectives (as detailed in the PHA Corporate Plan). Each risk identified is correlated to at least one of the corporate objectives. Risks are also aligned with the relevant performance and assurance dimensions as identified in the DoH Framework Document.

Stage 2 - Risk Assessment

Each risk is assessed to identify:

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

The PHA is committed to adhering to best practice in the identification and treatment of risks and works to the principles, framework and processes for Risk Management as contained in ISO 31000: 2018 and also adheres to the HSC Regional Risk Matrix (April 2013; updated June 2016 and August 2018).

Stage 3 - Risk Appetite

The PHA carefully considers its risk appetite, i.e. the extent of exposure to risk that is judged tolerable and justifiable. The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, stakeholders and the organisation alike. Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA's business viability or reputation is significantly high and may outweigh any benefits to be gained. Risk appetite is built into the risk assessment process as outlined above.

Stage 4 - Addressing the Risk

Whilst there are four traditional responses to addressing risk (terminate, tolerate, transfer and treat), in practice within the PHA the vast majority of risks are managed via the "Treat" or "Tolerate" route, both of which are underpinned by the identification of an action plan to reduce and, if possible, eliminate the risk.

Stage 5 - Recording and Reviewing Risk

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

To ensure the robustness of the PHA's system of internal control, fully functioning Risk Registers at both Directorate and Corporate levels are reviewed and updated on a quarterly basis, ensuring that risks are managed effectively and efficiently to meet PHA's corporate objectives and to continuously improve the quality of services.

Processes are established within each Directorate enabling risks to be identified, controls and/or gaps in controls highlighted and, where relevant, action to be taken to mitigate the risk. Directors and senior officers also identify risks which require

escalation to the Corporate Risk Register.

The Interim Director of Operations is the PHA Executive Board member with responsibility for risk management. The Corporate Risk Registers are reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). Directorate Risk Registers are also reviewed by AMT and the GAC on a rotational basis. The minutes of the GAC are brought to the following PHA Board meeting, and the Chair of the GAC also provides a verbal update on governance issues including risk. The Corporate Risk Register is brought to a PHA Board meeting at least annually, most recently on 17 June 2021.

During 2021/22, guidance and support was provided to staff who are actively involved in reviewing and co-ordinating the review of the Directorate and Corporate Risk Registers. A system has been established whereby the Senior Operations Manager meets with the planning and project managers supporting each Directorate and Division at the end of each quarter to ensure feedback and consistency in the review of the Risk Registers, and to share and learn from good practice.

All staff are required to complete the PHA risk management e-learning programme. In addition, staff have also been provided with other relevant training including fire, health and safety, security and fraud awareness.

All policies and procedures in respect of risk management and related areas are available to all staff through the PHA intranet (Connect) site.

5. Information Risk

The PHA has robust measures in place to manage and control information risks. The designated Senior Information Risk Owner (SIRO) for the management of information risk at Board level is the Interim Director of Operations. The Interim Director of Public Health as the Personal Data Guardian (PDG) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. Assistant Directors as Information Asset Owners (IAOs) are

responsible for managing and addressing risks associated with the information assets within their function and provide assurance to the SIRO on the management of those assets. The Interim Assistant Director of Planning and Operational Services as the Data Protection Officer (DPO) has responsibility for monitoring and advising on data protection.

The PHA's Information Governance Steering Group (IGSG) has the primary role of leading the development and implementation of the Information Governance Framework across the organisation, including ensuring that action plans arising from Internal and External Audit reports and the Information Management Checklist are progressed. The Group is chaired by the SIRO and membership includes all the IAOs, PDG, a Non-Executive Board member and relevant governance staff. The IGSG is scheduled to meet three times per year and provides a report to the GAC following each meeting. During 2021/22 the IGSG met twice due to COVID-19 pressures faced by staff and a meeting to report the year end position will take place in the first quarter of the 2022/23 year.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2018-2022 sets out the framework to ensure that the PHA meets its obligations in respect of information governance, embedding this at the heart of the organisation and driving forward improvements in information governance within the PHA. The Strategy was reviewed and approved in 2018 in line with UK GDPR and DPA 2018. This is supported by annual Action Plans setting out how it will be implemented. Alongside this, a range of policies and procedures are in place, including Data Protection/Confidentiality Policy, Data Breach Incident Response Policy and a Data Protection Impact Assessment Policy and Guidance.

The PHA has documented and agreed procedures in place to ensure compliance with the requirements of UK GDPR and DPA 2018.

The PHA 'Connect' intranet site provides staff with easy access to the latest PHA policies, news and resources. Through the use of this site the PHA ensures that all staff have access to information governance policies and procedures.

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

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and IT Security/cyber security continues to be rolled out to all staff. Specialised training is also organised for the SIRO and IAOs however, during 2021/22, no training sessions took place due to COVID-19 pressures faced by staff within PHA. During this time staff were supported by the IG team. Uptake of training is monitored by the IGSG.

The PHA is represented on the regional HSC Cyber Security Programme Board, and works with BSO ITS, as our IT provider, to take necessary measures in relation to cyber security risks.

One personal data incident was reported to the Information Commissioner's Office, in conjunction with other HSC Organisations, during 2021/22 (27 July 2021) and concerned the NI COVID Certification Service (CCS). Immediate steps were taken to stop the incident, an investigation was completed and measures were taken to prevent a repeat of the error. A further incident concerning payroll data processed by the BSO Payroll Service Centre (PSC) during 2021/22 has been identified during the first weeks of April 2022. The incident was reported to the Information Commissioners Officer and an investigation was undertaken. The ICO notified BSO in May 2022 that no further action is necessary by the ICO on this occasion.

6. Fraud

The Public Health Agency (PHA) takes a zero tolerance approach to fraud in order to protect and support our key public services. We have put in place an Anti-Fraud and Anti-Bribery Policy and Response Plan, which was updated during 2021/22, to outline our approach to tackling fraud, define staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer promotes fraud

awareness, co-ordinates investigations in conjunction with the BSO Counter Fraud and Probity Services team and provides advice to personnel on fraud reporting arrangements. All staff are supported in fraud awareness in respect of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate.

A fraud report is brought to the GAC on a regular basis.

7. Public Stakeholder Involvement

In the HSC there is a statutory duty to Involve and Consult and there are Personal and Public Involvement (PPI) policy responsibilities for which the PHA carries leadership responsibilities. In 2021/22 the PPI team focussed on building understanding, skills, knowledge and expertise in Involvement, Co-Production and Partnership Working with HSC staff, service users and carers. Some 200+ participants have now undertaken the Leading in Partnership programme. A number of staff were also facilitated to achieve their Certificate of Professional Development or Advanced Practitioners Certificate in Involvement and our webinar series had almost 1,000 people engaged.

The PHA has continued to support cultural change within the HSC, to one where the active involvement of and partnership working with people with lived and living experience is the norm. In 2021/22 Public Health Agency continued to lead on the implementation of the Online User Feedback Survey, Care Opinion, across the whole of the HSCNI. There are currently over 5000 stories collated through the service and over 150 changes recorded as informed by the stories.

The PHA recognises that PPI is core to the effective and efficient commissioning, design, delivery and evaluation of HSC services. PPI is the active and meaningful involvement of service users, carers and the public in those processes. In commissioning services, PHA actively considers PPI in all aspects of the commissioning process, ensuring that the input of service users and carers underpins the identification of commissioning priorities; in the development of service models and service planning; and in the evaluation and monitoring of service

changes or improvements.

The PHA is also cognisant of recent policy developments in this wider area; the 'Co-Production Guide for Northern Ireland - Connecting and Realising Value through People' (DoH, 2018) a practical guide, available at www.health-ni.gov.uk, to a co-production approach across the health and social care system. The guide was developed as part of the DoH's programme of work to transform health and social care as envisaged in 'Delivering Together 2026'.

8. Assurance

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

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

Internal and External Audit have a vital role in providing assurance on the effectiveness of the system of internal control. The GAC receives reviews and monitors reports from Internal and External Audit. Internal and External Audit representatives are also in attendance at all GAC meetings.

The Chair of the GAC reports to the PHA Board on a regular basis on the work of the Committee. The PHA Board also receives regular assurances through the financial and performance reports brought to it by the HSCB Director of Finance and PHA Interim Director of Operations.

The PHA Assurance Framework sets out a systematic and comprehensive

reporting framework to the Board and its committees and is normally reviewed twice yearly. However, following a review of the Assurance Framework by the GAC in April 21, it was agreed that fuller discussions should take place regarding the Framework and it is considered as part of a wider review of all PHA Board Performance Reporting processes, which will be completed by September 2022.

The PHA continues to ensure that data quality assurance processes are in place across the range of data coming to the PHA Board. Where gaps are identified, the PHA proactively seeks to address these, for example by the development and regular review of the Programme Expenditure Monitoring System (PEMS) to ensure comprehensive and robust information.

Information presented to the PHA Board to support decision making, is firstly presented to, and approved by, the Agency Management Team (AMT) and the Chief Executive, as part of the quality assurance process. Relevant officers are also in attendance at Board meetings when appropriate, to ensure that members have the opportunity to challenge information presented.

The PHA has in place an effective whistleblowing policy based on the HSC Whistleblowing Framework and Model Policy, developed in collaboration with the DoH and HSC organisations in response to the recommendations arising from the RQIA Review of the Operation of HSC Whistleblowing arrangements 2016.

9. Sources of Independent Assurance

The PHA obtains Independent Assurance from the following sources:

- Internal Audit
- Regulation and Quality Improvement Authority (RQIA)

In addition, the PHA receives an opinion on regularity from the External Auditor in the Report to Those Charged with Governance.

Internal Audit

The PHA utilises an Internal Audit function which operates to defined standards and whose work is informed by an analysis of the risk to which the body is exposed and annual audit plans are based on this analysis. In 2021/22 Internal Audit reviewed the following systems:

System reviewed	Level of Assurance*
Financial Review	**Satisfactory** - Non Pay Expenditure, Budgetary Control and Financial Reporting to the Board **Limited** - Payments to Staff
Recruitment of Vaccinators	**Satisfactory**
Performance Management	**Limited**
Serious Adverse Incidents[1]	**Limited**
Board Effectiveness	**Limited**

[1] *Joint HSCB and PHA audit*

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

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

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

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

Limited Internal Audit Reports – Summary of Findings/Recommendations

Financial Review

The internal audit opinion in respect of this report was split. Satisfactory assurance was provided in respect of Non Pay Expenditure, Budgetary Control and Financial Reporting to the Board processes but a limited assurance was provided in relation to Payments to staff. The limited assurance was provided on the basis that issues were identified in relation to additional payments, largely relating to additional hours worked during the COVID-19 response. New starts, leavers and contract changes were not processed on a timely basis, resulting in over and underpayments.

There were no Priority 1 recommendations made in this report and seven of the eight priority 2 recommendations are planned to be implemented by June 2022.

Performance Management

The internal audit opinion in respect of this report was limited. Limited assurance was provided on the basis that a formally defined performance management framework is not in place and a comprehensive performance report was not presented to the Agency Board. In addition, Key Performance Indicators have not been developed and measured against for new service areas of PHA, for example Contact Tracing.

There were 1 priority one and 1 priority two recommendations made in this report. Some actions have already been implemented in relation to the priority one recommendation and all remaining recommendations are due for implementation by 30 June 2022.

Serious Adverse Incidents

The internal audit opinion in respect of this report was limited. The limited assurance was provided on the basis that significant issues were identified in relation to the Serious Adverse Incident processes within the HSCB and PHA. In particular, internal audit findings highlighted that HSCB and PHA do not have a joint accountability mechanism in place to ensure each partner delivers their respective responsibilities. Also, delays in the dissemination of learning documentation and the cancellation of professional group meetings to consider serious adverse incident reports were highlighted by internal audit. The lack of a detailed Annual Quality report to the PHA Board and also the need to take forward the Joint Improvement Plan to improve Serious Adverse Incident processes across PHA and HSCB were also noted.

There were no Priority 1 recommendations made in this report and of the six priority 2 recommendations two have already been implemented and the remaining recommendations are due for implementation by October 2022.

Board Effectiveness

The internal audit opinion in respect of this report was limited as at the time of the audit fieldwork (November 2021). The limited assurance primarily related to a need to improve understanding of, and working between, Executive/Non Executive roles and to improve performance management and other reporting to the Board. Internal Audit have noted that the issues leading to a Limited assurance opinion in November 2021 have largely been addressed in the interim period up to March 2022 however, whilst recognising the improvements, Internal Audit was of the view that there is a need, with time, to embed and consolidate Board working relationships / collaboration further.

Follow Up on Previous Recommendations

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued on 5 April 2022, found that of the 59 recommendations with an implementation date of 31 March 2022 or earlier, 78% (46 recommendations) were fully implemented and 22% (13 recommendations) were partially implemented. Work will continue during 2022/23 to address those recommendations that have not yet been fully implemented.

2 priority one weaknesses in control remain outstanding:

- PHA Management of Contracts with the Voluntary/Community Sector audit, relating to the implementation of the PHA Social Care Procurement Plan; and
- Performance management systems at a corporate level.

Both recommendations have been partially implemented; however during the year progress was limited due to the re-prioritisation of staff to focus on the COVID-19 pandemic response. Work will continue in the 2022/23 year to fully address these recommendations.

BSO Shared Services Audits

A number of audits (summarised below) have been conducted in BSO Shared

Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Services audit reports are the responsibility of BSO Management to take forward and the reports have been presented to BSO Governance and Audit Committee.

System reviewed	Level of Assurance received
Payroll Service Centre (PSC)	**Satisfactory** – Elementary PSC processes **Limited** - End-to-End Manual Timesheet Processing, SAP / HMRC RTI Reconciliation
Accounts Receivable	**Satisfactory**
Recruitment Shared Service Centre (RSC)	**Satisfactory -** RSSC Processing Activities **Limited -** HSC Recruitment processes *
Regional Interpreting Service	**Satisfactory**
Accounts Receivable Shared Service	**Satisfactory**

** It is appreciated that the HSC Recruitment process, and therefore this assurance, is outside BSO's sole responsibility and is relevant to all HSC organisations.*

Overall Opinion

In her Annual Report, the Head of Internal Audit provided the following opinion on the PHA's system of internal control:

*Overall for the year ended 31 March 2022, I can provide **satisfactory** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control. However I would highlight that Limited assurance has been provided in a considerable proportion of audits during the current financial year. I am satisfied that prompt Management action has already been taken in response to the significant matters raised in the Board Effectiveness and Performance Management audit reports in particular. All of the Limited assurances provided in 2021/22 are related at least in part, to the impact of COVID-19 on PHA operations and the organisation's focus on the COVID-19 response. In 2022/23, I advise PHA to address the remaining outstanding audit recommendations and ensure Management focus is maintained on key governance, risk and control processes across the core functions of the organisation.*

RQIA

The HSCB/PHA has in place a Regional Safety and Quality Alerts Procedure which oversees the identification, co-ordination, dissemination and assurance on

implementation of regional learning issued by the HSCB/PHA/DoH/RQIA and other independent/regulatory bodies. Once a Safety and Quality Alert (SQA) has been issued to Arm's Length Bodies (ALBs) it is the responsibility of the HSCB/PHA to ensure adequate responses on assurances to the actions specified within relevant SQAs have been implemented accordingly. This process is overseen by relevant directors within the HSCB and PHA by way of weekly Safety Brief Meetings.

External Audit

For the year ended 31 March 2021, the Comptroller and Auditor General gave an unqualified audit opinion, without modification, on the financial statements. No findings were identified during the course of the audit and no recommendations were made.

10. Review of Effectiveness of the System of Internal Governance

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

11. Internal Governance Divergences

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

Neurology Call Back

Due to concerns being raised in relation to the practice of a consultant neurologist at the Belfast Trust including work he undertook on behalf of other Trusts and in

relation to his private practice, the HSCB and PHA, at the direction of the DoH, established a regional Coordination Group (which included Trust representatives and relevant independent sector providers) to co-ordinate the work necessary to complete a call-back review of those patients who remained under active review of the consultant (phase 1). This was followed by two call-backs of a defined cohorts of patients who had been seen by the consultant and whose care was subsequently returned to primary care (phases 2 and 3).

The PHA has worked closely with the HSCB, Trusts and independent providers to ensure that a consistent approach has been taken relating to the call back and review of patients who may be affected including providing consistent situation reports to the DoH on activity and progress. This work is now largely completed with:

- Phase 1 of the call-back exercise was completed in 2018 and a report on the activity and outcomes associated with Phase 1 was published.
- Phase 2 was completed in October 2019 and a report on the activity and outcomes associated with Phase 2 was published.
- Phase 3 of the call-back was completed in 2021 and a report has been submitted to the DoH in early 2022. This has yet to be published.

Cyber Security Incident at Queens University Belfast

A cyber security incident took place at Queens University Belfast (QUB) in February 2021. As the HSC has multiple contractual interactions with QUB, some concerning personal information, the HSC technology teams, with the backing of the HSC SIROs, took a number of actions to reduce potential disruption to HSC services, and continue to liaise with QUB on the impact of the cyber incident. The impact on the HSC was fully investigated as described below.

Following the incident, HSC Senior Information Risk Owner (SIRO) and BSO progressed actions with supplier/partner organisations since the cyber-attack. These focused on:

1. Seeking assurance on the technical efforts being made by QUB to “harden” their defences and bring them to a level which would give sufficient confidence to HSC of the infrastructure and technical defences, including the training and awareness of staff.

2. Mapping and recording data flows between the organisation affected, and the HSC, on an organisation-by-organisation basis. Seeking information on the measures being taken by the Supplier/partner to assure the security of HSC patient or client information held in partner/supplier systems, and determining what proof exists of a data breach due to the exfiltration of patient data from their systems during the cyber-attack.

3. Agreeing a protocol that all HSC organisations will use going forward, in order to restore data flows and technical connections through a risk-managed process, with the agreement of all HSC SIROs.

4. Bringing forward a revised corporate risk through Trust governance processes, which recognises the risk of an Information security breach through a supplier/partner cyber-attack. This will enable the mitigation measures to be described and the risk appetite of organisations to be considered through corporate processes.

HSC SIROs, BSO and lead officers in the cyber programme regionally met regularly throughout this process, to consider the position on the impact to the HSC and to the restriction of our transfer of information to/from QUB. There was specific and detailed attention paid to the mitigation actions carried out to QUB and to the root cause analysis.

On the basis of this information, and the assessed position, it was agreed that HSC SIROs would recommend a restoration of network connections with QUB, and that services should fully resume, subject to ongoing monitoring of the position with QUB through contract monitoring processes. All services were reconnected on 8 July 2021.

As work on this internal control divergence has completed no further action is required.

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

Financial Performance

While the budget for Health and Social Care in Northern Ireland continues to be challenging and set in the context of managing significant additional financial pressures relating to the response to the COVID-19 pandemic, the PHA approved a financial plan in June 2021 on its financial position and direct resources. Financial performance has largely remained in line with this plan during the financial year and PHA achieved a breakeven financial position in 2021/22.

Budget Position and Authority: The Assembly passed the Budget Act (Northern Ireland) 2022 in March 2022 which authorised the cash and use of resources for all departments and their Arms' Length Bodies for the 2021-22 year, based on the Executive's final expenditure plans for the year. The Budget Act (Northern Ireland) 2022 also included a Vote on Account which authorised departments' and their Arms' Length Bodies' access to cash and use of resources for the early months of the 2022-23 financial year. The cash and resource balance to complete for the remainder of 2022-23 will be authorised by the 2022-23 Main Estimates and the associated Budget Bill based on an agreed 2022-23 Budget. In the event that this is delayed, then the powers available to the Permanent Secretary of the Department of Finance under Section 59 of the Northern Ireland Act 1998 and Section 7 of the Government Resources and Accounts Act (Northern Ireland) 2001 will be used to authorise the cash, and the use of resources during the intervening period.

Budget Forward position: Following the resignation of the First Minister and the subsequent lack of an Executive, a Budget for 2022-23 could not be finalised. The Finance Minister wrote to departments to set out a way forward in the absence of an Executive to agree a Budget. This process involved DoF issuing departments with contingency planning envelopes for the 2022-23 financial year. These envelopes provided departments with an assessment of the minimum funding they could

reasonably expect for 2022-23 and allowed departments to plan for expenditure until such times as a Budget could be agreed.

An approach has been agreed with the Minister to enable opening allocations to proceed to continue to fund activity at current levels in 2022/23 while controlling spending in line with the advice from the Finance Minister. However there remains a great deal of uncertainty on the future financial position. The Department's reliance on significant levels of non-recurrent funding in recent years means that we are expecting to face an extremely challenging financial outlook. While we are anticipating significant allocations for Health once a Budget is agreed the 2022/23 budget will continue to require careful managing in order to develop a break even position.

Management of Contracts with the Community and Voluntary Sector

Previous Internal Audit reports on the management of health and social wellbeing improvement contracts have provided satisfactory assurance on the system of internal controls over PHA's management of health and social wellbeing contracts reflecting the significant work that has been undertaken by the PHA. Service Level Agreements are in place, appropriate monitoring arrangements have been developed and payments are only released on approval of previous progress returns. During 2021/22 we reviewed contract activity and agreed revised performance measures based on individual organisations ability to continue to deliver core services or re-purpose their resources to support wider emergency response plans. PHA has also highlighted to providers their legal duty to ensure they did not access duplicate funding under the Furlough scheme or other grant schemes available to cover costs already covered by PHA funding. An audit of the processes put in place to manage the COVID-19 response identified no significant issues.

Work continues to fully address the partially implemented priority one weakness in control relating to the implementation of the PHA Social Care Procurement Plan. PHA's ability to continue to implement the Procurement Plan since March 2020, has however been significantly impacted by the need to prioritise staffing resources to respond to the COVID-19 pandemic.

During 2021/22, the PHA Procurement Board has continued to progress plans for the re-tender of Drug and Alcohol services and Relationship and Sexual Education services as far as possible given the limitations resulting from the need to prioritise the response to the COVID-19 pandemic.

Following an engagement exercise with stakeholders on the Drug and Alcohol re-tender process the PHA and DoH agreed a delay to the procurement exercise to ensure maximum alignment with both the new regional Drug and Alcohol strategy launched by the Minister in September 2021 and ongoing work in regard to the commissioning of mental health and suicide prevention support services linked to the delivery of the Protect Life 2 strategy.

Further implementation of the report of a Task and Finish Group established to review how the PHA could improve its planning and procurement processes has been delayed due to COVID-19. Two new senior planning posts appointed to provide additional specialist capacity to support planning for procurement have been re-directed temporarily to support the Contact Tracing service. Implementation of the recommendations remains a priority for the PHA and will be addressed when appropriate staff have the capacity to take forward this work.

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

PHA Staffing Issues

The PHA has continued to work closely with DoH colleagues to take actions to address the number of vacancies and posts filled on a temporary basis across all Directorates and at all levels of the organisation. It has been noted that budget reductions over the past number of years and on-going budget constraints have curtailed the ability to further develop and grow the workforce to meet new and

increasing demands. This has impacted on the work of the PHA through constrained capacity across a number of key areas and functions.

While significant progress was made during 2020/21 to address staffing issues, most notably with the appointment of new Health Protection and Nursing/AHP staff and measures to recruit permanent staff to fill health improvement posts currently filled on a temporary basis it is recognised that some longer term actions are still required. This was highlighted in the report on the 'Rapid, focused external review of the Public Health Agency's resource requirement to respond to the COVID-19 pandemic over the next 18 – 24 months' conducted by Dr R Hussey, December 2020. The DoH has since confirmed that a review of the PHA will be undertaken beginning in 2022 and it is anticipated that an initial report will be completed by the end of June 2022. It is envisaged that this will produce a number of recommendations influencing the future operating model of the Agency and its staffing complement.

The impact of COVID-19 on resourcing PHA's normal operational business was also seen though the findings of Internal Audit in areas such as Serious Adverse Incidents and Performance Management reporting.

Additionally there has been significant change in the PHA senior management team over the past year, with one permanent and two interim appointments (Chief Executive, Director of Operations (Interim) and Director of Public Health (Interim)). The new Chief Executive took up post in July 2021.

PHA will continue to work with DoH colleagues to progress these issues.

COVID-19

The World Health Organisation (WHO) declared the outbreak of Coronavirus disease (COVID-19) a global pandemic on 11 March 2020. Following which the Department of Health and its ALBs immediately enacted emergency response plans across the NI Health sector. There is a UK-wide coordinated approach guided by the scientific and medical advice from respective Chief Medical Officers and Chief Scientific Advisers informed by the emergent evidence nationally and internationally.

Evidence-based UK-wide policies and guidelines continue to be carefully followed in conjunction with the PHA issuing local guidelines and ensuring readily accessible and continually updated advice.

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

Contingency arrangements were activated across all HSC organisations, including the PHA. Given the broad impact of COVID-19 and the need to react quickly to changing circumstances e.g. new variants and maintain a sustained pandemic response, this has impacted on the ability of the PHA to conduct core health business as resources were redirected to deal with the pandemic. In line with the Government advice to work from home where possible to reduce the transmission of COVID-19, the majority of staff have been working remotely for most of the year.

There has been a substantial resourcing impact across the Department and ALBs to scale up the response and to ensure adequate staff resourcing to meet increasing demands which included calling on volunteers, retired medical staff and medical students to rally together to strive to enable an optimum response to the pandemic. In the case of the PHA, additional temporary and fulltime staff had to be recruited to operate the contact tracing service and to enhance the health protection team to respond to the pandemic.

The Department prepared a COVID-19 Test, Trace and Protect Strategy (May 2020) which sets out the public health approach to minimising COVID-19 transmission in the community in Northern Ireland. The Department continues to have responsibility for oversight of the operation of the various elements of this Strategy.

The Strategy includes the COVID-19 testing arrangements. The Department's Expert Advisory Group chaired by the PHA has overseen the strategic approach in

NI, working with the UK Coronavirus National Testing Programme. PHA staff have worked closely with Departmental colleagues as part of both the strategic and operational management of the testing programme.

The Northern Ireland Contact Tracing Service, operated by the PHA, started contact tracing all confirmed cases of COVID-19 on 18 May 2020. This is a seven day service which has adapted to changing circumstances as it strives to ensure that every effort is made to limit transmission and protect the population. During each wave of the pandemic PHA staff are redeployed to help in contact tracing in order to provide a timely response to cases.

In December 2020, the first COVID-19 vaccine was approved, with supplies received in Northern Ireland and the mass vaccination programme (for all adults) commenced. The COVID-19 vaccination programme is led by the Department of Health and delivered by both HSC Trusts and primary care (general practice and pharmacy). The PHA is represented on the programme board and implementation group, with responsibilities including the management of a sessional COVID-19 vaccinator workforce to support primary care. PHA is leading on the vaccination of the 12-15 year age group and, in due, course will assume over responsibility for the COVID vaccination programmes (i.e. in common with other existing population immunisation/vaccination programmes, such as MMR, seasonal flu, etc).

It is anticipated that community transmission of COVID-19 will continue for the next 12 to 18 months. The pandemic response has required PHA to develop new services like 7 day contact tracing service, co-ordinate testing, increase communication with general public to ensure public awareness and engagement with core public health guidance, contribute to the vaccination programme and mobilise the pandemic response in all Directorates in the PHA. This will continue to be a focus and a challenge in 2022/23, as the organisation will also start to return to core business in the coming months. However, going forward into 2022/23, there is some uncertainty as to the direction of government policy (i.e. given the general intention of 'living with COVID'). This will have implications for PHA actions in terms of almost all COVID-related measures referred to in this document.

HSCQI

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

The budget allocation for 2021/22 included funding for some HSCQI posts, however it does not cover the totality of posts required. While the PHA welcomed the funding allocation, given the remaining ongoing gap in funding, it will still be challenging for the HSCQI to deliver on the design intent. There is therefore a risk that the HSCQI will be unable to fulfil its core function, service corporate requirements or undertake additional requests from the HSC system to support work and training. This risk was further exacerbated due to the redeployment of existing core HSCQI staff on occasions to support the PHA pandemic response.

The PHA Chief Executive and Director HSCQI will continue to work with the Department and the HSCQI Leadership Alliance to agree the priorities for HSCQI (in light of constrained resources) and to discuss funding for HSCQI.

Staff Resilience during COVID-19

As a result of the necessary response to COVID-19 the PHA was required to move to 7 day working in April 2020. While organisations are no longer required to maintain a 7 day working pattern, staff in the PHA have continued to face significant work pressures throughout the year, as they have worked to control and reduce the spread of COVID-19.

PHA has however limited staff capacity, and while additional staff have been brought in during the year, there is concern that in order to maintain the ongoing response a significant proportion of staff have had to work additional hours over a long and sustained period dating back to the beginning of the Pandemic in March 2020. It is noted that staff are tired, with many also unable to take all their leave for the second

successive year, and therefore there is a risk that staff may become ill and/or no longer be able to continue. A period of recovery for the Agency's staff, whilst desirable cannot be guaranteed given the ongoing response.

The PHA will continue to work with the Director of Human Resources (BSO), the wider HSC and the Department to support staff and seek ways to build resilience and reset to a business as usual position. The standing up of an Organisation Workforce Development group is one example of the steps taken in year to help support staff.

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

HRPTS system availability

The Business Services Organisation (BSO) has a contractual relationship with a supplier providing the managed service for the HR, Payroll, Travel and Subsistence System (HRPTS) for Health and Social Care NI. A sub-contractor of this supplier provides a service incorporating servers hosted at data centres owned by this sub-contractor. The sub-contractor went into administration in late March 2022. BSO were advised of the position by the supplier in early April 2022 and have been advised that the sub-contractor will continue to trade and operate their business as normal while their Administrators are exploring options for the company's future, including re-negotiating contractual terms with its existing customers.

BSO has invoked its business and technical contingency plans and set up Bronze Command. BSO has met with the Minister, Permanent Secretary, Trade Unions and all stakeholders has been informed of the situation and the contingency plans to address this issue.

12. Conclusion

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

Further to considering the accountability framework within the PHA and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the PHA has operated a sound system of internal governance during the period 2021/22.

Remuneration and Staff Report

Section 421 of the Companies Act 2006 requires the preparation of a Remuneration Report containing certain information about the Directors' remuneration in accordance with the requirements of Part 4 and Schedule 8 of Statutory Instrument 2008.

Remuneration Policy

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

While the salary structure and the terms and conditions of service for Senior Executives is determined by the Department of Health (DoH), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, were permitted by DoH, agreeing the discretionary level of performance related pay.

The 2016/17 and 2017/18 Senior Executive's pay awards were set out in DoH circulars HSC(SE) 1/2021 and HSC(SE) 2/2021 were paid during 2021/22, in line with the Remuneration Committee's agreement on the classification of Executive Directors' performance, categorised against the standards of 'fully acceptable', 'incomplete' or 'unsatisfactory' as set out within the circulars.

DoH Circulars on the 2018/19, 2019/20, 2020/21 and 2021/22 Senior Executive pay awards had not been received by 31 March 2022 and related payments have not been made to Executive Directors.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the PHA received any other bonus or performance related pay in 2021/22. It should be noted that Non-Executive Directors

do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts is normally for a term of 4 years. Details of newly appointed Non-Executive Directors or those leaving post have been detailed in the Senior Management Remuneration tables below. Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2021/22.

Membership of the Remuneration and Terms of Service Committee:

Mr Andrew Dougal - Chair
Professor Nichola Rooney – Non-Executive Director
Ms Anne Henderson – Non-Executive Director
Alderman Phillip Brett – Non-Executive Director

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

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

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA were as follows, it should be noted that there were no bonuses paid to any Director during 2021/22 or 2020/21.

Non-Executive Members (Table Audited)

Name	2021/22				2020/21			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Andrew Dougal (*Chair*)	35-40	-	-	35-40	30-35	-	-	30-35
Ms Deepa Mann-Kler	10-15	-	-	10-15	5-10	-	-	5-10
Professor Nichola Rooney	10-15	-	-	10-15	5-10	-	-	5-10
Mr John-Patrick Clayton	10-15	-	-	10-15	5-10	-	-	5-10
Mr Joseph Stewart	10-15	-	-	10-15	5-10	-	-	5-10
Councillor Robert Irvine *(Joined 12 October 2021)*	0-5	-	-	0-5	-	-	-	-
Alderman Phillip Brett *(Joined 12 October 2021)*	0-5	-	-	0-5	-	-	-	-
Mrs Anne Henderson *(Joined 12 October 2021)*	0-5	-	-	0-5	-	-	-	-
Alderman Paul Porter *(Left 31 July 2021)*	0-5	-	-	0-5	5-10	-	-	5-10
Alderman William Ashe *(Left 31 July 2021)*	0-5	-	-	0-5	5-10	-	-	5-10

Notes:

- *No Non-Executive Members may have received benefits in kind below £50 which would have been rounded down to nil as specified in the 2nd column of the table above.*
- *Payments to Non-Executive Members are based on DoH Circular HSC(F) 14-2021, with the most recent payments made being effective from 1/8/19. DoH Circulars relating to payments from 2020 and 2021 had not been received by 31 March 2022 and any related payments thereon have therefore not been made to Non-Executive Members.*

Executive Members (Table Audited)

Name	2021/22				2020/21			
	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s	Salary £000s	Benefits in Kind (to nearest £100)	Pension Benefits (to nearest £1,000)	Total £000s
Mr Aidan Dawson *Interim Chief Executive* *(Started 1 July 2021)*	80-85 (110-115 FYE)	-	131,000	215-220	-	-	-	-
Dr Stephen Bergin *Interim Director of Public Health*	190-195	800	58,000	250-255	60-65 (180-185 FYE)	-	(10,000)	50-55
Dr Brid Farrell *Interim Director of Public Health* *(From 1 July to 30 September 2021 and 8 to 31 March 2022)*	50-55 (160-165 FYE)	-	-	50-55	-	-	-	-
Dr Aideen Keaney *Director of HSCQI*	95-100	-	42,000	135-140	90-95	-	43,000	130-135
Mr Stephen Wilson *Interim Director of Operations*	80-85	600	33,000	110-115	20-25 (80-85 FYE)	-	21,000	45-50
Mr Rodney Morton *Director of Nursing & Allied Health Professionals*	85-90	6,600	21,000	110-115	80-85	6,600	86,000	175-180
Mrs Olive MacLeod Interim Chief Executive *(Retired 17 September 2021)*	50-55 (115-120 FYE)	-	23,000	75-80	110-115	-	188,000	295-300
Professor Hugo van Woerden Director of Public Health *(Retired 31 December 2020)*	-	-	-	-	160-165 (215-220 FYE)	-	-	160-165
Mr Edmond McClean Director of Operations / Interim Deputy Chief Executive *(Retired 30 September 2020)*	-	-	-	-	40-45 (85-90 FYE)	100	-	40-45

FYE – Full Year Equivalent

Note: *The Pension Benefits noted for Mr Dawson reflect all service in HSC organisations, not only that within PHA.*

There were no payments to past directors or compensation for early retirement or loss of office in the current year.

Pensions of Senior Management (Table Audited)

Name	2021/22				
	Real increase in pension and related lump sum at age 60 £000	Total accrued pension at age 60 and related lump sum £000	CETV at 31/03/21 £000	CETV at 31/03/22 £000	Real increase in CETV £000
Mr Aidan Dawson *Interim Chief Executive*	5-7.5 pension 10-12.5 lump sum	40-45 pension 85-90 lump sum	673	812	121
Dr Aideen Keaney *Director of Quality Improvement*	2.5-5 pension 0-2.5 lump sum	45-50 pension 95-100 lump sum	841	903	38
Dr Stephen Bergin *Interim Director of Public Health*	2.5-5 pension 0-2.5 lump sum	65-70 pension 145-150 lump sum	1,227	1,318	55
Mr Stephen Wilson *Interim Director of Operations*	2-2.5 pension 0-2.5 lump sum	30-35 pension 65-70 lump sum	601	650	32
Mr Rodney Morton *Director of Nursing & Allied Health Professionals*	0-2.5 pension 0 lump sum	35-40 pension 95-100 lump sum	726	765	22
Mrs Olive MacLeod *Interim Chief Executive*	0-2.5 pension 2.5-5 lump sum	30-35 pension 100-105 lump sum	784	807	32

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

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

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

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and 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 does not include the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. However, the real increase calculation uses common actuarial factors at the start and end of the period so that it disregards the effect of any changes in factors and focuses only on the increase that is funded by the employer.

Pension contributions deducted from individual employees are dependent on the level of remuneration receivable and are deducted using a scale applicable to the level of remuneration received by the employee.

Fair Pay Disclosures (Table(s) Audited)

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

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

	2022	2021
Band of Highest Paid Director's Remuneration (band in £000s)	190-195	215-220
Percentage Change of Highest Paid Director	-12%	-
Median Total Remuneration (£)	42,121	40,894
Ratio	4.56	5.28

The change to the ratio is impacted by the decrease in the highest paid director's remuneration.

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

	2021/22	25th Percentile	75th Percentile
Mid-Point of Top Salary	£192,500	£32,306	£53,219
Ratio		5.96	3.62

	2020/21	25th Percentile	75th Percentile
Mid-Point of Top Salary	£217,500	£30,615	£51,668
Ratio		7.10	4.21

No employee received remuneration in excess of the highest paid director, and remuneration ranged from £6,559 to £192,184 in 2021/22 (£6,559 to £216,071 in 2020/21). The lowest salary relates to Safeguarding Board lay members.

For 2021-22, the 25th percentile, median and 75th percentile remuneration values consisted solely of salary payments.

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

	2021/22 (£)	2020/21 (£)	Increase/ (Decrease) (£)	Change (%)
Average Salary	45,614	44,206	1,408	3.19%

Staff Report

Staff Costs (Table Audited)

PHA staff costs comprise:

	2022			2021
	Permanently employed staff £000s	Others £000s	Total £000s	Total £000s
Wages and salaries	23,338	3,891	27,229	21,458
Social security costs	2,445	411	2,856	2,179
Other pension costs	4,186	683	4,869	3,820
Total staff costs reported in Statement of Comprehensive Net Expenditure	**29,969**	**4,985**	**34,954**	**27,457**
Less recoveries in respect of outward secondments			(887)	(489)
Total net costs			**34,067**	**26,968**

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

The Public Service Pensions Act (NI) 2014 provides the legal framework for regular actuarial valuations of the public service pension schemes to measure the costs of the benefits being provided. These valuations inform the future contribution rates to be paid into the schemes by employers every four years following the scheme valuation. The Act also provides for the establishment of an employer cost cap mechanism to ensure that the costs of the pension schemes remain sustainable in future.

The Government Actuary's Department (GAD) is responsible for carrying out scheme valuations. The Actuary reviews employer contributions every four years following the scheme valuation. The 2016 scheme valuation was completed by GAD in March 2019. The outcome of this valuation was used to set the level of contributions for employers from 1 April 2019 to 31 March 2023.

An issue identified by the courts in the way that the 2015 pension reforms were introduced has led to eligible members, with relevant service between 1 April 2015 and 31 March 2022, being entitled to different pension benefits in relation to that period. The different pension benefits relate to the 1995, 2008 and 2015 HSC Pension Schemes. This is known as the 'McCloud Remedy' and will impact many aspects of the HSC Pension Schemes including the scheme valuation outcomes. Further information on this will be included in the HSC Pension Scheme accounts.

Average Number of Persons Employed (Table Audited)

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

	2022			2021
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	795	89	**884**	513
Less average staff number in respect of outward secondments	(15)	-	**(15)**	(9)
Total net average number of persons employed	**780**	**89**	**869***	**504**

**The increase in the 2022 staff numbers is primarily due to an increase of c381 WTEs relating to Contact Tracing and COVID-19 Vaccinators.*

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

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2022	2021	2022	2021	2022	2021
Total number of exit packages by type	-	-	-	-	-	-
Total resource cost £000s	£0	£0	£0	£0	£0	£0

The table above shows the total cost of exit packages agreed and accounted for in 2021/22 and 2020/21. No exit costs were paid in 2021/22, the year of departure (2020/21, nil).

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

Staff Benefits

The PHA had no staff benefits in 2021/22 or 2020/21.

Retirements due to ill-health

During 2021/22, there was 1 person from the PHA agreed early retirements on the grounds of ill-health.

Staff Composition

The staff composition broken down by male/female as at 31 March 2022 is illustrated in the table below.

	Male	Female	Total
Non-Executives	5	3	8
Chief Executive and Directors	4	2	6
Senior Management*	18	49	67
Other	125	394	519
Total	**152**	**448**	**600**

**Senior management is defined as staff in receipt of a basic whole time equivalent salary of an Agenda for Change Band 8C (greater than c£66k) and staff on Medical and Dental grades*

Note: *Excluded from the staff composition figures above are Contact Tracers, Seconded staff on payroll of other organisations, Vaccinators, Lay Members, Bank staff and Core Trainees.*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2020 – 31 March 2021 is 2.73% (2020/21 2.39%).

There were 25,356 hours lost due to sickness absence (2020/21 14,554 hours), or the equivalent of 47 hours (2020/21 42.8 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 6 days per employee (2020/21 5.7 days).

Staff Turnover Percentage

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

Staff Turnover %	2022	2021
Total Staff Turnover	6.46%	11.82%
Split between:		
Voluntary Turnover	6.46%	9.16%
Involuntary Turnover	0.00%	2.66%

Staff Engagement Scores

HSC organisations do not monitor Employee Engagement on an annual basis, but there is a *Regional Staff Survey* conducted every 3 years. The PHA employee engagement score from the most recent staff survey (2019) was 3.70 out of a possible 5. The response rate was 52%.

In addition to the regional survey, the PHA conducted a Cultural Assessment survey in February 2020 which measured the culture within the organisation across 8 dimensions. Each of the 8 dimensions was scored out of 5 and the table below shows the scoring against each dimension within PHA. The response rate for this survey was 37.4%.

Because of the pandemic, PHA conducted the Cultural Assessment twice to see if, and how, culture was impacted. Reassuringly, the scores improved against most dimensions when the survey was completed for the second time in November 2020.

Dimension	Feb 2020 Score	Nov 2020 Score	Change
Values	3.35	3.46	+ 0.11 ↑
Vision	2.51	2.73	+ 0.22 ↑
Goals & Performance	3.92	3.61	- 0.31 ↓
Quality & Innovation	2.96	3.09	+ 0.13 ↑
Team Working	3.59	3.68	+ 0.09 ↑
Compassionate Care	3.95	4.01	+ 0.06 ↑
Compassionate Leadership	3.40	3.47	+ 0.07 ↑
Collective Leadership	3.12	3.30	+ 0.18 ↑

Staff Policies / Employment and Occupation

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to

promoting equality of opportunity and good relations for all groupings under Section 75 of the Northern Ireland Act 1998.

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

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

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

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

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

Expenditure on Consultancy

The PHA had no expenditure on External Consultancy during 2021/22 (2020/21, nil).

Off-Payroll Engagements

The PHA is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed which cost more than £245 per day and lasted longer than 6 months during the financial year, which were not paid through the PHA Payroll.

The PHA had 18 such 'off-payroll' staff resource engagements as at 31 March 2022 (2020/21: 0).

The following table provides further analysis.

Temporary off –payroll worker engagements as at 31 March 2022

Number of existing engagements as of 31 March 2022	18
Of which have:	
Existed for less than one year at time of reporting	3
Existed for between one and two years at time of reporting	15

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

Assembly Accountability and Audit Report

Funding Report

Regularity of Expenditure (Audited)

The PHA has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit, and during 2021/22 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments (Table Audited)

Losses Statement	2021/22	2020/21
Total number of losses	2	0
Total value of losses (£)	£5,880	£0

There were no individual losses over £250k in the 2021/22 financial year (2020/21, nil).

Special Payments

There were no other special payments or gifts made during the year (2020/21, nil).

Other Payments and Estimates

There were no other payments made during the year (2020/21, nil).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 19 of the financial statements, the PHA also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability. As at 31 March 2022, the PHA is not aware of any remote contingent liabilities, and there were none in 2020/21.

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

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

Aidan Dawson
Chief Executive

Date: 16th June 2022

The Certificate and Report of the Comptroller and Auditor General

Opinion on financial statements

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2022 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes including significant accounting policies.

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

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

In my opinion the financial statements:

- give a true and fair view of the state of Public Health Agency's affairs as at 31 March 2022 and of the Public Health Agency's net expenditure for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

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

Basis for opinions

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

My staff and I are independent of the Public Health Agency in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Public Health Agency's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

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

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

Other Information

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

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

I have nothing to report in this regard.

Opinion on other matters

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

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

Matters on which I report by exception

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

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

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Accounting Officer is responsible for:

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

Auditor's responsibilities for the audit of the financial statements

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

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

individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Public Health Agency through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included governing legislation and any other relevant laws and regulations identified;
- making enquires of management and those charged with governance on Public Health Agency's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of Public Health Agency's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and posting of unusual journals;
- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:

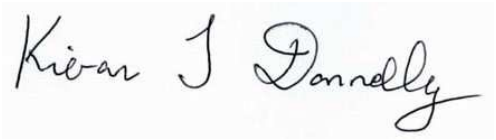
- performing analytical procedures to identify unusual or unexpected relationships or movements;
- testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
- assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias;
- investigating significant or unusual transactions made outside of the normal course of business; and

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

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

Report

I have no observations to make on these financial statements.



KJ Donnelly

Comptroller and Auditor General

Northern Ireland Audit Office

1 Bradford Court

Galwally

BELFAST

BT8 6RB

Date 30 June 2022

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2022

FOREWORD

These accounts for the year ended 31 March 2022 have been prepared in a form determined by the Department of Health (DoH) based on guidance in the Government Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2022

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

		2022	2021
Income	**NOTE**	**£000**	**£000**
Revenue from contracts with customers	4.1	2,890	3,471
Other operating income (excluding interest)	4.2	887	489
Total operating income		3,777	3,960
Expenditure			
Staff costs	3	(34,954)	(27,457)
Purchase of goods and services	3	(57,797)	(53,938)
Depreciation, amortisation and impairment charges	3	(399)	(200)
Provision expense	3	0	0
Other expenditures	3	(3,067)	(2,881)
Total operating expenditure		(96,217)	(84,476)
Net Operating Expenditure		**(92,440)**	**(80,516)**
Finance income	4.2	0	0
Finance expense	3	0	0
Net expenditure for the year		(92,440)	(80,516)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(20,977)	(19,706)
South Eastern Health & Social Care Trust		(6,118)	(5,386)
Southern Health & Social Care Trust		(8,967)	(7,929)
Northern Health & Social Care Trust		(10,174)	(9,445)
Western Health & Social Care Trust		(8,740)	(7,981)
NIAS Health & Social Care Trust		(117)	(87)
NI Medical & Dental Training Agency		(169)	(167)
PCC		0	(35)
Total RRL issued		(55,262)	(50,736)
Total Commissioner resources utilised		(147,702)	(131,252)
Revenue Resource Limit (RRL) received from DoH	22.1	147,796	131,358
Surplus / (Deficit) against RRL		**94**	**106**

OTHER COMPREHENSIVE EXPENDITURE		**2022**	**2021**
		£000	**£000**
Items that will not be reclassified to net operating costs			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	106	87
Net gain/(loss) on revaluation of intangibles	6.1/8/6.2/8	0	0
Net gain/(loss) on revaluation of financial instruments	7/8	0	0
Items that may be reclassified to net operating costs:			
Net gain/(loss) on revaluation of investments		0	0
TOTAL COMPREHENSIVE NET EXPENDITURE for the Year Ended 31 March		**(92,335)**	**(80,429)**

The notes on pages 135 to 163 form part of these accounts.

Statement of Financial Position for the Year Ended 31 March 2022

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

	NOTE	2022 £000	£000	2021 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	710		736	
Intangible assets	6.1/6.2	345		390	
Total Non Current Assets			1,055		1,126
Current Assets					
Trade and other receivables	12	5,065		4,154	
Other current assets	12	35		12	
Cash and cash equivalents	11	855		471	
Total Current Assets			5,955		4,637
Total Assets			**7,010**		**5,763**
Current Liabilities					
Trade and other payables	13	(13,844)		(15,551)	
Total Current Liabilities			(13,844)		(15,551)
Total Assets less Current Liabilities			**(6,834)**		**(9,788)**
Non Current Liabilities					
Provisions	14	0		0	
Other payables > 1 yr	13	0		0	
Total Non Current Liabilities			0		0
Total Assets less Total Liabilities			**(6,834)**		**(9,788)**
Taxpayers' Equity and Other Reserves					
Revaluation reserve		247		141	
SoCNE reserve		(7,081)		(9,929)	
Total Equity			**(6,834)**		**(9,788)**

The financial statements on pages 131 to 163 were approved by the Board on 16 June 2022 and were signed on its behalf by:

Signed  (Chairman) Date 16th June 2022

Signed  (Chief Executive) Date 16th June 2022

Statement of Cash Flows for the Year Ended 31 March 2022

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

	NOTE	2022 £000	2021 £000
Cash flows from operating activities			
Net operating expenditure	SoCNE	(92,440)	(80,516)
Adjustments for non cash costs	3	423	223
(Increase)/decrease in trade and other receivables	12	(934)	(1,531)
Increase/(decrease) in trade payables	13	(1,706)	4,669
Less movements in payables relating to items not passing through the Net Expenditure Adjustments (NEA)			
Movements in payables relating to the purchase of property, plant and equipment	13	0	10
Movements in payables relating to the purchase of intangibles	13	564	(560)
Use of provisions	14	0	0
Net cash outflow from operating activities		(94,093)	(77,705)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(146)	(495)
(Purchase of intangible assets)	6	(642)	230
Net cash outflow from investing activities		(788)	(265)
Cash flows from financing activities			
Grant in aid		95,264	77,554
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements			
Net financing from financing activities		95,264	77,554
Net increase (decrease) in cash & cash equivalents in the period		383	(416)
Cash & cash equivalents at the beginning of the period	11	471	887
	11	**855**	**471**

The notes on pages 135 to 163 form part of these accounts.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2022

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

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2020		**(6,992)**	**54**	**(6,938)**
Changes in Taxpayers' Equity 2020/21				
Grant from DoH		77,554	0	77,554
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(80,513)	87	(80,426)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	22	0	22
Balance at 31 March 2021		**(9,929)**	**141**	**(9,788)**
Changes in Taxpayers' Equity 2021/22				
Grant from DoH		95,264	0	95,264
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(92,440)	106	(92,334)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	24	0	24
Balance at 31 March 2022		**(7,081)**	**247**	**(6,833)**

The notes on pages 135 to 163 form part of these accounts.

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

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

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

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

1.1 Accounting convention

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

1.2 Currency and Rounding

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

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Buildings, Plant & Machinery, Information Technology, and Furniture & Fittings.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and

- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

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

Valuation of Land and Buildings

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

Assets under Construction (AUC)

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use. The PHA had no AUC in either 2021/22 or 2020/21.

Short Life Assets

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

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

Revaluation Reserve

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

1.4 Depreciation

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

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

The following asset lives have been used.

Asset Type	Asset Life
Freehold Buildings	25 – 60 years
IT assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure (SoCNE). If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the SoCNE and an amount up to the value of the impairment in the revaluation reserve is transferred to the SoCNE Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the SoCNE to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent expenditure

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

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

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible Assets under

Construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PHA's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the PHA where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition may be capitalised if the group is at least £5,000 in value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

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

1.8 Non-current assets held for sale

The PHA had no non-current assets held for sale in either 2021/22 or 2020/21.

1.9 Inventories

The PHA had no inventories as at 31 March 2022 or 31 March 2021.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed necessary in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to

determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

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

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

Income is stated net of VAT.

Grant in aid

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

1.11 Investments

The PHA did not hold any investments in either 2021/22 or 2020/21.

1.12 Research and Development expenditure

Research and development expenditure is expensed in the year it is incurred in accordance with IAS 38.

Following the introduction of the 2010 European System of Accounts (ESA10) from 2016/17, there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure. As a result, additional disclosures are included, where necessary, in the notes to the accounts.

1.13 Other expenses

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

1.14 Cash and cash equivalents

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

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The PHA as lessee

The PHA held no finance leases during 2021/22 or 2020/21.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and buildings components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general principle set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The PHA as lessor

The PHA did not have any lessor agreements in either 2021/22 or 2020/21.

1.16 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2021/22 or 2020/21.

1.17 Financial instruments

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

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

- Financial assets

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

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

Financial assets are classified into the following categories:

  - financial assets at fair value through Statement of Comprehensive Net Expenditure;

- held to maturity investments;
- available for sale financial assets; and
- loans and receivables.

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

- Financial liabilities

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

Financial liabilities are initially recognised at fair value.

- Financial risk management

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

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

- Currency risk

The PHA is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The PHA has no overseas operations. The PHA therefore has low exposure to currency rate fluctuations.

- Interest rate risk

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

- Credit and liquidity risk

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

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the PHA has a present legal or constructive obligation as a result of a past event, it is probable that the PHA will be required to settle the obligation, and a reliable estimate can be made of the

amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting year, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows as at 31 March 2022, using the discount rates issued by the Department of Finance (DoF) below.

Rate	Time period	Real rate
Nominal	Short term (0 – 5 years)	0.47%
	Medium term (5 – 10 years)	0.70%
	Long term (10 - 40 years)	0.95%
	Very long term (40+ years)	0.66%
Inflationary	Year 1	4.0%
	Year 2	2.6%
	Into perpetuity	2.0%

Note that Public Expenditure System issued a combined nominal and inflation rate table to incorporate the two elements – please refer to this table as necessary, as included within circular HSC(F) 39-2021.

The discount rate to be applied for employee early departure obligations is (1.30%) for 2021/22.

The PHA has also disclosed the carrying amount at the beginning and end of the year, additional provisions made, amounts used during the year, unused amounts reversed during the year and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the PHA has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the PHA develops a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it.

The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the PHA.

1.19 Contingent liabilities/assets

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

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

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

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

1.20 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2022. Untaken flexi leave is estimated to be immaterial to the PHA and has not been included.

Retirement benefit costs

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

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. FReM provides an interpretation of the IAS 19 standard and this standard requires the present value of defined benefit obligations to be determined with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date.

The 2021-22 accounts are based on membership data as at 31 March 2016 since it was not practicable to utilise data as 31 March 2020 within the time parameters available. The value of the liabilities as at 31 March 2022 has been calculated by rolling forward the liability calculated as at 31 March 2016 to 31 March 2022. The 2016 valuation assumptions are retained for demographics whilst financial assumptions are updated to reflect current financial conditions and a change in financial assumption methodology. The 2016 valuation is the most recently completed valuation, since the 2020 valuation is ongoing which is why the demographics assumptions are not updated.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

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

Revaluation Reserve

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

1.22 Value Added Tax (VAT)

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

1.23 Third party assets

The PHA had no third party assets in 2021/22 or 2020/21.

1.24 Government Grants

The PHA had no government grants in 2021/22 or 2020/21.

1.25 Losses and Special Payments

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

special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

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

Under IAS 8 there is a requirement to disclose those standards issued but not yet adopted.

The International Accounting Standards Board have issued the following new standards but which are either not yet effective or adopted. Under IAS 8 there is a requirement to disclose these standards together with an assessment of their initial impact on application.

IFRS10 Consolidated Financial Statements, IFRS 11 Joint Arrangements, IFRS 12 Disclosure of interests in Other Entities:

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards were effective with EU adoption from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on Office of National Statistics (ONS) control criteria, as designated by Treasury.

A similar review in NI, which will bring NI departments under the same adaptation, has been carried out and the resulting recommendations were agreed by the Executive in December 2016. With effect from 2022-23, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

IFRS 16 Leases:

IFRS 16 is effective from 1 April 2022 and has the effect of largely eliminating the current ‘off-balance sheet’ treatment of operating leases under IAS 17. A lessee is now required to recognise a “right-of-use” asset (the right to use the leased item) and a financial liability for any operating leases where the term is greater than 12 months, excluding those where the associated right-of-use asset is of low value.

The PHA has set the low value financial threshold at £5k and from the lease agreement can determine the non-cancellable periods for which the PHA has the

right to use the underlying asset. One key consideration is calculating the implicit interest rate within the lease agreement.

Based on the PHA's review to date of operating leases associated with buildings, equipment and other assets there is likely to be minimal financial impact on the 2022/23 financial statements.

The PHA hold 3 Leases which will transfer onto the Statement of Financial Position (SoFP) in accordance with IFRS 16 on 1 April 2022.

2 leases with a combined Net Book Value (NBV) of £36k will come onto the SoFP and will cease on 17 June 2022.

1 lease with a NBV of £499k will come onto the SoFP and cease on 30 September 2026.

1 lease with a NBV of £3k will not go onto the SoFP as it is categorised for a recognition exemption for leases of low-value.

IFRS 17 Insurance Contracts:

IFRS 17 Insurance Contracts will replace IFRS 4 Insurance Contracts and is effective for accounting periods beginning on or after 1 January 2023. In line with the requirements of the FReM, IFRS 17 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2023.

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

1.27 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2022.

NOTE 2 - ANALYSIS OF NET EXPENDITURE BY SEGMENT

The PHA has identified 4 segments: Commissioning, Family Health Services (FHS), Administration, and Safeguarding Board NI - an independent body hosted by the PHA. Net expenditure is reported by segment as detailed below:

Summary	NOTE	2022 £000	2021 £000
Commissioning	2.1	107,549	97,948
FHS	2.2	2,555	2,983
Agency Administration	2.3	36,855	29,592
Safeguarding Board NI	2.4	743	729
Total Commissioner Resources utilised		**147,702**	**131,252**

2.1 Commissioning

Expenditure	NOTE	2022 £000	2021 £000
Belfast Health & Social Care Trust	SoCNE	20,977	19,706
South Eastern Health & Social Care Trust	SoCNE	6,118	5,386
Southern Health & Social Care Trust	SoCNE	8,967	7,929
Northern Health & Social Care Trust	SoCNE	10,174	9,445
Western Health & Social Care Trust	SoCNE	8,740	7,981
NIAS Health & Social Care Trust	SoCNE	117	87
NI Medical & Dental Training Agency	SoCNE	169	167
PCC	SoCNE	0	35
Other	3.1	55,177	50,682
		110,439	101,418
Income			
Revenue from contracts with customers	4.1	2,890	3,471
Commissioning Net Expenditure		**107,549**	**97,948**

2.2 FHS

FHS Net Expenditure	3.1	**2,555**	**2,983**

2.3 Agency Administration

Expenditure	NOTE	2022 £000	2021 £000
Salaries and wages	3.2	34,432	27,050
Operating expenditure	3.2	2,887	2,808
Non-cash costs	3.3	24	22
Depreciation	3.3	399	201
		37,742	30,081
Other Operating Income			
Staff secondment recoveries	4.2	887	489
Administration Net Expenditure		**36,855**	**29,592**

2.4 Safeguarding Board NI

Expenditure			
Salaries and wages	3.2	522	407
Operating expenditure	3.2	221	322
Programme expenditure	3.1	0	0
		743	729
Safeguarding Board NI Net Expenditure		**743**	**729**

NOTE 3 EXPENDITURE

3.1 Commissioning:	2022 £000	2021 £000
General Medical Services	2,555	2,983
Other providers of healthcare and personal social services	44,263	39,893
Research & development capital grants	10,914	10,789
Total Commissioning	**57,732**	**53,666**

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	27,229	21,458
Social security costs	2,856	2,179
Other pension costs	4,869	3,820
Supplies and services - general	65	272
Establishment	2,066	2,159
Transport	5	3
Premises	804	546
Bad debts	6	0
Rentals under operating leases	162	150
Miscellaneous expenditure	0	0
Total Operating Expenses	**38,062**	**30,587**

3.3 Non cash items:		
Depreciation	275	150
Amortisation	123	50
Loss on disposal of property, plant & equipment (including land)	1	1
Increase / Decrease in provisions (provision provided for in year less any release)	0	0
Cost of borrowing of provisions (unwinding of discount on provisions)	0	0
Auditors remuneration	24	22
Total non cash items	**423**	**223**
Total	**96,217**	**84,476**

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

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers	2022	2021
	£000	£000
R&D	2,800	3,421
Other income from non-patient services	90	50
Social Investment Fund	0	0
Total	**2,890**	**3,471**

4.2 Other Operating Income	2022	2021
	£000	£000
Seconded staff	887	489
Total	**887**	**489**

TOTAL INCOME	**3,777**	**3,960**

NOTE 5.1 - Property, Plant & Equipment - Year Ended 31 March 2022

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2021	212	992	54	1,258
Indexation	10	0	1	11
Additions	0	146	0	146
Transfers	0	123	0	123
Disposals	0	(108)	0	(108)
At 31 March 2022	**222**	**1,153**	**55**	**1,430**
Depreciation				
At 1 April 2021	174	321	27	522
Indexation	10	0	0	10
Transfers	0	19	0	19
Disposals	0	(106)	0	(106)
Provided during the year	37	229	9	275
At 31 March 2022	**221**	**463**	**36**	**720**
Carrying Amount				
At 31 March 2022	**1**	**690**	**19**	**710**
At 31 March 2021	**38**	**671**	**27**	**736**
Asset financing				
Owned	1	690	19	710
Carrying Amount				
At 31 March 2022	**1**	**690**	**19**	**710**

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

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £nil (2021 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2021 - £nil).

NOTE 5.2 - Property, Plant & Equipment - Year Ended 31 March 2021

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2020	215	650	38	903
Indexation	0	0	1	1
Additions	0	470	15	485
Transfers	0	90	0	90
Disposals	(3)	(218)	0	(221)
At 31 March 2021	**212**	**992**	**54**	**1,258**
Depreciation				
At 1 April 2020	136	433	19	588
Indexation	0	0	0	0
Transfers	0	4	0	4
Disposals	(3)	(217)	0	(220)
Provided during the year	41	101	8	150
At 31 March 2021	**174**	**321**	**27**	**522**
Carrying Amount				
At 31 March 2021	**38**	**671**	**27**	**736**
At 31 March 2020	**79**	**217**	**19**	**315**
Asset financing				
Owned	79	671	27	315
Carrying Amount				
At 31 March 2021	**79**	**217**	**19**	**355**
Asset financing				
Owned	38	671	27	736
Carrying Amount				
At 31 March 2020	**38**	**671**	**27**	**736**

NOTE 6.1 - Intangible Assets - Year Ended 31 March 2022

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2021	265	292	557
Indexation	0	0	0
Additions	78	0	78
Disposals	0	0	0
At 31 March 2022	**343**	**292**	**635**
Amortisation			
At 1 April 2021	19	148	167
Indexation	0	0	0
Disposals	0	0	0
Provided during the year	74	49	123
At 31 March 2022	**93**	**197**	**290**
Carrying Amount			
At 31 March 2022	**250**	**95**	**345**
At 31 March 2021	**246**	**143**	**390**
Asset financing			
Owned	250	95	345
Carrying Amount			
At 31 March 2022	**250**	**95**	**345**

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

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2021 - £nil).

NOTE 6.2 - Intangible Assets - Year Ended 31 March 2021

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2020	91	298	389
Indexation	0	0	0
Additions	237	93	330
Disposals	(63)	(99)	(162)
At 31 March 2021	**265**	**292**	**557**
Amortisation			
At 1 April 2020	72	207	279
Indexation	0	0	0
Disposals	(63)	(99)	(162)
Provided during the year	10	40	50
At 31 March 2021	**19**	**148**	**167**
Carrying Amount			
At 31 March 2021	**246**	**143**	**390**
At 31 March 2020	**19**	**91**	**110**
Asset financing			
Owned	246	143	390
Carrying Amount			
At 31 March 2021	**246**	**143**	**390**
Asset financing			
Owned	19	91	110
Carrying Amount			
At 31 March 2020	**19**	**91**	**110**

NOTE 7 - FINANCIAL INSTRUMENTS

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

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2021/22 or 2020/21.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

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

The PHA did not hold any assets classified as held for sale in 2021/22 or 2020/21.

NOTE 10 - INVENTORIES

The PHA did not hold any inventories as at 31 March 2022 or 31 March 2021.

NOTE 11 - CASH AND CASH EQUIVALENTS

	2022 £000	2021 £000
Balance at 1st April	471	887
Net change in cash and cash equivalents	384	(416)
Balance at 31st March	**855**	**471**

The following balances at 31 March were held at	2022 £000	2021 £000
Commercial banks and cash in hand	855	471
Balance at 31st March	**855**	**471**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2022 £000	2021 £000
Amounts falling due within one year		
Trade receivables	764	665
Deposits and advances	353	259
VAT receivable	451	549
Other receivables - not relating to fixed assets	3,497	2,681
Trade and other receivables	**5,065**	**4,154**
Prepayments and accrued income	35	12
Other current assets	**35**	**12**
TOTAL TRADE AND OTHER RECEIVABLES	**5,065**	**4,154**
TOTAL OTHER CURRENT ASSETS	**35**	**12**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**5,100**	**4,166**

The balances are net of a provision for bad debts of £nil (2021 £nil).

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2022 £000	2021 £000
Amounts falling due within one year		
Other taxation and social security	709	502
Trade capital payables - property, plant and equipment	0	0
Trade capital payables - intangibles	1	565
Trade revenue payables	8,162	8,730
Payroll payables	2,326	2,565
BSO payables	477	172
Other payables	1,545	2,800
Accruals	0	0
Deferred Income	624	217
Trade and other payables	**13,844**	**15,551**
Total payables falling due within one year	**13,844**	**15,551**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**13,844**	**15,551**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2022

	Other £000	2022 £000
Balance at 1 April 2021	0	0
Provided in year	0	0
(Provisions not required written back)	0	0
(Provisions utilised in the year)	0	0
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2022	**0**	**0**

Comprehensive Net Expenditure Account charges	2022 £000	2021 £000
Arising during the year	0	0
Reversed unused	0	0
Cost of borrowing (unwinding of discount)	0	0
Total charge within Operating expenses	**0**	**0**

Analysis of expected timing of discounted flows

	Other £000	2022 £000
Not later than one year	0	0
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2022	**0**	**0**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2021

	Other £000	2021 £000
Balance at 1 April 2020	0	0
Provided in year	0	0
(Provisions not required written back)	0	0
(Provisions utilised in the year)	0	0
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2021	**0**	**0**

Analysis of expected timing of discounted flows

	Other £000	2021 £000
Not later than one year	0	0
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2021	**0**	**0**

NOTE 15 - CAPITAL AND OTHER COMMITMENTS

The PHA did not have any capital or other commitments as at 31 March 2022 or 31 March 2021.

NOTE 16 - COMMITMENTS UNDER LEASES

16.1 Finance Leases

The PHA had no finance leases in 2021/22 or 2020/21.

16.2 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise	2022 £000	2021 £000
Buildings		
Not later than 1 year	194	221
Later than 1 year and not later than 5 years	416	39
Later than 5 years	0	0
	610	**260**

16.3 Commitments under Lessor Agreements

The PHA had no lessor obligations in either 2021/22 or 2020/21.

NOTE 17 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT

The PHA had no commitments under PFI or service concession arrangements in either 2021/22 or 2020/21.

NOTE 18 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2022 or 31 March 2021.

NOTE 19 - CONTINGENT LIABILITIES

Clinical negligence

The PHA has contingent liabilities of £7k

	2022 £000	2021 £000
Total estimate of contingent clinical negligence liabilities	5	0
Amount recoverable through non cash RRL	(5)	0
Net Contingent Liability	0	0

Employers' liability

	2022 £000	2021 £000
Employers' liability	2	2
Amount recoverable through non cash RRL	(2)	(2)
Net Contingent Liability	0	0

In addition to the above contingent liabilities, provision for clinical negligence and employers' liabilites would be given in Note 14. Other litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

NOTE 20 - RELATED PARTY TRANSACTIONS

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

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

NOTE 21 - THIRD PARTY ASSETS

The PHA had no third party assets in 2021/22 or 2020/21.

NOTE 22 - FINANCIAL PERFORMANCE TARGETS

22.1 Revenue Resource Limit

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

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

	2022 Total £000	2021 Total £000
DOH (excludes non cash)	132,685	117,983
Other Government Departments	495	496
Non cash RRL (from DOH)	423	223
Total agreed RRL	133,603	118,702
Adjustment for Research and Development under ESA10	14,193	12,656
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**147,796**	**131,358**

22.2 Capital Resource Limit

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

	2022 Total £000	2021 Total £000
Gross capital expenditure	225	815
Net capital expenditure	225	815
Capital Resource Limit	14,426	13,719
Adjustment for Research and Development under ESA10	(14,193)	(12,656)
Overspend/(Underspend) against CRL	(8)	**(248)**

22.3 Financial Performance Targets

The PHA is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits.

	2022 £000	2021 £000
Net Expenditure	(147,702)	(131,252)
RRL	147,796	131,358
Surplus / (Deficit) against RRL	94	106
Break Even cumulative position(opening)	1,821	1,715
Break Even cumulative position (closing)	**1,915**	**1,821**

Materiality Test:	2021/22 %	2020/21 %
Break Even in year position as % of RRL	0.06%	0.08%
Break Even cumulative position as % of RRL	1.30%	1.39%

The PHA has met its requirements to contain Net Resource Outturn to within +/- 0.25% of its agreed Revenue Resource Limit (RRL), as per DoH circular HSC(F) 21/2012.

NOTE 23 - EVENTS AFTER THE REPORTING PERIOD

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

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 30 June 2022.