PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2016

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Laid before the Northern Ireland Assembly
under Schedule 1, para 17(5) of the Reform Act for the Regional Agency, by the Department of Health, Social Services and Public Safety.
On 30 June 2016

Using this report

This report reflects progress by the PHA in 2015/16 in delivering its corporate priorities and highlights examples of work undertaken to meet the targets as detailed in the PHA's annual business plan. 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 PDF file of this document is also available to download from www.publichealth.hscni.net

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This publication is also available for download from our website at:
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ISBN: 978-1-874602-79-8

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Overview

The Public Health Agency – Our role, purpose and activities

The 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, Business Services Organisation (BSO) and the Patient Client Council (PCC).

In operation since April 2009, it drives the public health and social wellbeing agenda, encompassing a wide range of functions to give a renewed, enhanced and sustained focus on health protection and improving health and wellbeing outcomes.

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

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;
- reduce inequalities in health and social wellbeing through targeted, effective action.

During 2015/16 we continued to work within and be guided by our purpose, vision and values.

Our purpose

- To protect and improve the health and social wellbeing of the people of Northern Ireland and to reduce health inequalities through strong partnerships with individuals, communities and key public, private and voluntary organisations.

Our vision

- That all people in Northern Ireland can achieve their full health and wellbeing potential.

Our values

- Improving the health and social wellbeing of the community we serve will be at the heart of everything we do;

- In conducting our business, we will act with openness and honesty, treating all with dignity and respect;
- We will work in partnership to improve the quality of life of those we serve;
- We will value and develop our staff and strive for excellence in all we do.

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Introduction from the Chair

When I took up my post as Chair of the PHA in June 2015, I was extremely impressed by the range and diversity of the work of the PHA.

Having worked in a medical charity for more than three decades, I had the opportunity to meet with a broad range of individuals within the PHA. I was aware of many of the PHA's responsibilities but not of the full extent of the excellent work which the organisation undertakes to improve the health and social wellbeing of the entire population of Northern Ireland.

Similarly, many people are unaware of all of the vital work being undertaken in helping to protect the population from ill-health, infection and disease.

Raising awareness of this work, and trying to inform and motivate individuals to make lifestyle changes, is an on-going challenge of our important public information campaigns.

I am pleased to be involved in the work to develop the new PHA Corporate Strategy for 2017–2021, a period which will see substantial change and reform within health and social care and one which may introduce some uncertainty. The PHA should, and will, I am sure, welcome such change as a challenging friend.

Recognising the wider financial constraints, it is essential that any reduction in our budget is managed in a manner which will continue to deliver optimal outcomes and impact. The community benefit deriving from every aspect of our work is a great motivation.

The accomplishments of the PHA over the last seven years should embolden and encourage staff to ensure that our programmes continue to enhance the health and wellbeing of the people of Northern Ireland.

A very small selection of the achievements from the past year is included in this report – ranging from notable successes in screening, through to important work to address social isolation and actively engaging with those who use our services through Personal and Public Involvement activity to name but a few.

I wish to acknowledge the commitment and dedication of all of the PHA Board members for their oversight, scrutiny and stewardship of the work of the PHA and I applaud the different perspectives they bring to the many diverse issues discussed by the Board.

It is with profound regret that I report the passing of Dr Jeremy Harbison in July 2015. Jeremy served as a valued member of the PHA Board since its inception until the end of April 2015; his wise counsel is sorely missed.

Our Agency Management Team (AMT) has also worked tirelessly over the last year along with the entire staff of the PHA who contribute so much to the health and wellbeing of the people in Northern Ireland. AMT and all the staff are to be commended for their enduring commitment to advancing the noble aims of the PHA.

A special final word must go to Dr Eddie Rooney, Chief Executive of the PHA since its inception in 2009, who has announced he is to retire in October 2016.

His outstanding leadership and exemplary ambassadorial skills have played no small part in the standing of the PHA and in the appreciation of its work throughout the community.

Looking to the future, it is our fervent hope that we will be able, even at a time of contracting budgets, to redouble our efforts to ensure that the goals for the health and wellbeing of the people in Northern Ireland will be further advanced in the years ahead. The work of the PHA has done so much to improve the quality of life for so many people in Northern Ireland.

I commend this report to you and hope that you find it both interesting and informative and trust that it clearly reaffirms our commitment to encourage that health and wellbeing are a priority for everyone.

Andrew Dougal OBE
Chair

Date 16 June 2016

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Chief Executive's Statement 2015/16

The Public Health Agency has a central role to play in protecting and improving the health and wellbeing of the people of Northern Ireland and the last year has been an important, challenging and eventful period.

We have seen many notable achievements and successes during the year. This annual report highlights a small selection of the activities undertaken with a particular emphasis on some of the targets and key priorities reflecting statutory requirements and DHSSPS and PHA objectives.

Our Business Plan for 2015/2016 contained some 66 key targets which cover every facet of our work. A further three targets for the PHA were set out in the DHSSPS document *Commissioning Plan Directions (Northern Ireland) 2015*.

Good progress has been made during the year against these targets, the achievement of which is monitored on a quarterly basis through our Performance Management Reports to the PHA Board.

An important focus during the year has been the implementation of *Making Life Better* (MLB) – the whole-system strategic framework for public health. MLB includes a range of strategic actions for government departments and other agencies and also sets the direction for a number of supporting areas for joint working at regional and local levels.

As designated lead agency for the regional implementation of the new framework, many of the targets within our annual Business Plan detailed above have been selected carefully with the key actions of MLB in mind. These have also been identified as having the biggest potential impact on improving levels of health and social wellbeing, protecting the health of the community, and ensuring patients continue to receive high quality and safe treatment and care services.

Important work during the year has also been undertaken with the MLB Regional Project Board which comprises representation from all relevant statutory agencies, local government, and the community, voluntary and private sectors, with a view to fulfilling MLB's key goals.

In addition to close partnership working with the Regional Project Board, we have been working closely with DHSSPS and other partners throughout the year to establish important structures that will facilitate implementation of MLB.

This important collaboration and partnership approach recognises that many factors can affect an individual's health and our collective aim and renewed focus is to ensure the creation of the right conditions for individuals and communities to take control of their own lives and ultimately achieve better health and wellbeing and reduce health inequalities.

Important partnership working has also continued with each of the 11 Councils under their new arrangements and, in light of their increased responsibility for community planning, the PHA has welcomed the increased collaboration focusing on the implementation of MLB. We look forward to continuing to work together and to aligning our common goals for the benefit of our communities.

In July 2015 the DHSSPS transferred responsibility for taking forward the work of the Unscheduled Care Task Group to the HSCB and PHA.

Regional and Locality Network Groups have been established and these report through to a Strategic Accountability Group chaired by the HSCB and PHA Chief Executives, with membership comprising the six HSC Trust Chief Executives, Senior Departmental representatives and the Chief Executive of the Patient and Client Council.

Eight key priorities for 2016/17 have recently been approved by the Strategic Accountability Group and work has commenced under each of these priorities to strengthen the emphasis on prevention, spread best practice on treatment and care, and improve the safe return of patients to the community.

Work is also underway to engage on a regional basis with the Institute of Health Improvement (IHI) to apply the IHI Triple Aim framework to optimise health system performance particularly with regard to improving services for frail older people accessing unscheduled care services.

A primary focus for the groups is also capturing and responding to patient experience and enhancing Personal and Public Involvement (PPI), which the PHA has lead responsibility for across the HSC through our Directorate of Nursing and Allied Health Professions (AHPs).

As part of this role, we have supported the HSC Trusts in meeting their PPI statutory and policy responsibilities.

During 2015/16, the PHA also supported the DHSSPS on implementation of *Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland*.

The goals of the strategy are the delivery of high quality services and for Northern Ireland to be recognised locally and internationally as a leader for excellence in health and social care. During the year a key piece of work was the delivery of the Q2020 Attributes Framework which promotes leadership in quality improvement across the whole of the HSC.

Cross-border partnership working was further enhanced through our work with Cooperation and Working Together (CAWT). Project proposals have been submitted to the EU health programme (Interreg 5) on a range of innovative ideas spanning all

health and social care sectors across hospital, primary and community care services with a focus on disadvantaged communities, children, and people with mental health problems, disabilities and the elderly.

Protecting and improving health and wellbeing and reducing health inequalities is at the core of all of our work. This is achieved through strong partnerships and reflected in our own focused programmes of work.

Our comprehensive screening and vaccination programmes, for example, again rose to the challenge with continued impressive uptake rates and the introduction of new important vaccines for children and young people.

Important health protection work continued with ongoing planning, training and exercises to ensure preparedness across all health services in the event of diseases such as Ebola or Zika presenting in Northern Ireland, none of which were recorded during 2015/16.

We welcomed the launch of the new HSC Research and Development (R&D) Strategy during the year. With an investment of over £10million annually, the new strategy aims to enhance the health, wellbeing and prosperity of people in Northern Ireland through world-renowned research and development and we look forward to the PHA's R&D Division delivering the Strategy's Implementation Plan.

Innovation and technology continue to play a key role in supporting changes to services and the Centre for Connected Health and Social Care (CCHSC), located within the PHA, has played a leading role in eHealth development, working closely with HSCB, DHSSPS and others to drive improvements in health and social care.

Our public information campaign activity continued to target the population during the year through the use of TV, radio and outdoor advertising as well as social media and targeted online advertising including high profile multi-channel campaigns on smoking, cancer, mental health and obesity.

Special mention should go to our Health Improvement team for winning the 2015 Public Health Leader Award; to the PHA's Quality Assurance Reference Centre (QARC) team on winning the prestigious 'Access to Information' award from the British Deaf Association; and to the transforming cancer follow-up team which won the prestigious RCN Cancer Nursing Award in May in recognition of the successful breast cancer follow-up programme. This latter award was a partnership between Macmillan, HSCB and PHA.

As Chair of the Northern Ireland Committee for Organ Donation and Transplantation I am delighted at the progress that has been made within the health services and by all of the organisations involved in promoting organ donation and transplantation.

The PHA launched its 'Speak up and save a life' organ donation campaign in February 2014, which aimed to raise awareness of the issue of organ donation in Northern Ireland and to encourage people to sign the NHS Organ Donor Register. At the end of 2013/14 32% of the population in Northern Ireland were registered as organ donors. At the end of the third quarter of 2015/16 (31 December 2015), the number of people in Northern Ireland who have registered their wishes to be a donor had risen to 36%.

Furthermore, the outgoing Health Minister Simon Hamilton endorsed a clause in the Health (Miscellaneous Provisions) Bill, which passed on 15 March 2016, placing a duty on his Department to promote organ donation and transplantation which will only help increase these figures even further.

A special word must go to each and every one of our dedicated staff and Board members for their tireless work during a year of significant change and challenge.

I would like to thank, in particular, those members of staff who have retired or are leaving under the Voluntary Exit Scheme and wish them the very best for the future.

The next chapter for the PHA will see further changes. The Minister's statement on the future structures of the HSC has reaffirmed the importance of prevention and early intervention to creating a healthier society. The PHA will play a full part during the coming year in helping to achieve that goal.

Dr Eddie Rooney
Chief Executive

Date 16 June 2016

Performance Analysis

Performance against the 69 targets detailed in our annual *Business Plan 2015/16* has been of a very high standard.

Figures, based on the position at 31 March 2016, report a total of 50 coded as green for having been achieved; 16 as amber – meaning they will be achieved, albeit with a short delay; and 3 as red – meaning they will not be achieved. It is also worth highlighting that each red coding has been for reasons outside of the PHA's control such as external funding issues or other environmental factors.

The following narrative from each of the PHA's three Directorates, namely, the Directorate of Public Health; the Directorate of Nursing and Allied Health Professions; and the Operations Directorate, details some of the activities undertaken during the year in fulfilment of organisational goals and attainment of targets.

In addition, it looks at the future development of the organisation; environmental, social and community issues; and other relevant issues affecting organisational development.

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DIRECTOR'S REPORT – PUBLIC HEALTH

During 2015/16 the Public Health Directorate continued to address the main public health challenges in Northern Ireland in fulfilment of our corporate objectives and business goals. The work of the Public Health Directorate covers four key areas:

- Health Protection;
- Health and Social Wellbeing Improvement;
- Service Development and Screening; and
- HSC Research and Development.

In line with *Making Life Better*, the Northern Ireland Executive's strategic framework for public health, the Public Health Directorate continued to work to protect and improve the health and social wellbeing of the people of Northern Ireland through a broad range of health programmes and initiatives.

An important area of work taken forward at the Department's request during the year was medical workforce planning for Northern Ireland (NI). Under the auspices of the Department's Regional Workforce Planning Group the PHA will lead on this important project up until 2019, the main aims of which are to identify appropriate medical staffing levels within health and social care in Northern Ireland.

Workforce plans for medical specialties are being developed on a specialty-by-specialty basis. As Senior Responsible Officer, along with Dr Gillian Rankin, Project Director and Medical Workforce Planning Lead, HSCB, we are developing a suite of workforce plans for primary and secondary care whilst working closely with commissioners, Trusts, the Northern Ireland Medical and Dental Training Agency (NIMDTA) and the British Medical Association (BMA).

To date, workforce plans have been completed for the following specialties:

- Paediatrics;
- General Practice;
- Trauma and Orthopaedics; and
- Emergency Medicine.

Workforce reviews are currently taking place in:

- Geriatric Medicine;
- Anaesthetics;
- Intensive Care Medicine;
- Occupational Medicine;
- Neurology;
- Acute Medicine (Acute Internal Medicine, Endocrinology, Gastroenterology, Respiratory Medicine, Rheumatology); and
- Palliative Care Medicine.

It is expected that work will commence later in 2016 in other specialties including:

- Ophthalmology;
- Psychiatry; and
- Dermatology.

Since new arrangements for processing Safety and Quality Alerts (SQAs) were introduced in April 2012, I have chaired the HSCB/PHA Safety and Quality Alerts Team (SQAT). Important progress has taken place this year to ensure the safety and quality process, which provides a mechanism to share learning and focus on quality, and is leading to service improvements for users.

SQAs come from a variety of sources, including Serious Adverse Incidents (SAIs); reviews by the Regulation and Quality Improvement Authority (RQIA); safeguarding reports; legislative changes; medicines regulators; equipment or device failures; national safety systems; and independent reviews.

Some SQAs relate to substantive safety issues that require a high level of assurance, while others relate to risk which can be managed within existing clinical and social care governance and risk management arrangements.

The Alerts Team manages the arrangements for the implementation and assurance of Category 1 SQAs which include:

- DHSSPS Safety Quality and Standards (SQS) guidance and letters;
- Learning letters arising from SAIs;
- National Patient Safety Agency (NPSA) alerts, or equivalent;
- Safety or quality-related professional letters from DHSSPS; and
- RQIA reports and other independent reviews.

The volume of alerts has been challenging for providers and commissioners to manage over the years but HSC Trusts are working more collaboratively with HSCB/PHA on single solutions and stronger direct reporting on detail to DHSSPS which has substantially improved the quality and safety of HSC services.

The fourth Public Health Annual Scientific Conference was held in June 2015, the theme of which was Improving Health and Care for Adults, in line with *Making Life Better*.

The conference showcased local evidence-based public health programmes and high quality research studies which helped improve the health and wellbeing of our adult population.

Appraisal for medical practitioners is a requirement for each doctor and annual enhanced appraisal is required for the General Medical Council's revalidation of doctors.

I am also the Responsible Officer for PHA Consultants, Academics in Public Health at Queens University Belfast, and the Responsible Officers (Medical Directors) of HSC Trusts and the Health and Social Care Board.

During the year, quality assurance processes were further strengthened to support and enhance the appraisal process and all of the doctors who were due for revalidation successfully completed the process.

During the year we continued to meet objectives and focused on improvements in mental and emotional wellbeing, successfully securing training for community, voluntary and statutory sector partners in mental health first aid and promoting and building resilience in schools, communities and workplaces. We also worked with the four main Christian churches through an initiative called 'Flourish' to provide support and help to deal with mental health and suicide in a parish context.

The Northern Ireland Self Harm Registry, a unique database in the UK, provides information on those presenting with self-harm to Emergency Departments of hospitals in Northern Ireland. A new service has now also been put in place across the region to support those who present with self-harm leading to improved health and wellbeing and ultimately preventing deaths from suicide.

Our commitment to research and development to ensure long-term improvements in the health and wellbeing of the Northern Ireland population was also underlined through various projects.

Partnership funding of research can boost the value of the HSC R&D Fund substantially and this year has seen the completion of the first of five research projects funded jointly between the HSC R&D Division and The Atlantic Philanthropies under the Bamford Implementation Programme.

The findings of this project, looking at resilience in children of parents who abuse alcohol, were launched on 8 March 2016. The four remaining projects are underway and will be completed during 2016/17.

HSC R&D also partnered during the year with The Atlantic Philanthropies and DHSSPS to support a research call across the three work streams of the Early Intervention Transformation Programme (EITP). This research is examining the effectiveness of the new services rolled out under this programme, focusing on whether they help to empower families, improve quality of life and assist parents to make informed choices about parenting styles.

Another important work stream for HSC R&D is the use of routinely collected data for health and social care research. This year, support was provided to include a survey of public attitudes to data sharing in Northern Ireland, as part of the Northern Ireland Life and Times Survey. This research will allow the capture of public attitudes

regarding the balance between privacy and the public good in the use of information gathered by government bodies.

Investment in the National Institute of Health Research (NIHR) funding streams has also brought further significant success during the year. From an investment of £4.28m, Northern Ireland researchers are now leading thirteen major research studies with a value of £10.87m, many of which are UK-wide multi-centre studies. Studies worth a further £26m currently involve researchers in Northern Ireland as co-investigators.

Cancer screening programmes in Northern Ireland continued to achieve very good uptake rates. The bowel cancer screening programme, for example, is now inviting over 140,000 people aged 60–74 to participate each year and uptake continues to increase with 58.4% of those invited between April 2015 and October 2015 taking up the invitation within 12 weeks compared to 55.6% in 2014/15.

Our Health Protection Service has also continued to work to protect the population in Northern Ireland from serious health risks due to communicable diseases and other hazards and during the year delivered a rapid response service over a five-day period to Harland and Wolff shipyard staff in response to an outbreak of Pneumococcal Infection at the Belfast shipyard.

This required close collaboration between Health Protection, Harland and Wolff and Belfast HSC Trust staff.

Immunisation remains one of our biggest work programmes and in September a new vaccine was introduced to the childhood programme – Meningococcal B.

This vaccine is now being offered to all babies at 2, 4 and 12 months. In addition, older children are being protected against Meningitis strains of ACWY through a routine programme introduced in January for those aged between 14 and 15 years.

A number of catch up campaigns were also initiated and in August 2015 GPs were advised to offer the Men ACWY vaccine to older first-time university students. In line with strategic objectives, the service continues to work with HSC Trusts and GPs to achieve high uptake rates for vaccines against preventable diseases.

The following sections illustrate further examples of Public Health Directorate activity and how we achieved our goals during 2015/16.

Health and Social Wellbeing Improvement

Tobacco

Cigarette smoking is the major cause of premature death and morbidity in Northern Ireland and accounts for 50% of the inequalities in health with 2,300 deaths each year, or roughly six deaths per day. For each person that dies as a result of smoking, 20 are left with long-term life-limiting conditions.

A new *10 Year Tobacco Strategy for Northern Ireland* was launched in 2012. This strategy is a multi-organisational strategy with the overall aim of creating a tobacco-free society for the population of Northern Ireland, achieved through three main objectives:

- fewer people starting to smoke;
- more smokers quitting; and
- protecting people from tobacco smoke.

The PHA has responsibility for implementing the strategy and to this end has created a multidisciplinary inter-sectoral group, the Tobacco Strategy Implementation Steering Group (TSISG), under the direction and Chairmanship of Dr Carolyn Harper, Director of Public Health.

In 2012, the hospital costs of smoking were estimated to be £164m per year (DHSSPS). The total costs to the economy are estimated to be around £450m (PHA, 2015) and the annual expenditure by the PHA on tobacco control is £4.5m.

In terms of investment in public information campaigns, the evaluation of the ‘Make them Proud’ campaign showed that the PHA spent one penny per second on the campaign which reached 72% of smokers in Northern Ireland and encouraged 6.8% of them to make a quit attempt. This can be compared to the $285 per second spent on advertising by the tobacco industry in the USA.

In the last two years, smoking prevalence has been reduced from 24% to 22% among the adult population. The aim is to reduce this to 15% by 2020.

In order to ensure the delivery of plans and specific actions on tobacco control, a senior officer from within the PHA has been tasked with the responsibility of developing coordinated action. A multi-disciplinary team is now developing, implementing, monitoring and evaluating a comprehensive programme of work.

In partnership with a broad range of external organisations, high quality, effective and efficient services and interventions are helping to improve and protect the public’s health.

The services and resources developed by the PHA are tested among target audiences before production. The test results are used to help shape future services. The findings are also shared with other parts of the United Kingdom, Republic of Ireland and further afield to inform and influence best practice.

Stop smoking services are commissioned by the PHA from over 600 service providers throughout Northern Ireland in a range of settings including: Community Pharmacies; General Practice; Trusts; workplaces; and throughout the community and voluntary sectors.

When benchmarked against services in Great Britain, local services consistently achieve greater reach and higher cessation rates.

Latest figures available from 2014/15 show that 59% of those using the services remained 'stopped' at four weeks – a recognised performance measure in this field (PHA 2016 – Key Performance Indicators).

Since 2009, 179,402 people have accessed stop smoking services across Northern Ireland, of whom 98,584 have remained 'stopped' at four weeks.

The reach of services to communities and those who are most likely to smoke is deemed 'good'. Four-week cessation rates among routine and manual workers are also recorded as being favourable at 62% (recent figures from 2014/15).

Training and development of staff, the integration of smoking within service frameworks and care pathways, and the promotion of a cultural change in the non-acceptability of smoking within the HSC, have all been major achievements within recent years.

The development of new models of training delivery and the more recent introduction of Smoke Free Campuses across all HSC Trusts in Northern Ireland are further examples of success.

HSC Research and Development

Support for Mental Health Research

HSC R&D works with a range of stakeholders to address issues of relevance to the HSC and the Northern Ireland population in many areas of health and social care including mental health. Two initiatives which have progressed substantially during the year are described below:

The Bamford Implementation Research Programme

The 2007 *Bamford Review of Mental Health and Learning Disability* ('Bamford') indicated a considerable number of areas of research need. These

recommendations for research were further developed in the *Bamford Action Plan* launched by the Minister for Health, Social Services and Public Safety in 2009.

The HSC R&D Division has worked with users of research (policy-makers, practitioners and commissioners) and with researchers to determine the main priority areas from among the Bamford recommendations. Patients, clients and carers were also consulted with as part of this process.

The HSC R&D Division subsequently commissioned a series of rapid reviews in the five priority research areas of: children and young people; primary care; patient outcomes; psychological therapies; and learning disability, to consider the available literature, identify policy implications, examine specified sub-themes and determine key research questions that would address current knowledge gaps.

Following their review by an expert panel, eight research questions were identified. These questions informed a subsequent research call and five projects were funded in 2012 to address some of these questions by multi-disciplinary teams of academics, clinicians and members of the voluntary sector (see table below) in our Bamford Implementation Scheme. To date, one of these projects has been completed and the remaining four will be completed during 2016/17.

A natural experiment investigating differences in how residential facilities support people with intellectual disabilities with challenging behaviour and/or mental health problems
Effective family support models during the transition of adults with intellectual disabilities (ID) into old age
Transitions and outcomes for care leavers with mental health and/or intellectual disabilities
Parental alcohol use and resilience in young people in Northern Ireland: A study of family, peer and school processes
Improving pathways and care for young people in Northern Ireland with mental health problems in the transition from Child and Adolescent Mental Health Service (CAMHS) to adult services (IMPACT)

Suicide Prevention Research Programme

In direct response to the recognition by DHSSPS of the high priority for a greater understanding of the complex needs of those affected by suicide in Northern Ireland, HSC R&D Division ran a number of commissioned calls for research in key areas which have been developed in conjunction with DHSSPS.

Projects funded to date include:

Providing meaningful care: learning from experiences of suicidal men to inform mental health services' which focuses upon young suicidal men
The National Confidential Inquiry into suicide and homicide by people with mental illness
Geodemographic factors associated with deliberate self-harm and death by suicide: a 'within and between' neighbourhoods analysis
Suicide in Northern Ireland: a comparison of service use and needs in urban and rural settings

The findings of the overall commissioned programme of research have provided valuable information to assist the implementation of the suicide prevention strategy in Northern Ireland. The first two projects were launched in 2011 with the remaining two projects and the recently completed Bamford project *(Parental alcohol use and resilience in young people: A study of family, peer and school processes)* being launched in March 2016.

Service Development and Screening

Screening throughout your lifetime

Northern Ireland screening programmes cover the entire population, from birth through to older age.

All PHA screening programmes aim to achieve early diagnosis and treatment, thereby reducing morbidity and mortality. A synopsis of each screening programme in Northern Ireland is detailed below:

Screening programme	Description	Number of attendees/ responders	Uptake rate 2014/15
Antenatal screening	All pregnant women are offered screening for hepatitis B, HIV and syphilis infection as well as for non-immunity to rubella infection.	25,500	>99%
New-born blood spot screening	All babies in Northern Ireland are offered screening for a range of rare conditions which can cause serious disability or death (e.g. cystic fibrosis).	23,810	>99%
New-born hearing screening	All new-born infants are offered hearing screening, aiming to reduce the effects of permanent childhood hearing impairment on the development of speech and communication skills.	23,859	>98%
Diabetic eye screening programme	Those with diabetes aged 12 and over are invited to have photographs taken of the backs of their eyes once a year. This checks for damage to the retina caused by diabetes and aims to reduce sight loss.	45,118	74%
Cervical screening programme	All women aged 25–64 are invited to attend for a 'smear' test, which aims to prevent cervical cancer by detecting early pre-cancerous changes in the cells that line the cervix.	116,085	77% Coverage
Breast screening programme	All women aged 50–70 are invited for screening mammography every three years. The aim of the programme is to reduce mortality from breast cancer.	57,758	75%
Abdominal Aortic Aneurysm (AAA) screening programme	In the year they turn 65; all men are invited for a one-off ultrasound scan of their abdomen. The aim of the programme is to reduce mortality from ruptured AAAs.	7,605	83%
Bowel cancer screening programme	This programme offers screening every two years to all men and women aged 60–74. If detected at a very early stage, bowel cancer treatment can be 90% successful.	78,420	57%
	Total screening attendances 2014/15	**378,155**	

Numbers of attendees/responders and uptake rates for each of the screening programmes in Northern Ireland for 2014/15 (latest available figures) are shown in the Table above. In total, there were 378,155 screening attendances during the year.

Health Protection

Invasive Pneumococcal Disease outbreak associated with Belfast Shipyard

One of the many roles of health protection staff within the PHA is to investigate and manage outbreaks of infectious disease in the community. In late April/early May 2015 the PHA declared an outbreak of serious pneumococcal disease (two or more cases of pneumococcal pneumonia or Invasive Pneumococcal Disease (IPD) being reported from a closed setting within a two-week period) in a shipyard in Belfast.

Pneumococcal disease is caused by the bacterium *Streptococcus pneumoniae* (pneumococcus). Infections caused by *S. pneumoniae* are associated with a spectrum of disease, ranging from milder illnesses such as otitis media and sinusitis, to presentations such as pneumonia, bacteraemia and meningitis.

Outbreaks of serious pneumococcal disease are relatively rare, and the majority that have been reported occurred in hospitals or long-term care facilities.

There is a recognised association between exposure to metal fumes and pneumonia, and between welding and IPD. As such, UK immunisation guidance recommends that consideration should be given to vaccinating those at risk of frequent or continuous occupational exposure to metal fumes, taking into account the exposure control measures in place. This is the first outbreak of IPD in the context of an oil rig or shipyard setting that we are aware of.

PHA staff convened an Outbreak Control Team (OCT) and worked with the shipyard owners and colleagues in the Belfast Health and Social Care Trust, the Northern Ireland Health and Safety Executive and the Port Health Team to investigate and manage the outbreak.

Control measures were put in place and included the setting up and running of dedicated clinics to offer chemoprophylaxis and vaccination to the group of shipyard workers who were assessed as being at higher risk.

The complexities of this outbreak such as the scale of the project; the large mobile workforce; the range of specialist work carried out on the oil rig; and the worker shift patterns all presented significant challenges to the OCT.

The setting up and running of clinics on site at very short notice was a particular challenge and had not been done before in Northern Ireland outside a health care setting.

Over 600 workers were given chemoprophylaxis and vaccination over three days of clinics and the main success of this was acknowledged as being the good working relationships between staff, not only within the PHA, but with BHSCT staff whose willingness to help at short notice must be applauded.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

DIRECTOR'S REPORT- NURSING AND ALLIED HEALTH PROFESSIONS

The PHA Nursing and Allied Health Professions (AHP) Directorate is responsible for professional advice, support and assistance relating to all areas of nursing, midwifery, health visiting and allied health professions with particular leadership in midwifery supervision and public health nursing.

In addition, the Directorate has lead responsibility for Personal and Public Involvement (PPI) across the HSC; the Patient Client Experience function; and management of the Health and Social Care Safety Forum. The Directorate also provides professional advice to local and regional commissioning groups.

The work of the Directorate focuses on ensuring people are enabled and supported to achieve their full health and wellbeing potential.

The main aim is to achieve better health and wellbeing for everyone and reduce inequalities as outlined in the *Making Life Better* strategy 2013-2023.

The team is committed to ensuring safe, effective and high quality care; to continually improving services; developing learning systems; and, supporting all staff to deliver compassionate care.

During the year the Directorate continued to fulfil strategic objectives and business goals and deliver upon a number of key areas and projects, some examples of which are detailed below.

- The development of 'Engage and Involve', the PPI training programme for HSC. This programme, launched in February 2016, contains both e-learning and taught training materials. The generic HSC-wide PPI training programme is now available and will be rolled out across HSC from 2016 onwards.
- The PPI team led on the development of a set of standards which were formally endorsed by the DHSSPS in 2015 and set out what is expected of HSC organisations and staff.
- In partnership with HSCB, HSC Trusts and NIPEC, a workforce tool was developed to ensure appropriate nurse staffing levels which are crucial to patient safety. As a result of this leading edge work over £12 million has been invested in nursing in medical and surgical wards. Work is also progressing in health visiting, emergency departments and district nursing.
- The '10,000 Voices' project, developed in partnership with the HSCB, continued during the year to provide a vehicle to collect personal stories from patients, clients and staff which will help to affect, inform and influence changes in the way services are commissioned and delivered.
- Supporting the introduction of Revalidation for Nurses and Midwives in October 2015, the PHA recognised that the GP-employed nurses would benefit from workshops to increase their awareness of revalidation, establish

networks and closer working relationships. To facilitate this, the team has provided ongoing support to individuals and practices and commissioned the Royal College of Nursing to deliver 15 evening sessions in local venues across Northern Ireland.

- An AHP demand-capacity analysis was completed, helping to ensure appropriate investment in key professions to improve patient access.
- The AHP Data Definitions was updated to ensure standardisation and consistency of data for elective AHP services.
- A regional scoping of District Nursing services took place which has helped to drive investment into District Nursing and a regional District Nursing Advisory Group has been established.
- A Marie Curie night service was developed to ensure a 24-hour service for people with palliative care needs.
- The Regional Learning Disability Healthcare and Improvement Steering Group, led by the PHA, continued to make progress through the improvement of the healthcare and health and social wellbeing of people with learning disabilities.
- We also worked closely with the HSCB eHealth Directorate on plans to implement the regional eHealth and care strategy.
- The Nursing Directorate has responsibility for recording and processing complaints received by the PHA. During the year we received one formal complaint.

Early Years

There is significant evidence to suggest that focusing efforts on the early years of an individual's development and health has significant impact on their long-term health and wellbeing as they become adults. To support this, the team has been involved in a number of initiatives including the following examples:

Implementation of the Maternity strategy

This strategy promotes safe, women-centred maternity care and "right care by the right person". A sub-group was set up to review community maternity care and has focussed on reviewing antenatal care in the community. The main output of this work is the development of a Core Care Pathway for Antenatal Care, particularly for women with a straightforward pregnancy.

This pathway will be incorporated into the maternity hand held record and will lay out for clinicians and women exactly what care, both clinical and emotional, that women should receive at each appointment.

Early Intervention Transformation Programme

Through the Early Intervention Transformation Programme (EITP), plans are in place to pilot group-based antenatal care and education in community settings using the Solihull approach and the revised maternity pathway for normal pregnancy.

A partnership between the health visiting service and the Department of Education funded pre-school settings has been agreed to promote the social and emotional needs of three to four year olds.

A review of AHP support for children with statements of special educational needs (SEN)

This child and family-centred review focussed on services meeting the assessed AHP needs of children in order to maximise their health and educational outcomes.

Engagement with stakeholders was a critical element of the review.

The five key themes, identified through engagement and information gathering, were:

- working together;
- informed, skilled workforce;
- timeliness;
- therapy environment and equipment; and
- best use of resource.

Family Nurse Partnership

The Family Nurse Partnership (FNP) programme has been implemented for five years and there are currently 310 mothers on the programme.

There were two new teams introduced in the Northern and South Eastern Trusts' areas in 2015/16, resulting in a team now operating in each Trust area.

Early indications from the programme data in Northern Ireland show the following positive outcomes:

- improved breastfeeding rates;
- reduction in maternal smoking;
- low levels of children attending Accident and Emergency departments; and
- positive changes in child development, improving the readiness of the child for school.

The PHA and the FNP teams are learning and adapting the FNP programme to respond to the latest evidence base and to respond to our young people's needs.

Safeguarding children

During the year the PHA worked with the Safeguarding Board for Northern Ireland and Queen's University Belfast to publish a thematic review on Sudden Unexpected Infant Death and is ensuring that practice reflects the learning from this important research. The PHA's Nursing, Midwifery and AHP Safeguarding Children Forum has produced a report on Female Genital Mutilation that will inform a multi-agency response to this issue.

Adults

Some of the work undertaken over the past year has focussed on addressing issues that impact on people of working age. This has included specific projects to help reduce inequalities to enable individuals to lead flourishing lives, and to support those fighting disease and recovering from injury. A few examples of the work undertaken include:

You in Mind

In support of the 'You in Mind' mental health care pathway and in response to the findings of a regional survey of service user and carer experience, 'Recovery Colleges' have been established across Northern Ireland.

'Recovery Colleges' are one part of an overall recovery model in mental health services which provides adult learning opportunities in mental health provision through blending 'expert by experience' and professional knowledge into the delivery of therapeutic educational programmes.

The Colleges enable people prior, during and post treatment, to discover personal talents and develop new skills for life which in turn open up opportunities for volunteering, further education, and entering or returning to employment.

The establishment of these Colleges creates a robust network of people with 'lived' experience who are now actively involved in the design and delivery of a wide range of co-education programmes across Northern Ireland.

Living Matters Dying Matters

Work has also been completed to implement Living Matters Dying Matters, the palliative and end of life care strategy for adults in Northern Ireland.

The second phase of the Transforming Your Palliative and End of Life Care programme has also been completed and during 2016/17 the PHA, in partnership with HSCB, is leading an amalgamated palliative care programme board to help improve and coordinate palliative and end of life care services across Northern Ireland. It also aims to facilitate equitable access to the most appropriate services, regardless of a person's diagnosis or geographical area, in order to meet the

person's holistic needs and to enable them to be cared for in their preferred place at the end of their lives.

Cancer services

During the year, a risk-based, incremental cancer clinical nurse specialist workforce plan was approved by the HSCB and PHA Senior Management Teams. This plan will be progressed in partnership with charitable organisations using a tapered funding model, with the aim of expanding the workforce by over 40 clinical nurse specialists over five years.

Radiotherapy services

The new radiotherapy unit in WHSCT is on schedule to open in September 2016. The radiotherapy team at the WHSCT have, with leadership from the PHA, worked to ensure the necessary legislative and statutory requirements for the safe delivery of radiotherapy are put in place to enable the unit to have the necessary health and safety accreditations required as a pre-requisite to delivering clinical radiotherapy.

Regionally, the radiotherapy service has been supported by the PHA to introduce a single electronic scheduling and data analysis system to ensure transparency of service delivery and enable regional treatment delivery schedules.

Older People

During the year the PHA began new work in this area which will be taken forward as a priority in 2016/17.

Work around how we look after and improve care for older people included some of the following activities:

Learning from incidents

A request was made by the Serious Adverse Incident (SAI) Regional Group to review and identify the numbers and types of SAIs relating to patients with a fall resulting in moderate to severe harm and reported as an SAI, across all programmes of care.

A thematic review was carried out to identify recurrent themes found within the reported SAIs to consider any regional learning and whether any further actions are required to reduce/prevent reoccurrence of these incidents.

It was clear from the review there was not a significant level of new learning identified from these SAIs.

A workshop with all relevant stakeholders was held in January 2016 to redesign the reporting process for these incidents to maximise learning. As a result, a revised

reporting process has been agreed to promote learning and ensure front line multi-disciplinary staff are involved in the post-falls review of these incidents.

The aim is that all falls resulting in moderate to severe harm will be reviewed locally by HSC Trusts on a quarterly basis and reported on through the Regional Falls Group to identify learning, themes and trends.

Dementia

The PHA, in partnership with the HSCB, leads on the implementation of the Northern Ireland Dementia Strategy and was successful in securing Delivering Social Change funds for the Dementia Together NI Project which runs from 2014–2017.

Important work was undertaken during the year around the following three key areas:

- Campaign – important preparatory work for a major public awareness campaign which is to be launched during the summer of 2016 to raise awareness of dementia and address stigma. The PHA has also contributed to a comprehensive dementia website that will be hosted by nidirect and which will contain improved information and support for people with dementia as well as for their carers;
- Training – a Dementia Learning and Development Framework has been developed and is due to be launched in June 2016. A target has been set to identify and train 300 dementia champions across Northern Ireland by 2017. To date 143 staff have expressed an interest. Pilot work has also started through the Safety Forum on implementation of a ‘Delirium bundle’ in the acute setting. Over 200 staff have received delirium training across Northern Ireland; and
- Pilot projects – These will also commence soon on innovative forms of short breaks for people with dementia and their carers.

DIRECTOR'S REPORT - OPERATIONS

The Operations Directorate provides expertise in Communications, Health Intelligence, Planning, Governance and Operational Services and through working with colleagues elsewhere in the PHA and other bodies, we ensure that the PHA's work is underpinned by good communication, a strong evidence base, effective business processes and management of resources.

During 2015/16 we continued important work to deliver upon our main corporate objectives and business goals.

Communications

The PHA's Communications function is critical to the work of the PHA through ensuring that effective messages and information are disseminated, internally and externally, in a timely manner tailored for the target audiences.

This important work can range from providing proactive advice on the many issues affecting individuals and communities' social wellbeing and health, developing tailored public information campaigns designed to address major issues such as cancer, obesity, and mental health and suicide, to ensuring accurate advice is disseminated to the public, staff and care professionals at times of infectious disease outbreak.

In delivering our key objectives, the PHA's Communications function covers a wide range of activities and professional services including developing and designing support materials, websites, public information campaigns, public relations and social media.

During the past year the Communications function has continued to work across and deliver a range of integrated activities to maximise the reach and impact of our communications programmes.

Social media

During 2015/16, we fulfilled our key goals to continue and enhance our social media activity to extend the reach and expand the types of content used.

Our presence continued to grow considerably, aided by the integration of bespoke 'rich media' such as infographics, video and photographs. This has helped extend the reach of PHA messaging to a wider audience, contributing to raising awareness and influencing behaviours in relation to important health issues.

Infographics in particular assisted in engagement through social media, as they enabled key messaging to be distilled into a 'bite size', attractive image, which increased the likelihood of people sharing them on their own social media accounts.

This has enabled the PHA to engage directly with the public on a range of important issues, through third party organic support. PHA social media posts regularly enjoyed an organic reach in the tens-of-thousands during the year.

As a result of wider efforts to develop the use of social media, the two main channels used by the PHA, Twitter and Facebook both enjoyed a significant increase in follower numbers and saw significant levels of 'shares', including from high profile individuals and organisations.

The number of Twitter followers rose from 3,446 on 1 April 2015 to 5,353 on 31 March 2016. Facebook followers increased from 4,735 on 1 April 2015 to 9,844 on 31 March 2016.

Public relations

The PHA undertook a sustained and effective programme of public relations activity around key programmes and issues during the course of the year, which resulted in high levels of coverage and dissemination.

For example, in support of the PHA's 'Be Cancer Aware' campaign, the PHA Communications Team secured a link up with a popular newspaper to run a series of weekly features focusing on different aspects of the illness, including symptoms, treatment and recovery. In addition, the PHA linked up with a radio station to run a cancer awareness week, aimed at raising knowledge about signs and symptoms. This was part of a wider promotional programme which secured widespread coverage across print, broadcast and online media on the issue.

The PHA Communications Team also continued its important work of proactively engaging with the media to promote positive mental health, and raise awareness of sources of support for individuals or families experiencing mental health problems or at risk of suicide and/or self-harm. This work also involved promoting the *Samaritans' Media Guidelines* for reporting suicide with print and broadcast media in Northern Ireland and taking action on poor reporting of suicide by the media.

The PHA also worked closely with the DHSSPS, HSC partner organisations, other departments and statutory bodies, and third sector organisations, to extend the reach of public health messaging, both through complementing others' public relations activity, such as with support quotes, and collaborative work.

Public information campaigns

Extensive campaign activity was undertaken during 2015/16 covering a wide range of issues and programmes. New multi-media campaigns were developed and implemented for smoking, obesity and sexual health; phase two of the cancer awareness campaign was rolled out to feature lung and breast cancers; while campaigns for stroke and mental health also ran.

Developmental work got underway in partnership with NIAMH to deliver a wide-ranging three-year mental health anti-stigma programme: Change Your Mind. Preliminary planning was also initiated on a dementia awareness campaign for 2016/17 as part of the Delivering Social Change dementia initiative funded by OFMDFM, DHSSPS and The Atlantic Philanthropies.

Management of health messaging on our suite of websites continued throughout the year. A new website www.sexualhealthni.info was developed in support of the sexual health campaign to signpost to information and services. Case studies, and links to Vimeo video platforms and supporting media, were added to the *Be Cancer Aware* site to reflect the latest phase of the campaign focusing on specific tumour sites. Campaign updates also featured on *Want2stop, Minding your head, and Choose to live better*.

In addition to the traditional channels of TV, radio, and press, the frequency and reach of campaigns is increasingly being supported by the use of digital advertising.

Website development

During the past year, the PHA Web Development Team consolidated the position of our websites. The emphasis continued on putting flexible website platforms in place, realigning the focus of web content from desktop computers to multiple platforms such as smartphones and tablets to further engage our audiences.

The HSC R&D website was successfully launched and development work began on a site for infection control.

Security was improved across all of our sites during the year and a custom-built tool for shortening URLs to improve security and promote PHA work was introduced.

Our online service continues to be resilient, featuring an across-the-board uptime of 99% as a result of our regular maintenance and updating regime.

We contributed to the planning and development of public health content for the nidirect government portal project.

Support materials and design

Work continued on designing and publishing our extensive range of printed and online resources that support the work of the directorates throughout the PHA, including booklets, leaflets, training resources and annual reports.

This included public and professional information on immunisation, information to support the various screening programmes, as well as health improvement information on topics such as smoking, nutrition and breastfeeding. Two publications which are updated annually and which remain extremely popular, both in print and online, are *The Pregnancy Book* and the *Birth to Five* book.

Among the new materials developed were:

- Director of Public Health Annual Report and the Annual Quality Report;
- booklets and factsheets on the addition of the men B and men ACWY vaccines to the routine childhood programme and the catch-up programme for university students;
- a booklet for smokers with mental health issues, published to coincide with the extension of smoke-free areas throughout all HSC Trust grounds or premises from March 2016;
- a new module for the Cook it! nutrition programme developed to engage with Northern Ireland's growing black and minority ethnic communities and to learn about the food habits and traditions of other cultures; and
- training materials to support the implementation of Personal and Public Involvement across the HSC.

Internal communication

Effective internal communication is essential to the efficient running of the organisation, particularly since the PHA is located over several regional offices.

To ensure this, we continued to work to develop and progress our internal communications strategy and action plan which will ensure PHA business is supported by efficient and effective internal communication systems. Work to take forward the development of PHA's intranet site, Connect, was led by the Internal Communications Working Group

Connect continues to be one of the primary internal communications channels with regular updates and organisational information provided to staff as well as carrying daily features on staff-related activities and achievements.

Health Intelligence

During the year, the health intelligence function contributed to a range of reports, workshops and presentations on topics as diverse as cancer, organ donation, obesity, smoking, and mental health and has supported the PHA's expanded programme of public information campaigns. Much of what we do in these areas is in a supportive role and rarely published under our own name.

Comprehensive briefs were produced on births; dementia; unintentional injuries; breastfeeding; potentially preventable premature mortality in Northern Ireland; suicide; and, Lesbian, Gay, Bi-sexual and Transgender (LGB&T) health. A one-off publication was produced on smoking in Northern Ireland.

Specific evaluations of effectiveness and outcomes were completed on major health improvement programmes including the maximising access to services; grants and benefits in rural areas (MARA) programme; Farm families; Food in Schools; weight

management in pregnancy and Lifeline; the suicide prevention helpline. New evaluations began on regional initiatives such as Relationship and Sexual Education in the community and One Stop Shops.

Family Nurse Partnership projects in the HSC Trusts have been expanded with a resultant increase in the demand for more comprehensive information and reporting systems. Health Intelligence has taken the lead in developing this system and providing the required data analysis services.

This includes providing information for annual reports and reviews.

A range of specific projects has also been completed including an analysis of potentially preventable premature mortality.

The supporting tables around public health and specific tables on adult health for the *Director of Public Health annual report* and the *Children's Health in Northern Ireland* report drawing data from Northern Ireland Chest Heart and Stroke (NICHS) and Northern Ireland Maternity Information System (NIMATS) to provide a regional and Trust level statistical profile of births in Northern Ireland were again produced and disseminated.

Qualitative work was undertaken to support antenatal education and breastfeeding.

We also worked to develop or enhance performance and outcome measures and the reporting of these for regional strategies such as on obesity, breastfeeding and smoking or for the PHA's own performance framework.

Following the publication of the *Making Life Better* strategy, we have worked with the Northern Ireland Statistics and Research Agency (NISRA), DHSSPS, colleagues in Health and Social Wellbeing Improvement (HSWBI) and the HSCB to reconfigure the Northern Ireland Neighbourhood Information Service (NINIS) web portal to make information available as widely as possible at as many geographical levels as practical across the breadth of the determinants of health e.g. from poverty and social isolation to individual behaviour.

This is designed to support the wider public health agenda and the development of community planning with the new councils and was released at Trust and then District Council level during 2015/16.

Operational Services

Good governance is an essential foundation to enable the PHA to take forward its business. During 2015/16, we continued to review, enhance and ensure that our core governance arrangements were implemented, and working effectively, providing expert advice and support across the organisation to assist staff.

This included reviewing and updating policies – for example the Records Management Policy, Data Protection Policy and IT Security Policy – coordinating the twice-yearly review and update of the PHA Assurance Framework and ensuring that Directorate and Corporate Risk Registers are reviewed and revised on a quarterly basis.

The Business Continuity Project Team, led and supported by the Operations Directorate, continued to review and refine the PHA Business Continuity Plan to ensure that this remains a robust and accurate document that is ready to be implemented should a business continuity event arise.

During 2015/16 this included an in-depth look at some practical issues that had been identified following a power outage in Belfast, with appropriate improvements made. The revised Plan was subsequently tested before being approved by the Agency Management Team, Governance and Audit Committee and the PHA Board.

During the year further work was also undertaken to ensure that all staff are aware of the Business Continuity Plan and that they understand their role at a time of disruption.

Good communication systems are vital to the PHA and during the year we worked with colleagues in the Business Services Organisation (BSO) and HSCB to introduce a new Voice Over Internet Protocol (VOIP) telephony system across our four main offices and to replace the outdated BlackBerry handsets with new devices with enhanced functionality under a more cost-effective contract.

These major pieces of work were successfully implemented and are benefiting the organisation both in terms of controlling costs and through the availability of modern telecommunications with greater functionality.

The PHA is committed to providing a safe and healthy working environment for its staff. During the year several members of staff volunteered to become First Aiders and successfully completed the appropriate training.

As well as the mandatory Fire Safety training for all staff, specialist Evac Chair Training was also provided to several members of staff so that they can help colleagues or visitors with mobility issues exit the building in the event of an emergency.

During the year we also promoted the Moving Forward programme, which offers a suite of short course programmes, through the HSC Leadership Centre, tailored for middle and senior managers within HSC Regional Organisations.

Additionally, we continued to undertake Display Screen Equipment (DSE) Assessments or Workstation Assessments during the year ensuring that the staff member’s workstation is appropriately equipped and adjusted to suit their needs.

Our annual Property Asset Management (PAM) plan was developed and approved early in 2015/16, setting out how we ensure that our facilities are managed in line with the Northern Ireland Asset Management Strategy.

Key areas of work progressed during the year included the business cases to renew the lease for Alexander House and to move staff currently based in Omagh to accommodation on the Tyrone and Fermanagh Hospital site.

Planning and Performance

During 2015/16, the PHA continued to progress the implementation of its Procurement Plan for the provision of health and wellbeing services. An additional six tenders have been progressed across a number of areas including Early Years parenting support, workplace health and smoking cessation.

These tenders have resulted in 22 new contracts being awarded with an annual value of £1.25m.

An important aspect of this work is to continue to review and develop our systems and processes for managing tenders. During the year we worked closely with colleagues in BSO Procurement and Logistics Service (PaLS) and Directorate of Legal Services (DLS) to develop updated tender documentation that is compliant with the EU Procurement Regulations, introduced to Northern Ireland in February 2015.

We also produced a new guidance document that sets out the key tasks within each of the stages from pre-procurement through the tender process to award of contract, to assist PHA staff in planning, progressing and successfully completing a tender. The document reflects the learning that has been gained to date and will be an important support tool for staff.

Working with colleagues across the PHA and HSCB Finance, we undertook a review of how the PHA manages and monitors programme expenditure. The review identified a number of areas where there was opportunity to improve and streamline how the PHA sets its annual programme budgets, steps that can be taken to agree baseline budgets earlier in the financial year, and practical measures to assist with monitoring budget expenditure. The recommendations from the review are currently being implemented in planning for 2016/17.

Information requests

Freedom of Information (FOI) Requests

The total of FOI requests received between 1 April 2015 and 31 March 2016 was 57. The number of Open Data requests received from 1 April 2015 to 31 March 2016 was 3.

The PHA's FOI register contains a total of 63 requests from 1 April 2015 to 31 March 2016. The figure of 57 is achieved by not counting the following: 2 requests which were subsequently withdrawn, 2 that were duplicates and 2 that were processed under normal business.

Assembly Questions

The PHA received and responded to 142 written Assembly Questions and 9 oral Assembly Questions during 2015/16.

Personal data-related incidents

No personal data protection incidents occurred during 2015/16.

The Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the PHA, continued to promote the use of technology and innovation in the HSC system in Northern Ireland to drive improvements in health and social care.

CCHSC contributed to improving health and wellbeing through a number of partnership activities including:

- working with the HSCB and DHSSPS to finalise development of the *eHealth and Care Strategy* for Health and Social Care, ensuring that the strategic aims of the PHA are fully reflected;
- the Telemonitoring NI service, which provides both Telehealth and Telecare services across Northern Ireland, continues to develop with the role of home-based vital-sign monitoring being explored in new areas such as renal patient monitoring and obesity management during pregnancy. Substantial work took place this year on the commissioning of research from Queen's University Belfast to evaluate the service. The results of this evaluation (to be reported upon in early 2016/17) will inform the design of services to be established when the contract for the existing Telemonitoring Service ends in March 2017. We anticipate that these new services will progress the Supporting People objective set out in the draft *eHealth and Care Strategy* and will feed into the 'HSC Connected Caring Communities' Partnership established under the auspices of *Making Life Better*;
- continuing to contribute to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) through involvement in a number of action groups to improve the health of older people in Northern Ireland and across Europe;
- coordination of the EU-funded project called Beyond Silos which aims to improve the integration of service delivery by building on the Northern Ireland Electronic Care Record and implementing an interactive Shared Care Summary;
- working in conjunction with Trusts, HSCB, PHA, universities and industry to pursue EU funding opportunities such as Horizon 2020, EU 3rd Health Programme, Interreg 5 and other EU funding streams.

Of particular note are:

- the SUNFRAIL project, funded through EU 3rd Health Programme, seeks to *"Improve the identification, prevention and management of frailty and care of multi-morbidity in community dwelling persons (over 65)"*. The project kicked-off at the end of May 2015 and will last for 30 months;

- Funded through Horizon 2020, the MAGIC project, which started on 1 January 2016, focuses on improving care and outcomes for stroke survivors with an on-going need for patient information. CCHSC will assist in the deployment of the technology over the 52 month project;
- extensive work is on-going in conjunction with the Health Service Executive (RoI) and NHS Scotland to ensure that eHealth features as a key facilitator of service improvement in bids being submitted for EU Cross-Border Funding Programme (Interreg 5).

Telecare and dementia

Telecare can make a real difference to patients with dementia and other cognitive impairments which have an impact on memory. Where these patients have capacity to make decisions but require some assistance, for example because of deterioration in mobility which leads to a greater risk of falling, Telecare can greatly enhance their ability to remain at home where they want to be. They would otherwise be at risk, particularly with regard to falls, having to wait until the next visitor or care visit, unable to call for help.

Having a monitored smoke detector also means that in the event of fire someone will be there to help, which for people with cognitive impairment can be a life saver. It also gives family and carers greater peace of mind, knowing they can go about their daily lives but will be contacted if they are needed.

Mary Stobie is an Occupational Therapist working for the Northern Trust, where Telecare is an integral part of the assessment checklist in dementia care. “As an occupational therapist my job is to maintain people’s independence and to enable them to continue to live within their own familiar environment.

“Telecare is a fantastic tool that helps me to achieve this by managing all sorts of different risks. Particularly for people with dementia, Telecare so often makes the difference between someone being able to remain at home and independent, or having to go into residential care. The technology is also a great support to carers, alleviating stress and worry.”

Sustainability – Environmental, social and community issues

The PHA is committed to protecting the environment and has a commitment to sustainability, environmental, social and community issues.

It aims to understand the impact on the environment of its activities and to manage its operations in ways that are environmentally sustainable and economically feasible.

The PHA has had an Environmental policy and Waste management strategy and policy in place for several years now.

These policies are designed to bring to the attention of all employees, suppliers and contractors, the PHA's position in regard to environmental issues and waste reduction (prevent/reuse/dispose) and demonstrate a desire to continually improve its performance in environmental sustainability and waste management.

The PHA also has a *Sustainable Development Strategy* in place. This strategy sets out the PHA's approach to sustainable development. It has been shaped around the priority areas contained within the Office of the First Minister and Deputy First Minister's (OFMDFM's) *Sustainable Development Strategy*.

The PHA is committed to the principles of sustainable development and will endeavour to integrate these into its daily activities.

It will seek to increase awareness of sustainable development within the PHA generally and to ensure that wherever possible its overall business activities support the achievement of sustainable development objectives.

The PHA continues to support and implement a range of sustainability initiatives such as the Cycle to Work Scheme; Bus/Rail Translink Scheme (which encourages employees to use public transport and reduce their carbon footprint); the adoption of new online-based systems (HRPTS/e-procurement) moving away from paper-based systems; centralised printing devices for the production of printed material (replacing printing equipment at each workstation); waste paper recycling and video and teleconferencing facilities.

Equality

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. More information is available on the PHA's website at www.publichealth.hscni.net

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.

Disability Action Plan

As part of the Disability Discrimination Order 2006, the PHA developed a Disability Action Plan to demonstrate how the organisation promotes positive attitudes towards disabled people and involves disabled people in the work that we do. Specific work during the year to deliver on our commitments under the plan are included below.

Disabled employees

If a member of staff has become disabled during the period when they are employed by the PHA, the organisation then works closely with BSO Human Resources (HR) who are guided by advice from Occupational Health. Subsequently, reasonable adjustments can be made to accommodate the employee, 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.

Training

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.

Equality screenings and equality impact assessments

During 2015/16 we dedicated substantial resources to giving in-depth consideration to equality issues for two major pieces of work. Over and above equality screenings, thus, we conducted equality impact assessments on the Lifeline Crisis Intervention Service and the Review of Allied Health Professions Support for Children and Young People with a Statement of Special Educational Needs.

Gender Identity Employment policy

Together with our Health and Social Care (HSC) partner organisations we engaged with groups and individuals from the gender identity sector as well as the LGB&T staff forum to commence development of a dedicated employment policy.

Staff Disability Forum

With regards to the disability agenda, much work went into setting up a disability forum for staff working in the regional HSC organisations. Together with our partners we undertook a staff survey and held discussions with staff across the 11 organisations on a future forum, its role, remit and membership. The forum was formally launched on 14 March 2016, sponsored by our partner, the Health and Social Care Board.

Disability Work Placements

In December 2015, two individuals began their 26-week placement with us as part of the work placement scheme for people with a disability. The scheme is run jointly with the other regional HSC organisations and has 15 participants this year.

Accessible Formats Policy

The PHA's accessible formats policy provides staff with access to a toolkit to support them in delivering on the commitments made in the policy. This includes making sure that information provided to staff is delivered in accessible formats for those staff who have a disability.

Disability Awareness Days

We also featured two staff awareness days on disabilities during 2015/16. In September 2015, we focused on Hearing Loss. In February 2016, we drew attention to Learning Disabilities. On both days, staff across a number of our office locations had the opportunity to attend a talk from Action on Hearing Loss, Mencap and the Evergreen Centre. In addition, we provided staff with information materials and signposting information on how to access further support.

Good Relations Statement

In recognition of the need to reinvigorate the good relations agenda we worked with our partners to develop a common Good Relations Statement. We launched the statement combined with a visit to the premises of the Belfast Islamic Centre on 3 March 2016.

Looking Forward – The Continuing Work of the PHA

In planning our work for 2016/17 and beyond the PHA must take account of the strategic, regulatory and legislative environment in which we operate, including:

- Reform;
- Financial context;
- Programme for Government;
- *Making Life Better*;
- DHSSPS policy priorities;
- Partnership working; and
- Personal and Public Involvement.

In particular, the future development and performance of the PHA's business will be influenced and impacted by the following:

On 4 November 2015, the Minister announced his intention to remodel the administrative structures of the Health and Social Care system. This was followed by the launch of a consultation on 15 December 2015. The proposals are that the Health and Social Care Board should cease to exist in its current form. The PHA is to be retained, with a focus on early intervention and prevention.

While there is still uncertainty, with the details of the reformed structures still to be set out, it is clear that 2016/17 will be a year of change, for the PHA itself and for the HSC organisations we work closely with.

In the midst of this environment, it will be important for the PHA to remain focused, and to effectively manage the changes, in particular ensuring that staff are supported throughout the process.

The PHA, like all other HSC organisations and the wider public sector, faces financial challenges in light of the constrained Northern Ireland budget. Already in 2015/16 the PHA management and administration budget was reduced by 15%. While actions were taken to reduce goods and services expenditure in 2015/16, the implementation of the Voluntary Exit Scheme (VES) was necessary to achieve the levels of savings required.

It will be 2016/17, however, when the impact of these staff reductions will be felt. The outworking of VES, along with the potential for further budget reductions in 2016/17 will have implications on how we do our business. The PHA will continue to closely monitor and review its expenditure to ensure that it is used to maximum effect to help improve the health and wellbeing of the people of Northern Ireland and maintain the safety and quality of the services we commission.

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The Programme for Government (PfG) 2011–2015 was extended for a further year (2015/16) in line with the extension to the life of the current Northern Ireland Executive. Following Assembly elections which were held in May 2016, a new PfG is currently being considered.

The PHA will, however, continue to work closely with the DHSSPS and other partners, to ensure that we are positioned to achieve the relevant PfG targets.

The year ahead will be challenging as we strive to meet our commitments while working in an environment of change and uncertainty and the impact of budget reductions. It will, however, also be a year of opportunity, and we remain committed to working to achieve improvements in the health and wellbeing of the population of Northern Ireland, making best use of our resources to do so in 2016/17 as well as planning for the future.

Dr Eddie Rooney
Chief Executive

Date 16 June 2016

PUBLIC HEALTH AGENCY

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ACCOUNTABILITY REPORT

Corporate Governance Report

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. He was previously Chief Executive of Northern Ireland Chest Heart and Stroke from 1983 and prior to that worked for 10 years in Education. Over the last 25 years, he has been a Non-Executive Director of organisations spanning the private, public and voluntary sectors.

He is currently a Trustee and Chair of the HR Committee of the UK Health Forum. He is 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.

Julie Erskine

Julie Erskine was acting Chair from the start of December 2014 until the end of May 2015. Julie is a member of the Northern Ireland Social Care Council, the Northern Ireland Local Government Officers' Superannuation Committee and Chair of the Audit Committee for the Northern Ireland Commissioner for Children and Young People.

She is also a member of the Audit Committee for the Commissioner for Older People for Northern Ireland, a board member of the Probation Board for Northern Ireland and Panel Member of the Northern Ireland Medical and Dental Training Agency.

She worked in the healthcare service industry for over 25 years and held the position of Operations Director and Support Services Director within a Belfast-based private healthcare company.

Dr Eddie Rooney

Dr Eddie Rooney is Chief Executive of the PHA. Prior to joining the PHA, Dr Rooney served as Equality Director at the Office for the First Minister and Deputy First Minister and as Deputy Secretary at the Department of Education from 2004–2008.

Councillor Billy Ashe

Councillor Billy Ashe currently serves as Mayor of Mid and East Antrim Borough Council. He previously was Coordinator of a Carrickfergus-based community project and is a former Mayor of Carrickfergus.

Brian Coulter

Brian has extensive experience in Healthcare Regulation as former Non-Executive Director of both the General Dental Council and the Human Tissue Authority.

He is past Chair of the General Optical Council, the Regulation and Quality Improvement Authority, the Northern Ireland Federation of Housing Associations, Parkview Special School Governors and the Eastern Health and Social Services Council.

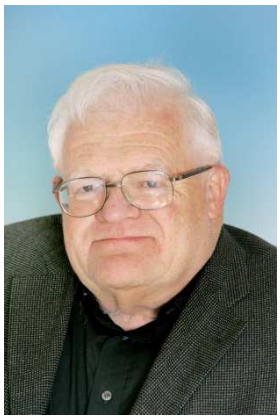
He had a 23 year career in Health and Social Services followed by 18 years as Chief Executive of The Fold Group. His last employment was as Prisoner Ombudsman for Northern Ireland.

Les Drew

Les is employed by Northern Ireland Electricity Networks as Head of Procurement. During the past 38 years he has held a number of other senior management posts including Group Financial Controller; Governance and Risk Manager; Regulation Officer; and Information Technology Contract Manager.

He was a Non-Executive Director of the former South and East Belfast HSS Trust where he was Chair of the Audit Committee. He also served as a member of the Belfast HSC Trust since its establishment on 1 April 2007.

Dr Jeremy Harbison



Dr Jeremy Harbison's term as a Board member finished on 28 April 2015. He sadly passed away shortly after in July. He worked in the Northern Ireland Civil Service for over 25 years at senior level across a range of Departments, following ten years working in the health service as a Clinical Psychologist

During his civil service career he had senior policy responsibility in a range of social areas including health, social care, community relations, urban regeneration and social exclusion.

As well as being a Non-Executive Director of the PHA he was Pro Chancellor in the University of Ulster and Chair of the Northern Ireland Social Care Council from 2001 until 2010.

Dr Carolyn Harper

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

Mary Hinds

Mary Hinds is the PHA's Director of Nursing and Allied Health Professions.

She was previously Director of the Royal College of Nursing (RCN) in Northern Ireland. Prior to joining the RCN, she was Director of Nursing at the Mater Hospital in Belfast.

Miriam Karp

Miriam Karp's term as Board member finished on 6 April 2015. Miriam is a former Council Member of the Northern Ireland Social Care Council, a 'Fitness to Practise' Panellist for the Northern Ireland Pharmaceutical Society (Statutory Committee), a 'Fitness to Practise' Panellist for the General Medical Council, and a member of the Exceptional Circumstances Body for School Transfer.

She is also a Lay Representative for the Northern Ireland Medical and Dental Training Agency. Within the Nursing and Midwifery Council Miriam is also Chair of the Interim Orders Panel and Chair of the Investigating Committee.

Judena Leslie

Judena Leslie was appointed as a Non-Executive Director on 29 May 2015 and served until 17 September 2015, when she was appointed as Northern Ireland Commissioner for Public Appointments.

Judena is a lawyer with 19 years' experience at senior management level in the Northern Ireland Civil Service and wider public sector. She was the founding CEO and Accounting Officer of Northern Ireland's first Law Commission and is Deputy Chair of the Council for Nature Conservation and the Countryside and of the Consumer Council for Northern Ireland.

Thomas Mahaffy

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

Deepa Mann-Kler

Deepa Mann-Kler began her term as Board member on 1 March 2016. She is a Non-Executive Director with the Registers of Scotland; an Independent Assessor with the Commissioner for Public Appointments; a Council Member for Ulster University and Chair of the Crescent Arts Centre in Belfast.

She served as a Non-Executive Director of the South Eastern Health and Social Care Trust for nine years. Her areas of expertise include corporate governance, risk management, communications, stakeholder engagement, research skills, strategic planning, ethics, equality and anti-discrimination. As a visual artist, she works in neon and light installations, painting, drawing and photography.

Edmond McClean

Edmond McClean is the PHA's Director of Operations and heads the PHA's communications, governance, business planning and health intelligence functions.

His background includes lead Director supporting the initial development of Belfast and East Local Commissioning Groups from 2007 to 2009 and from 1997 to 2007 he was Director of Strategic Planning and Commissioning with the Northern Health and Social Services Board.

Alderman Paul Porter

Alderman Paul Porter has served as a councillor from 2001 and was elected to the new Lisburn and Castlereagh City Council.

Over the past 15 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.

Paul Cummings

Paul Cummings is Director of Finance, HSCB. He has previously been a Director of Finance in the South Eastern, Mater and Ulster Community and Hospitals Trusts with over 25 years' experience in Health and Social Care and was the national chair of the Healthcare Financial Management Association in 2002/03, continuing to be an active member.

Paul, or a deputy, will attend all PHA Board meetings and have attendance and speaking rights.

Fionnuala McAndrew

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

Related party transactions

The PHA is an arm's length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the PHA has had various material transactions during the year.

During the year, none of the board members, members of the key management staff or other related parties has 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 Edmond McClean, PHA 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 and the notional charge for the year ended 31 March 2016 was £16,000.

Statement on Disclosure of Audit Information

All Directors can confirm that they are not aware of any relevant audit information of which the external auditors are unaware. The Accounting Officer has taken all necessary steps to ensure that all relevant audit information which he is aware of has been passed to the external auditors.

Public Sector Payment Policy – Measure of Compliance

The Department requires that the PHA pays its non-HSC trade creditors in accordance with the CBI Prompt Payment Policy and Government Accounting guidance.

The PHA's payment policy is consistent with the CBI prompt payment codes and Government Accounting guidance and its measure of compliance can be found within Note 14 of the Annual Accounts within this combined document.

PUBLIC HEALTH AGENCY

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STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health, Social Services and Public Safety has directed the Public Health Agency 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 Public Health Agency, 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 Accounts Direction issued by the Department of Health, Social Services and Public Safety 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 the going concern basis, unless it is inappropriate to presume that the Public Health Agency will continue in operation.
- keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Public Health Agency.
- pursue and demonstrate value for money in the services the Public Health Agency provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Principle Accounting Officer for Health and Personal Social Services Resources in Northern Ireland has designated Dr Eddie Rooney of the Public Health Agency as the Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Public Health Agency's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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, Social Services and Public Safety.

As Chief Executive, 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 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 finance) and in taking forward the health and wellbeing agenda.

Systems are also in place to support the inter-relationship between the PHA and the DHSSPS, through regular meetings and 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 DHSSPS 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; 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 three Executive Directors. The current Chair took up post on 1 June 2015 (an Acting Chair was in place from 1 December 2014 to 31 May 2015). Two new Non-Executive members also took up post during 2015/16. One Non-Executive Member stepped down in September 2015 and this vacancy was subsequently filled in March 2016. As a result there have only been 6 Non-Executive members between September 2015 and March 2016.

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 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. During 2015/16 the PHA Board met on nine occasions (plus one Special Board meeting to consider the Annual Report and Accounts). All meetings were quorate.

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 four Non-Executive Directors supported by the PHA's Director of Operations and the HSCB's Director of Finance. Representatives from Internal and External Audit are also in attendance. During 2015/16 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 DHSSPS. 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 normally meets at least once every 6 months. During 2015/16 the Committee only met on one occasion, due to changes in the PHA Board membership. The meeting was quorate. Arrangements are in place for two meetings in 2016/17.

4. 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 has a five year Corporate Strategy for 2011–2015 setting out its purpose, vision, values and strategic goals. An Annual Business Plan is prepared taking account of DHSSPS guidance and priorities as well as PHA priorities for the year ahead. The plan is developed with input from the PHA Board and staff from all Directorates, taking account of engagement with wider stakeholders throughout the year. The PHA Annual Business Plan for 2015/16 was approved by the PHA Board on 20 August 2015 and by the DHSSPS on 23 September 2015. The later timescales, which were discussed with DHSSPS, were due to ongoing discussions regarding budget reductions in 2015/16. Regular performance monitoring reports are brought to the Board.

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.

Organisation risk is related to the PHA's objectives (as detailed in the Corporate Strategy and Annual Business 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 DHSSPS Framework Document.

Stage 2 - Risk Assessment
After risks are identified they are assessed to establish:

- 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. The AS/NZS 4360:2004 standard (adopted by DHSSPS) which incorporates a "5x5" Risk Matrix is used, along with a Risk Analysis Tools Impact Table which gives detail of the impact definitions to be used when assessing each identified risk.

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 to be escalated to the Corporate Risk Register.

The Director of Operations is the PHA Executive Board member with responsibility for risk management. The Corporate Risk Register is reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). 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.

During 2015/16 guidance and support was provided to staff who are actively involved in reviewing and coordinating 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, safety and 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 Director of Operations as Senior Information Risk Owner (SIRO) is the focus for the management of information risk at board level. The 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 (IAO's) 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 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 controls assurance standards assessments 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 meets quarterly, and provides a report to the GAC.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2015-2019 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 covers the four year period from 2015 to 2019 and 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 Records Management, IT Security and Data Protection.

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. This has also been enhanced by the introduction of a MetaCompliance system ('iKnow') which can be used to send a 'pop-up' reminder to staff when they log in to their personal computers.

Information asset registers have been developed, and are kept under review. Information risks are incorporated in the Corporate and Directorate Risk Registers and control measures are identified and reviewed as required.

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and IT Security continues to be rolled out to all staff. Uptake of training is monitored by the IGSG.

6. 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 and 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 Director of Operations.

The PHA Assurance Framework, which is reviewed twice yearly by the GAC and annually by the PHA Board, sets out a systematic and comprehensive reporting framework to the Board and its committees.

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.

Controls Assurance Standards

The PHA assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress was expected in 2015/16.

The PHA achieved the following levels of compliance for 2015/16:

Standard	**DHSS&PS Expected Level of Compliance**	**PHA Level of Compliance**	**Verified by Internal Audit**
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	83%	-
Decontamination of medical devices	75% - 99% (Substantive)	N/A	-
Emergency Planning	75% - 99% (Substantive)	95%	-
Environmental Cleanliness	75% - 99% (Substantive)	N/A	-
Environment Management	75% - 99% (Substantive)	83%	-
Financial Management *(Core Standard)*	75% - 99% (Substantive)	87%	✓
Fire safety	75% - 99% (Substantive)	93%	-
Fleet and Transport Management	75% - 99% (Substantive)	N/A	-
Food Hygiene	75% - 99% (Substantive)	N/A	-
Governance *(Core Standard)*	75% - 99% (Substantive)	89%	✓
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	92%	-
Infection Control	75% - 99% (Substantive)	N/A	-
Information Communication Technology	75% - 99% (Substantive)	87%	-
Management of Purchasing and Supply	75% - 99% (Substantive)	88%	-
Medical Devices and Equipment Management	75% - 99% (Substantive)	N/A	-
Medicines Management	75% - 99% (Substantive)	N/A	-
Information Management	75% - 99% (Substantive)	80%	✓
Research Governance	75% - 99% (Substantive)	89%	-
Risk Management *(Core Standard)*	75% - 99% (Substantive)	88%	✓
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	87%	-

7. 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 2015/16 Internal Audit reviewed the following systems:

System reviewed	Assurance received
Financial Review	Satisfactory
Procurement and Contract Management	Satisfactory
Management of Health and Social Wellbeing Improvement Contracts	Satisfactory
Risk Management	Satisfactory
Management of Complaints, Incidents and Claims	Satisfactory
Local Supervisory Authority (Nursing and Allied Health Directorate Audit)	Satisfactory

Internal audit also carried out the year end Controls Assurance verification and a mid-year and end of year follow up reports.

In the Annual Report, the Head of Internal Audit reported that there was a satisfactory system of internal control in PHA.

One priority one weakness in control was identified in the PHA Management of Health and Social Wellbeing Contracts Audit. The recommendation to address this control weakness has been partially implemented. Three further priority one findings were identified in two of the voluntary/community organisations visited and audited, resulting in limited assurances. These are being addressed by the respective organisations; progress will be audited by Internal Audit.

In particular the PHA continues to take robust actions to address the weakness identified in respect of the procurement of health and social wellbeing services. This has included the regular meeting of the PHA Procurement Board (chaired by the Chief Executive), which monitors progress against the procurement plan. The PHA continues to work with BSO Procurement and Logistics Service (PALS) and Legal

Directorate to progress PHA procurement of health improvement services as well as participating in the regional HSC Social Care Procurement Groups.

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued on 31 March 2016, found that of those recommendations with an implementation date of 31 March 2016 or earlier, 78% were fully implemented, a further 18% partially implemented and 4% (2 recommendations) had not yet been implemented. The two recommendations (both priority two) that have not yet been implemented relate to the reissuing of arrangements for reporting of adverse incidents and SAIs to all organisations which the PHA contract for public/patient facing services, and the ownership of data in a service development and screening contract. Actions to address both recommendations will be implemented in early 2016/17.

RQIA

The RQIA Review of the Diabetic Eye Screening programme was published in May 2015. A modernisation programme was established and action plan developed. Progress will be reported by the PHA to the DHSSPS.

External Audit

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2015, the Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the PHA's accounts, with no priority 1 or 2 issues being raised.

8. 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.

9. Internal Governance Divergences

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

Accommodation

The new agents for the Ormeau Baths facility are working well with the PHA, ensuring that any issues are dealt with promptly. The PHA and PCC continue to be accommodated in Ormeau Baths.

The business cases for the renewal of the lease for Alexander House, Belfast and to move from Anderson House, Omagh to the Tyrone and Fermanagh Hospital site have both been approved by the DHSSPS, allowing the previously identified issues relating to the holding over of leases to be resolved.

While reductions in staff numbers due to vacancy control and VES are easing immediate accommodation pressures, the PHA will continue to work with DHSSPS and other HSC colleagues, taking account of proposed HSC reorganisation in 2016/17 to ensure appropriate accommodation for PHA staff.

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

Quality, Quantity and Financial Controls

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase and the budget available for commissioning them remains constrained, the actions taken by the PHA during 2015/16 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget. The PHA will continue to take appropriate actions and manage its budget to ensure the most effective service provision possible within budget constraints.

Business Services Transformation Project/Shared Services

The Business Services Transformation Project (BSTP) introduced new HSC wide computer systems in 2012/13 and began implementation of Shared Services for Accounts Payable, Receivable and Payroll in 2013/14.

While BSO has made significant progress in the control environment for Accounts Payable and Accounts Receivable there remain priority one audit recommendations for Payroll, which has received a limited assurance rating by the Head of Internal Audit. These priority one audit recommendations have limited impact on PHA and therefore this control issue is not considered as a significant issue for 2015/16.

The PHA has been advised that the Recruitment and Selection Shared Service has been given an unacceptable level of assurance from the Internal Auditor in March

2016. There is potential for this to impact negatively on the PHA, especially in respect of the "Getting Structures Right" programme, in terms of delivery of business, budget management and reputation. Additionally, the impact on the wider HSC is also of concern, as it may be impacting on the timescales for recruitment to Trust posts and may also create slippage in budgets allocated by PHA.

The delivery of these shared services will continue to be monitored by the PHA with HSCB Finance Directorate, via monthly assurances and performance reports, as well as the regular Customer Forum meetings.

Management of Contracts with the Community and Voluntary Sector

The 2015/16 Internal Audit report on the management of health and social wellbeing improvement contracts provided satisfactory assurance on the system of internal controls over PHA's procurement and 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, payments are only released on approval of previous progress returns, and a procurement plan is in place, with action being taken against it during the year.

However, while Internal Audit acknowledged the improving position, a priority one finding was identified in respect of the procurement of services. Further progress has now been made and at the end of December 2015 PHA had awarded 57 contracts with an annual value of £7.1m. A number of other tenders are currently in progress, and preparatory work is being taken forward for the next tranche of tenders.

The PHA's Procurement Plan is a live document, and is continually revised to ensure that all contracts are included and the timelines set are achievable given the significant resources required to manage each Tender. Progress against the Procurement Plan is monitored by the PHA Procurement Board.

PHA also continues to work closely with BSO Procurement and Logistics Service (PALS) and Directorate of Legal Services (DLS) to develop appropriate social care procurement processes and documentation. This work is overseen by the PHA Procurement Board.

It is recognised however that social care procurement is a new area for the wider HSC, and the PHA continues to work closely with colleagues in HSCB, BSO, the HSC Trusts and the DHSSPS, to develop and put in place appropriate and proportionate regional processes that meet the new procurement regulations.

Reduction in the PHA Management and Administration Budget

The 2015/16 management and administration allocation for the PHA was reduced by 15% (£2.8m). The reduction is recurrent and is part of the collective Departmental response to address the overall DHSSPS funding gap. In order to meet this significant budget reduction, the PHA introduced a number of controls reducing goods and services expenditure, along with vacancy controls. However in order to

achieve the savings required on a recurring basis it was necessary to avail of the Voluntary Exit Scheme (VES).

While the end dates of staff leaving under VES have been phased in with effect from January 2016, it will be 2016/17 when the full impact of these reductions are felt. The loss of the knowledge and experience of the staff and of the posts, will have a significant impact on how the PHA undertakes its business in the coming year. While the PHA is taking measures to ensure that core and essential work is maintained, it is likely that it will not be possible to take forward some areas of work in 2016/17. The PHA continues to liaise with DHSSPS to ensure that they are aware of the situation.

Additionally PHA has been advised by the DHSSPS of a further reduction of £1.6m or 10% of the management and administration budget for 2016/17. Plans are being developed to deliver these savings in 2016/17 taking into account the impact on PHA core functions.

The PHA will continue to work closely with the DHSSPS in this regard.

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

Emergency Department (ED) (4 and 12 hour performance standards)

Performance against the 4-hour and 12-hour ED standards remains below the level required (95% of patients attending an ED are either treated and discharged home, or admitted, within four hours of their arrival; and no patient should wait longer than 12 hours).

Regionally, in the year to end of January 2016, there has been an increase in the number of patients who waited longer than 12 hours (2,714) compared with the same period last year (1,915).

In relation to performance against the 4-hour standard, in the year to end of January 2016, 77% of patients were either treated and discharged home, or admitted, within four hours of their arrival – this is a slight reduction on the same period last year (79%).

Improving performance against the 4 and 12 hour standards remains a priority and revised arrangements, jointly led by the Health and Social Care Board (HSCB) and PHA, have been put in place to take forward the unscheduled care agenda. The revised structures comprise a Strategic Accountability Group, a Regional Network Group and five Locality Network Groups.

10. 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 2015/16.

REMUNERATION AND STAFF REPORT

Remuneration Report

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.

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

A circular on the 2015/16 Senior Executive pay award had not been received from the DHSSPS by 31 March 2016, therefore related payments have not been made to Executive Directors.

The 2014/15 Senior Executive's pay award was set out in DHSSPS circular HSC (SE) 1/2015 and was paid in line with the Remuneration Committee's agreement on the classification of Executive Directors' performance, categorised against the standards of 'fully acceptable' or 'incomplete' as set out within the circular.

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 2015/16. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in the following tables in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DHSSPS under the Public Appointments process and the duration of such contracts is normally for a term of 4 years. During 2016/17 two of the PHA's Non-Executive Directors have had an extension of a further 4 years approved by the DHSSPS. 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 2015/16.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

Membership of the Remuneration and Terms of Service Committee:

A Dougall - Chair
J Erskine – Non-Executive Director
Cllr W Ashe – Non-Executive Director

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

Senior Management Remuneration – Non Executive Members (Table Audited)

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 other bonuses paid to any Director during 2015/16 or 2014/15:

	2015/16				2014/15			
Name	**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**
A Dougall (commenced 01/06/15)	25-30	0	-	25-30	-	-	-	-
J Erskine (Interim Chair from 01/12/14 to 31/05/15)	10-15	0	-	10-15	15-20	100	-	15-20
T Mahaffy	5-10	0	-	5-10	5-10	0	-	5-10
P Porter	5-10	0	-	5-10	5-10	0	-	5-10
W Ashe	5-10	0	-	5-10	5-10	0	-	5-10
B Coulter	5-10	0	-	5-10	5-10	0	-	5-10
L Drew (commenced 01/07/15)	5-10	0	-	5-10	-	-	-	-
D Mann-Kler (commenced 01/04/16)	0-5	0	-	0-5	-	-	-	-
J Leslie (20/04/15 to 18/09/15)	0-5	0	-	0-5	-	-	-	-
J Harbison (left 28/04/15)	0-5	0	-	0-5	5-10	0	-	5-10
M Karp (left 07/04/15)	0-5	0	-	0-5	5-10	0	-	5-10
M McMahon (left 30/11/14)	-	-	-	-	20-25	200	-	20-25

Senior Management Remuneration Continued – Executive Members (Table Audited)

	2015/16				2014/15			
Name	**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**
Chief Executive E P Rooney	115-120	200	22,000	140-145	115-120	700	22,000	140-145
Director of Public Health Medicine C Harper	145-150	0	14,000	155-160	145-150	0	33,000	175-180
Director of Operations E McClean	80-85	300	14,000	90-95	80-85	300	29,000	110-115
Director of Nursing M Hinds (1)	100-105	0	14,000	115-120	-	-	-	-
P Cullen (Acting Director of Nursing 01/06/13 to 31/03/15 (2)	-	-	-	-	85-90	0	-	85-90

Notes

(1) No prior year figures shown as post holder was employed by DHSSPS at 31/03/15.

(2) Postholder returned to substantive post on 01/04/15.

Median Salary (Table Audited)

The relationship between remuneration of the most highly paid director and the median remuneration of the workforce is set out below. There has been no significant change to the ratio when compared to 2014/15.

	2016	**2015**
Highest Earner's Total Remuneration (band in £000s)	145-150	145-150
Median Salary (£)	36,666	34,530
Median Total Remuneration Ratio	**4.0**	**4.3**

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

Pensions of Senior Management (Table Audited)

	2015/16				
Name	**Total accrued pension at age 60 and related lump sum £000s**	**Real increase in pension and related lump sum at age 60 £000s**	**CETV at 31/03/16 £000s**	**CETV at 31/03/15 £000s**	**Real increase in CETV £000s**
Chief Executive E P Rooney	10-15 pension	0-2.5 pension	213	178	30
Director of Public Health Medicine C Harper (3a)	35-40 pension 115-120 lump sum	0-2.5 pension 2.5-5 lump sum	716	668	26
Director of Operations E McClean (3b)	20-25 pension 70-75 lump sum	0-2.5 pension 2.5-5 lump sum	565	523	24
Director of Nursing M Hinds (4)	15-20 pension 55-60 lump sum	0-2.5 pension 2.5-5 lump sum	391	354	25
P Cullen (Acting Director of Nursing 01/06/13 to 31/03/15) (5)	-	-	-	668	-

Notes

(3) CETV at 31/03/15 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:

(a) 684 to 668
(b) 533 to 523

(4) Post holder was employed by DHSSPS at 31/03/15 and CETV is as at 01/04/15 for comparative purposes.

(5) No pension figures shown in 2015/16 as these are annual calculations as at 31/03/16; post holder was not employed as an Executive Director at 31/03/15.

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 decrease due to transfer of pension rights.

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 in 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 or 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 include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSS pension scheme. They also include any additional pension benefits accrued to the member as a result of 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 takes account of 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 column market valuation factors for the start and end of the year.

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.

Staff Report

The following tables set out the PHA's staff costs and numbers for the 2015/16 financial year.

Staff Costs

PHA staff costs comprise:

	2016			2015
	Permanently employed staff	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	13,946	477	14,423	14,203
Social security costs	1,265	43	1,309	1,299
Other pension costs	2,029	69	2,098	1,684
Total staff costs reported in Statement of Comprehensive Expenditure	**17,240**	**590**	**17,830**	**17,186**
Less recoveries in respect of outward secondments			452	288
Total net costs			**17,378**	**16,898**

The PHA participates in the HSC Superannuation 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 DHSSPS. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

Average Number of Persons Employed

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

	2016			2015
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	310	12	**322**	**341**
Less average staff number in respect of outward secondments	(5)	(0)	**(5)**	**(3)**
Total net average number of persons employed	**305**	**12**	**317**	**338**

Reporting of early retirement and other compensation scheme – exit packages

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2016	**2015**	**2016**	**2015**	**2016**	**2015**
<£10,000	0	0	2	0	**2**	**0**
£10,000-£25,000	0	0	5	0	**5**	**0**
£25,000-£50,000	0	0	13	0	**13**	**0**
£50,001-£100,000	0	0	13	0	**13**	**0**
£100,001-£150,000	0	0	4	0	**4**	**0**
Total number of exit packages by type	**0**	**0**	**37**	**0**	**37**	**0**
Total resource cost £000s	**£0**	**£0**	**£1,979**	**£0**	**£1,979**	**£0**

Redundancy and other departure costs have been paid in accordance with the provisions of the 2015/16 Voluntary Exit Scheme and the HSC Pension Scheme Regulations where appropriate. 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 employing authority 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 2015/16 or 2014/15.

Retirements due to ill-health

During 2015/16 there were no early retirements from the PHA on the grounds of ill-health.

Staff Composition

The staff composition, broken down by male/female and whole time equivalent as at 31 March 2016, was as follows:

Gender	Headcount	Whole Time Equivalent
Female	250	232.7
Male	73	71.7
Grand Total	**323**	**304.4**

Staff Gender Breakdown within PHA 2015–16 Senior Management (excl. Board Members)*		
	Headcount	**WTE**
Female	31	28.6
Male	19	17.7
Grand Total	**50**	**46.3**

**senior management is defined as staff in receipt of a basic WTE salary of greater than £67k inclusive of medical staff.*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2015–31 March 2016 is 4.35%. (2014/2015 2.55%)

There were 25,749 hours lost due to sickness absence, or, the equivalent of 81.5 hours lost per employee. Based on a 7.5 hour working day, this is equal to 10.9 days per employee.

This is 0.9 days higher than the national average of 10 days per employee for the Health Sector. (*CIPD Absence Management Report 2015*).

Staff Policies Applied During the Financial Year

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 (HR) who are guided by advice from Occupational Health.

Subsequently, reasonable adjustments can be made to accommodate the employee, 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.

More information on the PHA's work regarding equality is available in this report under the section entitled 'Equality' as well as on the PHA's website www.publichealth.hscni.net

Expenditure on Consultancy

The PHA expended £14k on 2 consultancy projects during 2015/16, these were all considered and approved under the extant guidance and related to an evaluation of the MARA scheme (Maximising Access in Rural Areas) and support to the Safeguarding Board for NI in relation to the Child Sexual Exploitation Thematic Review.

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 with a total cost of over £58,200 during the financial year, which were not paid through the PHA Payroll. There were no such 'off-payroll' engagements in 2015/16 or 2014/15.

PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure

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 are self-assessed in controls assurance standards. During 2015/16 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments

Type of loss and special payment	2015-16		2014-15
	Number of Cases	£	£
Claims abandoned			
Waived or abandoned claims	0	0	55
	0	**0**	**55**
Stores losses			
Losses of accountable stores	0	0	73
	0	**0**	**73**
TOTAL	**0**	**0**	**128**

Special Payments

There were no other special payments or gifts made during the year.

Other Payments and Estimates

There were no other payments made during the year.

Losses and Special Payments over £250,000

There were no losses or special payments greater than £250k during the year.

Remote Contingent Liabilities

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 21 of the Annual Accounts, 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 2016, the PHA is not aware of any remote contingent liabilities, and there were none in 2014/15.

Dr Eddie Rooney
Chief Executive

Date 16 June 2016

PUBLIC HEALTH AGENCY

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Public Health Agency for the year ended 31 March 2016 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. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and Accountability and Audit Report within the Accountability Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. 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. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Public Health Agency's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Public Health Agency; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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.

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.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Public Health Agency's affairs as at 31 March 2016 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health (formerly the Department of Health, Social Services and Public Safety) directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Accountability and Audit 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 for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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 Remuneration and Staff Report and the Accountability and Audit Report to be audited are not in agreement with the accounting records; 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 Department of Finance's (formerly Department of Finance and Personnel) guidance.

Report

I have no observations to make on these financial statements.

K J Donnelly

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

20 June 2016

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2016

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

FOREWORD

These accounts for the year ended 31 March 2016 have been prepared in a form determined by the Department of Health, Social Services and Public Safety (DHSSPS) based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 78 to 110) which I am required to prepare on behalf of the Public Health Agency have been compiled from and are in accordance with the accounts and financial records maintained by the Public Health Agency and with the accounting standards and policies for HSC bodies approved by the DHSSPS.

Simon Christie

Acting Director of Finance

Date 16 June 2016

I certify that the annual accounts set out in the financial statements and notes to the accounts (page 78 to 110) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Andrew Dougal

Chairman

Date 16 June 2016

Dr Eddie Rooney

Chief Executive

Date 16 June 2016

PUBLIC HEALTH AGENCY

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2016

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.

		2016	2015
Income	**NOTE**	**£000**	**£000**
Income from activities	4.1	707	477
Other income	4.2	662	681
Deferred income	4.3	7	0
Total operating income		1,376	1,158
Expenditure			
Staff costs	3	(17,830)	(17,186)
Purchase of goods and services	3	(38,617)	(38,465)
Depreciation, amortisation and impairment charges	3	(148)	(148)
Provision expense	3	5	0
Other expenditure	3	(13,372)	(11,467)
Total operating expenditure		(69,962)	(67,266)
Net Expenditure		**(68,586)**	**(66,108)**
Finance income	4.2	0	0
Finance expense	3	0	0
Net expenditure for the year		(68,586)	(66,108)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(12,844)	(11,924)
South Eastern Health & Social Care Trust		(3,861)	(3,539)
Southern Health & Social Care Trust		(5,848)	(5,458)
Northern Health & Social Care Trust		(7,906)	(7,302)
Western Health & Social Care Trust		(6,282)	(6,131)
NI Ambulance Service		(5)	0
NI Medical & Dental Training Agency		(107)	(133)
Total RRL issued		(36,853)	(34,487)
Total Commissioner resources utilised		(105,439)	(100,595)
Revenue Resource Limit (RRL) received from DHSSPS	24.1	105,617	100,738
Surplus / (Deficit) against RRL		**178**	**143**

	2016	2015
OTHER COMPREHENSIVE EXPENDITURE	**£000**	**£000**
Items that will not/may be reclassified to net operating costs	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2016	**(68,586)**	**(66,108)**

The notes on pages 82 to 110 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of FINANCIAL POSITION as at 31 March 2016

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.

		2016		2015	
	NOTE	£000	£000	£000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	352		377	
Intangible assets	6.1/6.2	157		141	
Total Non Current Assets			509		518
Current Assets					
Inventories	10	0		0	
Trade and other receivables	12	579		812	
Other current assets	12	27		150	
Cash and cash equivalents	11	310		276	
Total Current Assets			916		1,238
Total Assets			**1,425**		**1,756**
Current Liabilities					
Trade and other payables	13	(7,773)		(7,014)	
Other liabilities	13	0		0	
Provisions	15	(5)		(10)	
Total Current Liabilities			(7,778)		(7,024)
Total assets less current liabilities			**(6,353)**		**(5,268)**
Non Current Liabilities					
Provisions	15	0		0	
Other payables > 1 yr	13	0		0	
Financial liabilities	7	0		0	
Total Non Current Liabilities			0		0
Total assets less total liabilities			**(6,353)**		**(5,268)**
Taxpayers' Equity and other reserves					
Revaluation reserve		36		36	
SoCNE reserve		(6,389)		(5,304)	
Total equity			**(6,353)**		**(5,268)**

The financial statements on pages 78 to 110 were approved by the Board on 16 June 2016 and were signed on its behalf by:

Signed  (Chairman) Date 16 June 2016

Signed  (Chief Executive) Date 16 June 2016

The notes on pages 82 to 110 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of CASH FLOWS for the year ended 31 March 2016

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	2016 £000	2015 £000
Cash flows from operating activities			
Net surplus after interest/Net operating cost	SoCNE	(68,586)	(66,108)
Adjustments for non cash costs	3	161	165
(Increase)/decrease in trade and other receivables	12	356	124
Increase/(decrease) in trade payables	13	759	(2,462)
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment	13	(87)	233
Movements in payables relating to the purchase of intangibles	13	(23)	(23)
Use of provisions	15	0	0
Net cash outflow from operating activities		(67,420)	(68,072)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(5)	(281)
(Purchase of intangible assets)	6	(26)	(76)
Net cash outflow from investing activities		(31)	(357)
Cash flows from financing activities			
Grant in aid		67,485	68,487
Net financing		67,485	68,487
Net increase (decrease) in cash & cash equivalents in the period		34	59
Cash & cash equivalents at the beginning of the period	11	276	217
Cash & cash equivalents at the end of the period	11	**310**	**276**

The notes on pages 82 to 110 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2016

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, Social Services and Public Safety) 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 2014		**(7,699)**	**36**	**(7,663)**
Changes in Taxpayers' Equity 2014/15				
Grant from DHSSPS		68,487	0	68,487
(Comprehensive expenditure for the year)		(66,108)	0	(66,108)
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2015		**(5,304)**	**36**	**(5,268)**
Changes in Taxpayers' Equity 2015/16				
Grant from DHSSPS		67,485	0	67,485
(Comprehensive expenditure for the year)		(68,586)	0	(68,586)
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2016		**(6,389)**	**36**	**(6,353)**

The notes on pages 82 to 110 form part of these accounts.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel'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 follow International Financial Reporting Standards to the extent that it is meaningful and appropriate to the Public Health Agency (PHA). Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the PHA for the purpose of giving a true and fair view has been selected. The PHA's accounting policies 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.

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.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise 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 buildings. The premises occupied by the PHA are leased by the Department of Health, Social Services and Public Safety on behalf of the PHA.

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
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 2015/16 or 2014/15.

1.9 Inventories

The PHA had no inventories as at 31 March 2016 or 31 March 2015.

1.10 Income

Operating Income relates directly to the operating activities of the PHA and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in aid

Funding received from the Department 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 2015/16 or 2014/15.

1.12 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.

1.13 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.

1.14 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 2015/16 or 2014/15.

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 building 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 guidance 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 2015/16 or 2014/15.

1.15 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2015/16 or 2014/15.

1.16 Financial instruments

- Financial assets

Financial assets are recognised on the Statement of Financial Position (SoFP) when the PHA 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 derecognised when the contractual rights have expired or the asset has been transferred. Financial assets are initially recognised at fair value.

- Financial liabilities

Financial liabilities are recognised on the SoFP when the PHA 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 derecognised 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 DHSSPS, 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 Department of Health, Social Services and Public Safety, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.17 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 using DFP's discount rates of -1.55% (1-5 years), -1.00% (5-10 years), -0.80% (>10 years), in real terms.

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.

1.18 Contingencies

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.

Where the time value of money is material, contingencies are disclosed at their present value.

The PHA had no contingencies as at 31 March 2016 or 31 March 2015.

1.19 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 2016. 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 DHSSPS. 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, Social Services and Public Safety.

The costs of early 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 at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2012 valuation for the HSC Pension Scheme will be used in 2015/16 HSC Pension Scheme accounts.

1.20 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.

1.21 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.

1.22 Third party assets

The PHA had no third party assets in 2015/16 or 2014/15.

1.23 Government Grants

The PHA had no government grants in 2015/16 or 2014/15.

1.24 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 and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.25 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.

Management consider that any other new accounting policies issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

1.26 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2016. Due to changes in the template, there have been amendments to the layout and display of some figures.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

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:

	NOTE	2016	2015
Summary		**£000**	**£000**
Commissioning	2.1	81,213	79,063
FHS	2.2	2,392	2,103
Agency Administration	2.3	21,044	18,412
Safeguarding Board NI	2.4	790	1,017
Total Commissioner Resources utilised		**105,439**	**100,595**
2.1 Commissioning			
Expenditure			
Belfast Health & Social Care Trust	SoCNE	12,844	11,924
South Eastern Health & Social Care Trust	SoCNE	3,861	3,539
Southern Health & Social Care Trust	SoCNE	5,848	5,458
Northern Health & Social Care Trust	SoCNE	7,906	7,302
Western Health & Social Care Trust	SoCNE	6,282	6,131
NIAS	SoCNE	5	0
NI Medical & Dental Training Agency	SoCNE	107	133
Other	3.2/3.3	45,074	45,053
		81,927	79,540
Income			
Income from activities	4.1	714	477
Commissioning Net Expenditure		**81,213**	**79,063**
2.2 FHS			
FHS Net Expenditure	3.2	**2,392**	**2,103**
2.3 Agency Administration			
Expenditure			
Salaries and wages	3.1	17,350	16,634
Operating expenditure	3.3	4,195	2,295
Non-cash costs	3.4	13	16
Depreciation	3.4	148	149
		21,706	19,094
Income			
Staff secondment recoveries	4.2	452	288
Operating Income	4.2	210	393
		662	682
Administration Net Expenditure		**21,044**	**18,412**
2.4 Safeguarding Board NI			
Expenditure			
Salaries and wages	3.1	480	553
Operating expenditure	3.3	310	465
		790	1,017
Safeguarding Board NI Net Expenditure		**790**	**1,017**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3 - STAFF COSTS

3.1 Staff Costs:	**2016 Total £000**	**2015 Total £000**
Wages and salaries	14,423	14,203
Social security costs	1,309	1,299
Other pension costs	2,098	1,684
Total staff costs reported in Statement of Comprehensive Expenditure	**17,830**	**17,186**
Less recoveries in respect of outward secondments	452	288
Total net costs	**17,378**	**16,898**

A breakdown of the above costs into permanent staff and others can be found in the Remuneration and Staff Report within the Accountability Report.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 3 - OPERATING EXPENSES

3.2 Commissioning:	**2016**	**2015**
	£000	**£000**
General Medical Services	2,392	2,103
Other providers of healthcare and personal social services	36,143	36,259
Total Commissioning	**38,535**	**38,362**
3.3 Operating expenses are as follows:		
Supplies and services - general	82	103
Establishment	3,611	1,729
Transport	10	3
Premises	672	770
Rentals under operating leases	130	154
Research & development expenditure	8,931	8,794
Total Operating Expenses	**13,436**	**11,553**
3.4 Non cash items:		
Depreciation	115	131
Amortisation	33	17
Loss on disposal of property, plant & equipment (including land)	2	1
Provisions provided for in year	(5)	0
Auditors remuneration	16	16
Total non cash items	**161**	**165**
Total	**52,132**	**50,080**

During the year the PHA purchased no non audit services from its external auditor (NIAO).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 4 - INCOME

4.1 Income from Activities	**2016**	**2015**
	£000	**£000**
R&D	707	477
Total	**707**	**477**

4.2 Other Operating Income	**2016**	**2015**
	£000	**£000**
Other income from non-patient services	210	393
Seconded staff	452	288
Total	**662**	**681**

4.3 Deferred income	**2016**	**2015**
	£000	**£000**
Income released from conditional grants	7	0
Total	**7**	**0**

TOTAL INCOME	**1,376**	**1,158**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.1 - Property, plant & equipment - year ended 31 March 2016

	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2015	0	650	102	752
Additions	10	82	0	92
Disposals	0	(26)	(30)	(56)
At 31 March 2016	**10**	**706**	**72**	**788**
Depreciation				
At 1 April 2015	0	332	43	375
Disposals	0	(24)	(30)	(54)
Provided during the year	0	107	8	115
At 31 March 2016	**0**	**415**	**21**	**436**
Carrying Amount				
At 31 March 2016	**10**	**291**	**51**	**352**
At 31 March 2015	**0**	**318**	**59**	**377**
Asset financing				
Owned	10	291	51	352
Carrying Amount				
At 31 March 2016	**10**	**291**	**51**	**352**

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 (2015 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2015 - £nil).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 5.2 - Property, plant & equipment - year ended 31 March 2015

	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation			
At 1 April 2014	634	106	740
Additions	49	0	49
Disposals	(33)	(4)	(37)
At 31 March 2015	**650**	**102**	**752**
Depreciation			
At 1 April 2014	241	39	280
Disposals	(32)	(4)	(36)
Provided during the year	123	8	131
At 31 March 2015	**332**	**43**	**375**
Carrying Amount			
At 31 March 2015	**318**	**59**	**377**
At 1 April 2014	**393**	**67**	**460**
Asset financing			
Owned	318	59	377
Carrying Amount			
At 31 March 2015	**318**	**59**	**377**
Asset financing			
Owned	393	67	460
Carrying Amount			
At 1 April 2014	**393**	**67**	**460**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 6.1 - Intangible assets - year ended 31 March 2016

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2015	62	99	161
Additions	0	49	49
At 31 March 2016	**62**	**148**	**210**
Amortisation			
At 1 April 2015	15	5	20
Provided during the year	13	20	33
At 31 March 2016	**28**	**25**	**53**
Carrying Amount			
At 31 March 2016	**34**	**123**	**157**
At 31 March 2015	**47**	**94**	**141**
Asset financing			
Owned	34	123	157
Carrying Amount			
At 31 March 2016	**34**	**123**	**157**

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 (2015 - £nil).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 6.2 - Intangible assets - year ended 31 March 2015

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2014	14	48	62
Additions	0	99	99
Reclassifications	48	(48)	0
At 31 March 2015	**62**	**99**	**161**
Amortisation			
At 1 April 2014	2	0	2
Provided during the year	13	5	18
At 31 March 2015	**15**	**5**	**20**
Carrying Amount			
At 31 March 2015	**47**	**94**	**141**
At 1 April 2014	**12**	**48**	**60**
Asset financing			
Owned	47	94	141
Carrying Amount			
At 31 March 2015	**47**	**94**	**141**
Asset financing			
Owned	12	48	60
Carrying Amount			
At 1 April 2014	**12**	**48**	**60**

NOTE 7 - FINANCIAL INSTRUMENTS

As the cash requirements of PHA are met through Grant-in-Aid provided by the Department of Health, Social Services and Public Safety, 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 2015/16 or 2014/15.

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 2015/16 or 2014/15.

NOTE 10 - INVENTORIES

The PHA did not hold any inventories as at 31 March 2016 or 31 March 2015.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 11 - CASH AND CASH EQUIVALENTS

	2016 £000	2015 £000
Balance at 1st April	276	217
Net change in cash and cash equivalents	34	59
Balance at 31st March	**310**	**276**

The following balances at 31 March were held at	2015 £000	2016 £000
Commercial banks and cash in hand	310	276
Balance at 31st March	**310**	**276**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2016 £000	2015 £000
Amounts falling due within one year		
Trade receivables	176	302
Deposits and advances	0	0
VAT receivable	279	318
Other receivables	124	192
Trade and other receivables	**579**	**812**
Prepayments and accrued income	27	150
Other current assets	**27**	**150**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**579**	**812**
TOTAL OTHER CURRENT ASSETS	**27**	**150**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**606**	**962**

The balances are net of a provision for bad debts of £nil (2015 £nil).

NOTE 13 - TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2016 £000	2015 £000
Amounts falling due within one year		
Other taxation and social security	0	389
Trade capital payables - property, plant and equipment	92	5
Trade capital payables - intangibles	46	23
Trade revenue payables	4,250	5,208
Payroll payables	705	250
BSO payables	635	624
Other payables	2,039	477
Accruals and deferred income	6	38
Trade and other payables	**7,773**	**7,014**
Other current liabilities	**0**	**0**
Total payables falling due within one year	**7,773**	**7,014**
Amounts falling due after more than one year		
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**7,773**	**7,014**

NOTE 14 - PROMPT PAYMENT POLICY

14.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that PHA pay their non HSC trade creditors 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:

	2016 Number	2016 Value £000	2015 Number	2015 Value £000
Total bills paid	5,860	56,627	10,308	59,543
Total bills paid within 30 day target or under agreed payment terms *	5,440	55,278	9,267	53,619
% of bills paid within 30 day target or under agreed payment terms	**92.8%**	**97.6%**	**89.9%**	**90.1%**
Total bills paid within 10 day target	4,833	51,117	8,047	39,977
% of bills paid within 10 day target	**82.5%**	**90.3%**	**78.1%**	**67.1%**

14.2 The Late Payment of Commercial Debts Regulations 2002

The PHA did not pay any compensation or interest for payments made late in 2015/16 (2014/15 £nil).

* New late payment legislation **(**Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

A regional review of the BSO calculation, supported by legal advice has resulted in an adjustment to the prior year comparator figures.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2016

	Other £000	2016 £000
Balance at 1 April 2015	10	10
Provided in year	0	0
(Provisions not required written back)	(5)	(5)
(Provisions utilised in the year)	0	0
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2016	**5**	**5**

Comprehensive Net Expenditure Account charges	2016 £000	2015 £000
Arising during the year	0	0
Reversed unused	(5)	0
Cost of borrowing (unwinding of discount)	0	(0)
Total charge within Operating expenses	**(5)**	**(0)**

Analysis of expected timing of discounted flows

	Other £000	2016 £000
Not later than one year	5	5
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2016	**5**	**5**

Provisions have been made for 1 type of potential liability: Employer's and Occupier's Liability. For Employer's and Occupier's claims, the PHA has estimated an appropriate level of provision based on professional legal advice.

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2015

	Other £000	2015 £000
Balance at 1 April 2014	10	10
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 2015	**10**	**10**

Analysis of expected timing of discounted flows

	Other £000	2015 £000
Not later than one year	10	10
At 31 March 2015	**10**	**10**

NOTE 16 - CAPITAL COMMITMENTS

The PHA did not have any capital commitments as at 31 March 2016 or 31 March 2015.

NOTE 17 - COMMITMENTS UNDER LEASES

17.1 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	2016 £000	2015 £000
Buildings		
Not later than 1 year	131	129
Later than 1 year and not later than 5 years	53	273
Later than 5 years	4	0
	188	**402**

17.2 Finance Leases

The PHA had no finance leases in 2015/16 or 2014/15.

17.3 Commitments under Lessor Agreements

The PHA had no lessor obligations in either 2015/16 or 2014/15.

NOTE 18 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

The PHA had no commitments under PFI or service concession arrangements in either 2015/16 or 2014/15.

NOTE 19 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2016 or 31 March 2015.

NOTE 20 - FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which the PHA is funded, financial instruments play a more limited role within the PHA 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.

The PHA did not have any financial instruments at either 31 March 2016 or 31 March 2015.

NOTE 21 - CONTINGENT LIABILITIES

The PHA did not have any unquantifiable contingent liabilities as at 31 March 2016 or 31 March 2015.

NOTE 22 - RELATED PARTY TRANSACTIONS

The PHA is an arms length body of the Department of Health, Social Services and Public Safety and as such the Department is a related Party with which the PHA has had various material transactions during the year.

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

NOTE 23 - THIRD PARTY ASSETS

The PHA held £nil cash at bank or in hand as at 31 March 2016 relating to third parties.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

NOTE 24 - FINANCIAL PERFORMANCE TARGETS

24.1 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:

	2016 Total £000	2015 Total £000
DHSSPS (excludes non cash)	105,456	100,573
Other Government Departments	0	0
Non cash RRL (from DHSSPS)	161	165
Total agreed RRL	105,617	100,738
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**105,617**	**100,738**

24.2 Capital Resource Limit

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

	2016 Total £000	2015 Total £000
Gross capital expenditure	141	148
Net capital expenditure	141	148
Capital Resource Limit	141	147
Overspend/(Underspend) against CRL	**0**	**1**

24.3 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.

	2015/16 £000	2014/15 £000
Net Expenditure	(105,439)	(100,595)
RRL	105,617	100,738
Surplus / (Deficit) against RRL	178	143
Break Even cumulative position(opening)	1,023	880
Break Even cumulative position (closing)	**1,201**	**1,023**

Materiality Test:	2015/16 %	2014/15 %
Break Even in year position as % of RRL	0.17%	0.14%
Break Even cumulative position as % of RRL	1.14%	1.02%

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

NOTE 25 - POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

NOTE 26 - DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 30 June 2016