PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2017

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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

On 23 June 2017

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2016/17 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 Portable Document Format (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: 978-1-874602-80-4

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ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017

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PERFORMANCE REPORT

Overview

The Public Health Agency – our role, purpose and activities

The Public Health Agency (PHA) is the statutory body responsible for improving and protecting the health of our population and an integral part of the 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).

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.

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

During 2016/17 we continued to work 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

The past year has been both a notable and an eventful year for the Public Health Agency (the Agency) and its work.

In October 2016 we said farewell to former Chief Executive, Dr Eddie Rooney, who led the Public Health Agency (PHA) since its inception in 2009 until his retirement.

Agreeing to act as interim Chief Executive of the Agency, Valerie Watts took up post on 17 October 2016 while continuing as Chief Executive of the HSCB.

In support of her role, PHA Director of Operations, Edmond McClean, will act for a three year period as Interim Deputy Chief Executive in addition to his normal duties.

I am confident that these appointments will ensure that the work of both the Agency and the HSCB will be aligned more closely during the restructuring within HSC.

On 22 October 2016, Health Minister Michelle O'Neill published the report of the Expert Panel led by Professor Raphael Bengoa entitled *Systems not structures*.

This report strongly recommended that we must prioritise prevention and early intervention to ensure that people stay well.

The report also urges that initiatives which have proven to work well in one part of the system should be replicated elsewhere. Furthermore, the co-design and co-production of services should be standard practice.

The Minister also published *Health and Wellbeing 2026 – Delivering Together,* stating that this would build upon the achievements of Transforming Your Care and would address many of the recommendations of the 2015 Donaldson report.

Co-production is regarded as the pinnacle of involvement where Health and Social Care staff and service users, carers and the public share power to generate policy and deliver services together, recognising that all partners have vital contributions to make in order to transform health and social care.

The PHA, as the lead body for Personal and Public Involvement (PPI), welcomes this development with enthusiasm. It is our great hope that PPI and the excellent 10,000 voices programme will be able to work well with co-production.

It is essential that the achievements, gains and advances in this area over many years are not lost. The distinct and scarce expertise and skills in involvement with service users and carers must be preserved and enhanced.

On 6 March 2017 the Agency published research which it had commissioned from Queen’s University Belfast and Ulster University on monitoring, measuring and evaluating the impact of PPI in Health and Social Care in Northern Ireland.

One leading recommendation is that PPI should be built into accountability structures and decision-making processes at senior management and director level. PPI issues at a strategic level should then be overseen by Boards.

The researchers also recommended that it is essential to include PPI as a criterion in job descriptions, selection interviews, as well as in all appraisals and revalidations.

A wider public health challenge, one which was highlighted recently in the O'Neill Review of Antimicrobial Resistance, is the excessive and inappropriate use of antimicrobials. The Review warned that without the emergence of new drugs and with the continued excessive use of existing antibiotics the world could experience 10 million deaths by 2050 at a cost of £66 trillion.

It is extremely heartening to note in the report of the Director of Public Health that a Regional Healthcare associated Infection and Antimicrobial Stewardship Improvement Board has been established under the chairmanship of the Assistant Director of Public Health (Health Protection).The PHA has also played a critical role in producing antimicrobial prescribing guidelines for Primary Care.

It is very positive that 'Antibiotic Champions' have been identified in general practices to undertake antimicrobial stewardship audits and quality improvement actions.

In Northern Ireland, the rate of prescribing of antibiotics in the community is 54% higher than that in England. Across hospitals and community settings together, the rate in Northern Ireland is 43% higher than that in England.

There is a need for a communications and influencing strategy targeting both health professionals and the population as a whole. Prescribers must resist the demands and pressures from patients to issue prescriptions inappropriately for antimicrobials.

We must endeavour to convince members of the public that it is not always in their best interests to seek an antibiotic. We must make the public aware that the inappropriate use of antibiotics can be harmful both in the short term to the individual and in the long term to the population as a whole.

The Northern Ireland Audit Office, in November 2016, published a report on board effectiveness outlining ways in which boards could enhance their operation.

This followed research commissioned by the Public Sector Chairs' Forum and carried out by Ulster University.

As a result of the report, the PHA's Board, with some external facilitation, has endeavoured to ensure that the relevant recommendations of this report will further enhance board effectiveness, governance and subsequent delivery.

I wish to acknowledge and put on record the long and dedicated service of Julie Erskine as a Non-Executive Director who served from April 2009 until 30 November 2016. Julie was also Chair of the PHA's Governance and Audit Committee from 29 June 2009 until 12 June 2014. Along with all of her colleagues, I wish her every success in her new post as Chair of the Business Services Organisation.

I wish to commend all of our Board members on their continued service and contributions not only for the good of our organisation but ultimately for the good of the entire population of Northern Ireland.

Non-Executive Director Deepa Mann-Kler has kindly agreed to serve on the Corporate Strategy Project Board as well as being lead Non-Executive PHA Board representative for PPI.

Non-Executive Director Leslie Drew serves as lead Non-Executive Director for Finance; and, Non-Executive Director Alderman Paul Porter has agreed to serve on the Remuneration Committee, taking over from Julie Erskine.

Non-Executive Director Brian Coulter continues to chair the Governance and Audit Committee and also serves on the Corporate Strategy Project Board and the Information Governance Steering Group.

I also pay tribute to the Chief Executive, the Agency Management Team and the entire staff throughout the organisation for their unswerving commitment to the goals of the agency.

We must celebrate the distinct achievements of the Agency over recent years including, by way of example, the increasing numbers of people whose illnesses are identified at an early stage through screening programmes; serious illnesses in adults and children prevented by the increasing numbers receiving vaccinations; and, the increasing numbers of service users and carers involved in decision making in their health and social care.

It is gratifying that life expectancy has been increasing. However, we must strive to ensure that the striking inequalities in health and in the quality of life of our fellow citizens are reduced and eventually eradicated.

The successes which have already been achieved by the work of the Agency will embolden us all to face with confidence and enthusiasm the exciting challenges in the months and years ahead.

I commend this report to you on the achievements of, and challenges for, the PHA over the last year.

I hope that the report shows and underscores our commitment to enabling better health for all in Northern Ireland.

Andrew Dougal OBE
Chair

Date 13 June 2017

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Chief Executive's Statement

This annual report for the 2016/17 financial year provides a broad overview of the work of the Public Health Agency (PHA) as the statutory body responsible for improving and protecting the health and wellbeing of the people of Northern Ireland.

This last year has been an extremely busy and eventful period for public health and we have risen to numerous challenges against a backdrop of ongoing work to develop the new Health and Social Care (HSC) structures and of reduced resources and staffing levels.

We have seen many notable achievements and successes over the course of the year and through this report we will highlight a small selection of these with a particular emphasis on fulfilment of PHA targets and goals, statutory requirements and Department of Health objectives.

Our *Business plan* for 2016/17 contained some 90 key targets which cover every facet of our work. The PHA reports on a further four targets set out in the Department of Health (DoH) document *The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2016*.

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

A continuing focus and main priority for the PHA over the last year has been on the implementation of *Making Life Better* (MLB).

This whole-system, strategic framework for public health, launched in June 2014, builds on the earlier *Investing for Health* strategy which covered the years 2002–2012, and acknowledges that health and wellbeing are influenced by a broad range of social, environmental and economic factors.

As designated lead agency for the regional implementation of *Making Life Better* we have been working over the course of the year with a range of stakeholders to develop a programme of regional action and awareness raising to ensure it is aligned with other key government policies and strategies.

This programme builds on the many years' experience and practice that have taken place over the years and considers key areas of work that, through partnership, collaboration and our collective efforts, will stand the best chance of making a positive and sustained impact on the health and wellbeing of individuals and communities.

This requires driving action at a local level, based on local needs, and aligning implementation with other relevant key strategies and policies.

The whole-system approach is essential to the successful implementation of MLB; the health and social care sector cannot tackle the root causes of poor health and wellbeing and inequalities in health alone.

We fully support this important collaborative and partnership approach which recognises that many factors can affect an individual's health.

Our collective aim and renewed focus is therefore to ensure the creation of the right conditions for individuals and communities to take control of their own lives and ultimately be able to achieve better health and wellbeing and reduce health inequalities. Too many people are dying prematurely in Northern Ireland or are living with ailments and conditions that they need not have.

A delivery-focused structure for the regional implementation of MLB that allows for local flexibility and shared outcomes will be essential to the successful implementation of the framework and ultimately the delivery of improved health and wellbeing for everyone and we look forward to working with our partners to achieve this common goal.

When the 11 new councils were established in 2015, as a result of *local government* reform, they acquired new powers and responsibilities regarding community planning. As a statutory partner, the PHA has welcomed an increase in collaboration and partnership between the PHA and the councils as a result.

The past year has been no exception with continued close working, particularly regarding the development of community plans.

We have also been working to align our own common goals and outcomes across community planning and MLB and have been very much influenced by this important work in the development of our own Corporate Plan for 2017–2021, helping to set the right direction for our organisation over the next five years.

Building on engagement with staff, colleagues and a wide range of external stakeholders through formal consultation during the year, we employed an Outcomes Based Accountability (OBA) approach and ensured all wider external influences were being taken into consideration.

In planning for 2017/21, we have taken account of not only MLB and community planning but also the vision set out by the Minister of Health in *Health and Wellbeing 2026: Delivering Together*; the *Draft Programme for Government Framework 2016–21*, other DoH and wider government priorities and the outworkings of current HSC reform.

Good progress has been made regarding HSC restructuring and, through the Transformation Implementation Programme Group, work is progressing to develop an operating model for a new regional body comprising elements of the PHA and the Health and Social Care Board (HSCB).

This organisation will operate alongside the DoH undertaking many of the functions currently carried out by both organisations. I look forward to working with all staff as we commence this important new chapter.

We have made good progress on many fronts and important developments have taken place across all three PHA Directorates.

The important '*Stay Well This Winter*' campaign ran from October 2016 to the end of March 2017 advising everyone to look after themselves over the winter period and to take appropriate action to stay well. This was an important collaborative campaign undertaken by the PHA and HSCB across a range of channels including TV, outdoor advertising, social media and websites.

The *10,000 Voices project*, which provides a mechanism for patients and clients to share their experiences, reached an important milestone during 2016/17 with the attainment of their 10,000th voice. This will undoubtedly ensure a more patient-focused approach to services and help shape future healthcare in Northern Ireland.

Another momentous milestone reached was the 12,000th person to have a '*Farm Families Health Check'*. The Farm Families Programme, delivered by the PHA in conjunction with the Northern Health and Social Care Trust, provides invaluable bespoke screening services and advice to rural communities which have particular needs.

During the year we also continued to lead the implementation of the *Q2020 Strategy*, overseeing the development of the Q2020 Attributes Framework e-learning training programme which aims to raise awareness of the importance of quality improvement for us all, whether in a clinical or non-clinical role.

In August 2016 the PHA launched a new initiative to work with employers to promote better health at work. The Workplace Health and Wellbeing Service engages small, medium and large businesses to commit to improve the health, wellbeing and safety of employees within the workplace. Over each of the three years of the programme it will reach over 200 new businesses across all five Health and Social Care Trust areas and aim to see a difference made to employees in the workplace as well as benefits to their families and communities.

Another important development during the year came with the publication of a framework which aims to improve Infant Mental Health.

This framework, which was the subject of extensive engagement and consultation, will ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge.

Acknowledging our commitment to equality of opportunity for everyone, including people with a disability, the PHA assisted with the further development of the Disability Staff Network '*Tapestry*'.

The establishment last year of this network across HSC organisations comes from a commitment given in our *Disability action plan* and sits alongside, and complements, other significant pieces of work we are involved in, such as our very successful disability placement scheme and disability awareness days.

The 2016/17 year saw another first in the form of the inaugural annual awards for Personal and Public Involvement (PPI) in Health and Social Care.

PPI remains a priority for the PHA and these awards, in conjunction with Queens University Belfast, recognise the excellent work taking place. We congratulate all of the winners helping to involve service users, carers and the public all of which can only lead to improvements being made.

During the year we were delighted to learn that an award of €8.8m was secured by the PHA's R&D Division to support a collaborative programme of cross-border healthcare intervention trials in partnership with the Health Research Board in Dublin.

This European-funded INTERREG VA programme aims to provide opportunities for populations in remote regions of the island of Ireland who would otherwise not have been likely to participate in health and social care research.

At the core of all of our work is protecting and improving health and wellbeing and reducing health inequalities. We achieve this through strong partnerships and through focused, comprehensive programmes of work.

Immunisation remained one of our biggest work programmes during the year and Northern Ireland again had the highest uptake rates for immunisation programmes in the UK.

For example, over the period October to December 2016, uptake of the two doses of the new Meningitis B vaccine programme to children up to the age of one year was 96%. Uptake of one MMR vaccine to children up to 2 years was 95% and two MMR vaccines to children up to 5 years of age was 92%. These are very impressive figures and we congratulate everyone involved across all screening programmes.

The Centre for Connected Health and Social Care (CCHSC), located within the PHA, continued to use technology and innovation to contribute to improving health and wellbeing. This was achieved through a number of partnership activities including working with the HSCB on the implementation of the *eHealth and Care Strategy for* Health and Social Care.

Our communications service continued to play an important role with a number of new, public information campaigns being developed and implemented in 2016/17 including those on dementia awareness, positive mental health and tackling obesity.

Of particular note was the '*Still me*' dementia awareness campaign, launched in September 2016, which was developed in partnership with the Department of Health,

the Executive Office and Atlantic Philanthropies and has achieved awareness levels of 86%.

Special mention should go to the Children and Young People's Strategic Partnership (CYPSP) and the PHA Lesbian, Gay, Bisexual, and Transgender (LGBT) subgroup which won the '*Involving you and Improving care*' award at the PPI awards.

The important work by the PHA on LGB&T issues was further recognised during the year through being nominated in two categories at the Pride in Newry Awards and becoming the first HSC organisation to be recognised as a 'Diversity Champion'.

The PHA was also a double winner at the Chartered Institute of Public Relations (CIPR) PRide Awards, taking away two silver awards for the breast cancer phase of its '*Be Cancer Aware*' public information campaign.

Mention must also go to several PHA supported and funded programmes including the Belfast Health and Social Care Trust's (BHSCT) Chairman's Partnership Award winners the BHSCT Respiratory Team for their '*Belfast Breathing Better*' initiative which included liaising with National Energy Action, which was also funded by the PHA; and to FareShare NI, supported by the PHA, who won the award for Promoting Health Equity at the fourth annual WHO Belfast Healthy Cities Awards in December 2016.

Since taking up the role as Interim Chief Executive of the PHA I have been very impressed by the breadth and quality of work being undertaken throughout all areas of the organisation and by the high professional standards that staff and board bring to the wider public health agenda.

As this report highlights, significant progress has been made in many important areas and I applaud and thank each and every member of staff on these key successes and for their continued commitment and dedication.

As we enter a new era within health and social care in Northern Ireland I am confident that the future of our population's health is in good hands and that, irrespective of imminent changes within HSC, that the work of the PHA will not only continue, but be built upon.

The work of the PHA is held in very high regard and this is due, in no small part, to the outstanding leadership that Dr Eddie Rooney, former Chief Executive who retired on 14 October 2016, brought to the organisation.

We wish him a long and healthy retirement and thank him for his unstinting commitment to public health and helping to improve the health of everyone in Northern Ireland.

Valerie Watts
Chief Executive (Interim)

Date 13 June 2017

Performance Analysis

The PHA Annual Business Plan 2016/17 contains 90 targets to take forward the six corporate objectives:

- protecting health;
- improving health and wellbeing and tackling health inequalities;
- improving the quality of health and social care services;
- improving the early detection of illness;
- using evidence, fostering innovation and reform;
- developing our staff and ensuring effective processes.

Performance against these targets has been of a very high standard.

Figures, based on the position at 31 March 2017, report a total of 80 coded as green for achievability, 10 as amber, meaning they will be achieved, albeit with a short delay; and 0 as red.

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

In 2016/17, the Public Health Directorate continued to work to a challenging agenda in fulfilment of corporate objectives and business goals in the four key areas of work:

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

As lead agency for the implementation of *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.

Through these targeted initiatives and programmes, staff remained focussed on prioritising prevention and early intervention to ensure the health and wellbeing of our local population.

Furthermore, with the publication in October 2016 of the Minister's 10 year vision for the transformation of the health and social care system entitled *Health and Wellbeing in 2026: Delivering Together*, the Public Health Directorate has refocussed its efforts to help reduce inequalities, to enable more preventative and proactive care, and enable earlier detection and treatment of physical and mental health problems.

As Director of Public Health, it is a statutory obligation of mine to produce an annual report.

The theme of my most recent Director of Public Health Annual Report for 2015, published on 8 June 2016, focussed on the economic case for prevention and the health and social benefits of public health interventions for the people of Northern Ireland, or in the words of Benjamin Franklin: "*An ounce of prevention is worth a pound of cure"*.

The report, launched at the PHA's fifth Public Health Annual Research and Practice Conference, was brought to life at the event through the highlighting of local examples of successful interventions to tackle primary risk factors. Among those featured were the following two examples on obesity and physical activity.

Obesity is still one of the most important public health challenges facing the Northern Ireland population. According to the latest Northern Ireland Health Survey for 2015/16, 26% of adults were obese and a further 34% were overweight, making a concerning combined total of 60% of adults being either overweight or obese.

It is estimated that loss to the local economy as a result of obesity is approximately £400 million per year with £100 million due to direct healthcare costs.

A wide range of programmes are currently in place and being delivered in different settings such as through schools, community spaces and in the workplace which aim to prevent obesity.

The workplace has been recommended as a potentially valuable setting for behavioural weight management interventions, due to the amount of time potentially spent sedentary in work, the food consumed there, and the social norms and support within organisations.

A novel initiative entitled the '£1 for 1lb Challenge' is one such intervention that has been very successful locally.

The workplace-based, 12-week behavioural weight management programme was run over a three year period from 2014–2016.

Delivered in partnership with Business in the Community (BITC), the PHA, the Belfast Health and Social Care Trust (BHSCT) and a corporate sponsor, it has attracted almost four thousand employees:

- In 2014, the first year of the project, 734 employees participated and lost a combined total of 1,541.4kg in weight, an average of 2.1kg/person;
- In 2015, a total of 1,585 employees participated and lost a combined total of 3,989.4kg, an average of 2.5kg/person; and
- In 2016, a total of 1,513 employees participated and lost a combined total of 3,633kg, an average of 2.4kg/person.

Physical activity is also a strong modifiable risk factor for many chronic diseases and a number of physical activity interventions supported by the PHA have demonstrated significant returns on investment.

One such programme is the Physical Activity Referral Scheme (PARS) which operates across Northern Ireland.

The programme enables GPs and other health professionals to refer inactive people who also meet other relevant criteria into a programme of activity of between 8 and 12 weeks.

Under the guidance of an exercise professional they set goals and undertake supervised exercise. A regionally-standardised PARS programme is currently being developed and will be rolled out across Northern Ireland from mid-April 2017.

Between 1 April 2016 and 31 December 2016 a total of 4,134 individuals had enrolled in the PARS programme across Northern Ireland.

During the year the PHA continued to lead on the Department of Health's (DoH) review of emergency medicine workforce requirements for 2014–2022 to identify appropriate medical staffing levels within health and social care in Northern Ireland.

As Senior Responsible Officer, along with Dr Gillian Rankin, Project Director and Medical Workforce Planning Lead, we are progressing 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, reports on the following specialties have been submitted to DoH:

- Paediatrics;
- Primary Care;
- Emergency Care Medicine;
- Trauma and Orthopaedics;
- Radiology, Radiography and Medical Physics;
- Anaesthetics and Intensive Care Medicine.

The Emergency Medicine Workforce Planning Project Team continues to take forward workforce plans for other specialties including:

- Acute Medicine;
- Urology;
- Neurology;
- Specialist Palliative Care Medicine;
- Geriatric Medicine; and
- Occupational Medicine.

Another important area, of which I am Senior Responsible Officer (SRO), is the Northern Ireland Electronic Care Record (NIECR) programme. This wide-ranging Health and Social Care programme enables the delivery of faster, safer and better care across Trusts and Primary Care.

The system, which went live in July 2013, covers a wide spectrum of health and social care roles, including nearly 90% of the medical workforce. In a typical week over 9,000 unique health and social care professionals access NIECR to view around 1 million laboratory reports, clinical documents, radiology investigations, GP eReferrals, medications and allergies.

This project has led the groundwork for the Minister's vision for a 'consolidated health record' for the population of Northern Ireland as set out in *Delivering Together*.

The Health Protection team within the Public Health Directorate continues to play a lead role in protecting the local population from infectious and environmental hazards through:

- the surveillance, prevention and control of infectious diseases;
- environmental health, emergency planning and response; and
- the public health response to chemical, radiation and poison exposures.

Immunisation remains one of our biggest work programmes and Northern Ireland has the highest uptake rates for immunisation programmes in the UK.

For the period October to December 2016, uptake of the two doses of the new Meningitis B vaccine programme by the age of one year was 96%. Uptake of one MMR vaccine by 2 years was 95% and two MMR vaccines by 5 years of age was 92%.

Up to the period 31 January 2017, influenza vaccine uptake in Northern Ireland was 72% among those aged 65 years and over 56% among those under 65, in an at risk group, 52% among 2 to 4 year olds and 78% among primary school children.

The population screening programmes have also maintained good uptake rates.

Following a fourth successful year of screening, the Northern Ireland Abdominal Aortic Aneurysm (AAA) Screening Programme has seen an encouraging increase in uptake from 81% (for the 2012/13 screening year) to 83% in 2015/16.

This follows a wide range of promotional activities by programme staff within the HSC, community and voluntary sectors as well as with pharmacies, libraries and local supermarkets.

The main aim of this partnership working has been to raise awareness of AAA screening and encourage men aged 65 to seriously consider taking up the offer of screening.

The cervical screening programme offers all women aged 25 to 64 the opportunity to be tested for pre-cancerous changes to the cells which line the cervix. A total of 114,546 women were tested during 2015/16 (latest available figures) and 77% of women in the target age group have had a test within the last five years.

The PHA works to ensure that all women have equal access to screening opportunities and we were delighted to work with the UK Defence Medical Services in 2016/17 to improve access to cervical screening for serving personnel based in Northern Ireland.

As part of our ongoing programme of quality assurance, a peer review visit was undertaken in October 2016 to the cervical screening services provided by the Western Health and Social Care Trust (WHSCT).

Participation in the bowel cancer screening programme continues to improve with 81,769 people having completed a test kit in 2015/16 (latest available figures) and uptake reaching a key threshold of 60%. The home test kit is sent to all men and women in Northern Ireland, aged 60–74.

Over recent months the PHA has worked with the Prison Healthcare Service of the South Eastern Health and Social Care Trust (SEHSCT) to put in place robust, ongoing arrangements, for offering bowel cancer screening to all eligible individuals in custody.

The learning from this programme is now being used to look at how we can improve access to other cancer screening programmes for this population.

During 2016/17, peer review visits were undertaken to the bowel cancer screening services provided by the Southern and Western HSC Trusts, and we have introduced a process to identify and learn from any bowel cancers that are diagnosed in the period between screening episodes.

The Northern Ireland Breast Screening Programme provides screening for breast cancer for eligible women aged 50 and over living in Northern Ireland. Eligible women aged from 50 to 70, who are registered with a GP, are invited every three years for breast screening.

Women aged over 70 are not automatically invited for breast screening, but if they wish to attend they can self-refer. In 2015/16 (latest available figures) 61,612 women were screened, an uptake rate of 76.1%.

As part of the ongoing quality assurance of the Breast Screening Programme, a peer review visit was undertaken in February 2017 to the breast screening service provided by the Southern HSC Trust.

A small number of women in Northern Ireland are part of the Surveillance Screening Programme for Women at Higher Risk of Breast Cancer and receive invitations for breast imaging at a younger age, and more frequently, in some cases using different investigations (e.g. Magnetic Resonance Imaging (MRI) rather than a mammogram). These women will have been identified by clinicians as being at particularly high risk of breast cancer, for example, due to their genetics.

Through the HSC Research and Development (R&D) Division of the PHA, we continued to support research and development across the entire spectrum of health and social care including public health.

Following the launch of the third HSC R&D strategy *Research for Better Health and Social Care* in February 2016, a Strategy Implementation Workshop was held in May 2016 to give stakeholders the opportunity to feed into the process of implementation.

One of the key actions for the implementation of the third R&D strategy, which was initiated in 2016/17, is a consultative review of the HSC R&D funded core infrastructure, helping to ensure it continues to provide an effective platform for health and social care research.

Within the R&D infrastructure, the Northern Ireland Public Health Research Network (NIPHRN) continues to flourish with a membership of almost 400, drawn from a broad range of stakeholders.

The main aim of the network is to bring together researchers, practitioners, policy makers and others with a common interest in progressing public health research, with a view to developing robust proposals for funding.

A number of research studies commissioned by the HSC R&D Division of the PHA and partners in key priority areas were completed and the findings shared during 2016/17 including an evaluative research study of a school-based smoking prevention intervention, jointly funded by Cancer Focus NI and the HSC R&D Division, and the second of five commissioned research studies funded in response to the Bamford report entitled *You Only Leave Once?: Transitions and Outcomes for Care Leavers with Mental Health and/or Intellectual Disabilities*, which focused on the experiences of a highly vulnerable group of young people during their transition to adulthood.

The HSC R&D Division continues to embed personal and public involvement (PPI) in all its activities, and an R&D associate PPI group, named Public Involvement Enhancing Research (PIER) has been established, jointly chaired by a PPI representative and the HSC R&D Division.

Over 90 HSC R&D funded research awards now include PPI representatives as members of the research team or as collaborators or co-producers of research.

The R&D Division has also been actively pursuing opportunities to secure additional funding for health and social care research, including leading a bid to the European funded INTERREG VA Health Programme.

An award of €8.8m has also just been secured during 2016/17 to support a collaborative programme of cross-border healthcare intervention trials in partnership with the Health Research Board in Dublin.

This programme aims to provide opportunities for populations in remote regions of the island of Ireland, who would otherwise not have been likely to participate in health and social care research.

Investment in the National Institute of Health Research (NIHR) UK-wide funding streams also continues to bring success to Northern Ireland, with twenty-two studies led by Northern Ireland researchers, bringing £20.36 million to support health and social care research across the universities, and Trusts, in a period of less than five years.

The following section outlines some examples of the work undertaken within the Public Health Directorate during the year and how we achieved our goals.

Health and Social Wellbeing Improvement

Breastfeeding Promotion and Support

The importance of breastfeeding to both maternal and child health is increasingly being recognised. Recent evidence confirms that breastfeeding decreases the incidence of otitis media, gastroenteritis, respiratory infections, obesity, diabetes, childhood cancers, necrotising enterocolitis and sudden infant death syndrome.

Breastfeeding mothers also benefit from decreased incidence of breast cancer and ovarian cancer.

The PHA is supporting implementation of the Northern Ireland Breastfeeding Strategy, *Breastfeeding – A great start 2013–2023,* with the aim of improving outcomes and creating supportive environments for breastfeeding.

While our breastfeeding rates are gradually increasing, rates remain lower here than in other parts of the UK. Evidence suggests that effective action should include improving the information and support expectant and new mothers receive within health services.

As recommended by the National Institute for Health and Care Excellence (NICE) we have been working with UNICEF UK Baby Friendly Initiative (BFI) and HSC Trusts to implement best practice across maternity, health visiting and Sure Start services.

This involves putting in place effective policies, staff training, parent information and practical support to enable mothers to make well-informed choices about how they feed their babies.

In July 2016, Northern Ireland became the first country within the UK to achieve the goal of delivering 100% of births in BFI fully accredited maternity services. By comparison, the rate in England is 58%, Wales 55%, and Scotland 88%.

Support for breastfeeding in neonatal units is also a priority. In 2016 we provided UNICEF courses for 188 staff and, of that figure, 47 neonatal nurses and allied health professionals working in child health completed UNICEF training.

We have also supported Tiny Life to maintain and enhance their breast pump loan service for mothers whose babies are being cared for in a neonatal unit.

Mother-to-mother support is important in enabling women to stay with a decision to breastfeed. We have developed and supported a new role of Peer Support Workers who work within maternity units to connect new mothers with local trained volunteer peer supporters. Evidence suggests that breastfeeding mothers need both peer and professional support. Our own user feedback from mothers is very positive about this approach.

We are also helping to create supportive environments in the community through the PHA's Breastfeeding Welcome Here scheme. This initiative now has over 500 members including businesses and councils.

Health Protection

Antimicrobial resistance

During 2016, the PHA established a multi-agency, collaborative Antimicrobial Resistance and Healthcare-associated Infection Improvement Board for Northern Ireland.

Chaired by the Assistant Director of Public Health (Health Protection), the Board promotes the use of quality improvement methods at a tactical and operational level to reduce the burden of harm from antimicrobial-resistant pathogenic microbes. Significant progress was made during the year towards developing a formal antimicrobial use and resistance surveillance programme, with recruitment of a dedicated team.

A process of consulting with stakeholders will be followed by a period of designing, developing, piloting and implementing new a surveillance system that will provide intelligence to the Health and Social Care system and help guide systems improvement.

This significant task will take place over the coming year and the amount of information reported by the programme is expected to increase over time as the team gains access to new sources of data and develops new methods of presenting information.

The PHA has also worked over the last year with HSCB and HSC Trust partners to produce and distribute antimicrobial prescribing guidelines for primary care, including electronic and mobile device resources and collaborated on the development of new roles for pharmacists, including new pharmacists linked to nursing home and intermediate care settings and new general practice-based pharmacists, who will contribute to antimicrobial stewardship.

Contribution to the introduction of a Locally Enhanced Service to support a named Antibiotic Champion in general practices to undertake antimicrobial stewardship audits and quality improvement actions was also completed as was planning of a point-of-care Community Response Plan (CRP) testing programme in a number of GP practices in Northern Ireland which seeks to establish how GPs can use this technology to make the most appropriate prescribing decisions for respiratory infections.

Evaluation of the pilot will guide whether a more widespread roll-out is warranted.

A Regional Outpatient and Home Parenteral Antibiotic Therapy Group was established during the year to provide greater availability and harmonisation of

appropriate home antimicrobials, facilitating earlier discharge from hospital and ensuring a consistent and high-quality approach to antimicrobial use in this context.

European Antibiotic Awareness Day and World Antibiotic Awareness Week in November 2016 were again both supported with mainstream and social media coverage.

The extensive work undertaken during 2016/17 has paved the way for an improving information environment across Health and Social Care, which will allow decision-making and quality improvement efforts to be guided by up-to-date and local intelligence about antimicrobial resistance, consumption and stewardship.

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. Most people invited for screening do attend.

Numbers of attendees/responders and uptake rates for each of the screening programmes in Northern Ireland for 2015/16 (latest available figures) are shown in the Table below. In total, there were 385,113 screening attendances during the year.

Screening programme	Description	Number of attendees/ responders	Uptake rate 2015/16
Antenatal infection screening	All pregnant women are offered screening for hepatitis B, HIV and syphilis infection as well as for non-immunity to rubella infection.	25,100	>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. Congenital hypothyroidism).	24,200	>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.	23,900	>98%
Diabetic eye screening programme	Everyone with diabetes (aged 12 and over) is invited to have photographs taken of the backs of their eyes once a year. This checks for early signs of damage to the retina caused by diabetes and aims to reduce sight loss through early identification and treatment.	46,215	69%
Cervical screening programme	All women aged 25 to 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.	114,546	77% Coverage in past 5 years
Breast screening programme	All women aged 50 to 70 are invited for screening mammography every three years. The aim of the programme is to reduce mortality from breast cancer.	61,612	76%
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 abdominal aortic aneurysms (AAAs).	7,771	83%
Bowel cancer screening programme	This programme offers screening every two years to all men and women aged 60 to 74. If detected at a very early stage, bowel cancer treatment can be 90% successful.	81,769	60%
	Total screening attendances 2015/16	**385,113**	

HSC Research and Development

Early Intervention Transformation Programme

The Early Intervention Transformation Programme (EITP) is a Northern Ireland Executive/Atlantic Philanthropies Delivering Social Change Signature Programme.

The Delivering Social Change framework aims to combat poverty and social exclusion in Northern Ireland through cross-departmental working and thus helps to reduce inequalities in outcomes.

The EITP aims to improve outcomes and opportunities for children and young people through a range of early intervention approaches.

There are a total of four work streams and the PHA's HSC R&D Division, in partnership with Atlantic Philanthropies and EITP, issued an EITP commissioned research call for work streams 1, 2 and 3.

The work streams, and research questions for each, are described below.

Work stream 1 – led by the Department of Education and the PHA

Work stream 1 aims to equip all parents with the skills needed to give their child the best start in life. It focusses on three key parenting stages:

- Getting ready for baby;
- Getting ready for toddler; and
- Getting ready to learn.

The research call was made for projects aimed to answer the following questions:

- the critical success factors associated with rolling out system-wide changes in universal parenting supports; and
- how extensively and successfully they have changed the way associate professions go about their work.

Work stream 2 – led by the PHA

Work stream 2 aims to support families when problems arise, before they need statutory involvement. It will deliver Early Intervention Services with a range of practical and therapeutic supports to families.

The research call was for projects investigating the key factors which make these early intervention support services work in Northern Ireland.

Work stream 3 – led by the Health and Social Care Board

Work stream 3 aims to positively address the impact of adversity on children and focuses on four projects:

- the Belfast Intensive Family Support project;
- the Home on Time project;
- the Edges project; and
- the Families Inside Out project.

The research call was for projects to answer questions around the benefits and risks of using the voluntary sector to provide services to children and families with complex needs as an alternative to social work services.

Work stream 4

Work stream 4 has recently been developed.

The *Working Better Together* professional development project aims to strengthen inter-professional working practice through undergraduate, postgraduate and post-qualifying training.

Studies associated with the research call commenced in 2016/17 and are due to be completed by 2020.

The findings will inform the implementation and roll out of programmes and will provide evidence in relation to the critical success factors of the project which can be shared across other agencies, policy makers and commissioners who are considering similar investment.

DIRECTOR'S REPORT – NURSING AND ALLIED HEALTH PROFESSIONS

The PHA's 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.

We have lead responsibility for a range of quality and safety issues including responsibility for the Health and Social Care Safety Forum, Personal and Public Involvement (PPI) and improving the patient and client experience.

The PHA has fulfilled the role of Local Supervising Authority having held the statutory responsibility for midwives practising within Northern Ireland.

As we anticipate changes in the statutory function of the Local Supervisory Authority, the Local Supervising Authority Midwifery Officer and the Midwifery Supervisors within Trusts, it is important to reflect on and acknowledge the significant contribution that has been made to safety, quality and the experiences of women and their families.

Their impact has been significant; they have achieved much and have left a wonderful legacy for the future.

Our work is based on valuing and respecting service users, partners and each other.

We work with, through, and in, support of others with the objective of ensuring people are enabled and supported to achieve their full health and wellbeing potential.

The team has worked over the past year in fulfilment of its goals and objectives, helping to reduce inequalities whilst being guided by the voice of service users and staff and taking account of *Making Life Better* and *Health and Wellbeing 2026, Delivering Together.*

The following report highlights some of the Directorate's key achievements and outcomes and the impact they are having.

During the year the PHA continued to lead the implementation of the *Q2020 Strategy,* overseeing the development of the Q2020 Attributes Framework e-learning training programme and the establishment of five task groups to take forward quality improvement work in a range of areas such as human factors and simulation training; learning from adverse incidents and never events; supporting staff and developing a list of always events.

Learning from Serious Adverse Incidents resulted in the development of new standards for nursing and midwifery education providers regarding cervical screening sample taking; the publication of the *Learning Matters* Newsletter and the carrying out of a range of thematic reviews, all of which directly impact of the quality of patient care.

The Safety Forum facilitated a Northern Ireland wide agreed single solution to Early Warning Scores for all paediatric, adult and maternity patients. Over the last year, in conjunction with local Trusts, they developed agreed tools to facilitate the decision to escalate care for adult in-patients with sepsis and for patients with acute illness superimposed on long-term respiratory or neurological conditions.

Personal and Public Involvement (PPI) remains a priority for the PHA and during the year the first annual awards for PPI in Health and Social Care where presented in the areas of Quality and Safety, Service Improvement, Innovation and Involvement, and Best Involvement Story.

In February 2017 the PHA, working with the Patient Client Council, launched their commissioned research into PPI along with its impact.

During 2016/17, the PHA-led 10,000 Voices Initiative, which aims to provide a robust and systematic mechanism for patients and clients to share their experiences, reached the 10,000th voice.

The initiative has been implemented in a range of settings including Unscheduled Care, Autism and Child and Adolescent Mental Health Services (CAMHS) services, Eye Care Partnership services and the Northern Ireland Ambulance Service HSC Trust.

A broad range of work is currently being undertaken as a result of feedback received regarding improvements and sharing good practice.

Working in partnership with Age NI, local Trusts, service users and carers over the year, we published *What really matters* which considers the changing service needs, nurse education requirements and promotion of innovative practices to support public health outcomes for older people.

A DVD was also produced in partnership with Age NI which will be utilised to promote nursing careers in older people's services with HSC, external and nurse education partners.

A regional guidance document was produced during the year to assist nurses, midwives and allied health professionals in planning opportunities to develop their skills, knowledge, attitudes and behaviours to improve their performance and competence in relation to the safeguarding of children and young people in Northern Ireland.

The roll out of the Family Nurse Programme (FNP) continued with a small team in each Trust area comprising nurses working with young parents to develop and expand their strengths and to help promote change.

During 2016/17, nearly 400 young parents took part in the programme. A formal evaluation has been commissioned that will focus on the value of FNP among service users, practitioners and FNP teams with the final evaluation report expected in June 2017.

Throughout 2016/17 the nursing team worked with HSC Trusts, the Health and Social Care Board (HSCB) and external partners to lead on the development and redesign of regionally consistent electronic solutions to support health visiting and district nursing workforce and caseload intelligence. This work will continue to be developed alongside the eHealth strategy.

The PHA, working with school nurses, supported the development and testing of a school health profiling tool in partnership with education. The profile creates a picture of child health in the school setting while giving consideration to their environment.

This practice-development process has facilitated the development of stronger partnerships between health and education colleagues over the past year and allowed them to consider how health improvement opportunities can be provided.

The following section highlights some examples of the work undertaken by the team throughout the year under the broad headings of 'Early years'; 'Adults' and 'Older people'.

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:

Early Intervention Transformation Programme

The Public Health Nursing Team for Children and Young People has been working with midwives, health visitors, pre-school teachers, parents and others to transform universal public health nursing and midwifery services across all five Trusts as part of the Early Intervention Transformation Programme.

Group-based antenatal care and education using the Solihull approach has been introduced for first-time parents receiving midwifery-led care.

A health visitor review of three-year-olds in the pre-school setting, that aims to support parents prepare their children for school with the support of earlier interventions where these are needed, has been rolled out.

A named health visitor is now aligned with every pre-school educational setting in Northern Ireland. The purpose of this transformation is in line with the aim of giving every child a better start.

The maternity handheld record

Following the development of the Antenatal Care Core Pathway in Northern Ireland, it was recognised that an update of the maternity handheld record was required.

Staff and users worked in partnership to review the record and develop an additional booklet which includes a new 'birth preferences' section where women can identify their needs and requests for pregnancy and labour. Within the clinical record for each appointment there is also a 'what matters to me' section for women to write any questions they may have between appointments that they can raise with their care provider at their next appointment.

10,000 Voices, autism and CAMHS services

During 2016/17 the 10,000 Voices initiative was used to capture the experiences of people who use Child and Adolescent Mental Health Services (CAMHS) and paediatric autism services.

This was the first time that the 10,000 Voices initiative had been applied to children's services and it provided an innovative and meaningful insight into the experience of those who have both accessed and delivered these services.

The aim was to establish a baseline of the experience of children, young people and their parents/carers to improve, and influence, the future development and delivery of these services systematically.

Service users were involved from the outset in the design of the survey, participating in the survey and in the analysis and formulation of recommendations.

A total of 456 children, young people, parents, carers and staff across CAMHS and paediatric autism services completed the survey with the information used to inform the future planning and delivery of CAMHS and paediatric autism services.

Neonatology

During 2016/17, the PHA led on the development of an enhanced and integrated AHP neonatal service across Northern Ireland.

This service will include additional support in neonatal wards across all trust areas from Dietetics, Occupational Therapy, Speech and Language Therapy and Physiotherapy.

The appointed AHP staff will work closely with nursing and medical staff to address the extensive needs of premature babies and their families.

This will ensure that parents/carers and babies receive specialist intervention at an early stage in the child's life to meet and enhance a wide range of developmental needs such as physical, nutrition, feeding, respiratory and sensory needs.

The additional support is aimed at enhancing timely and safe discharge of babies which includes advice and training for parents and carers to ensure a better understanding of the child's development needs and how this can be supported post-discharge.

ADULTS

Work undertaken over the past year, focussed on addressing issues that impact on people of working age, including 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:

Mental health

The recovery model in mental health continued to strengthen with Recovery Colleges now being fully established in all Trust areas across Northern Ireland and the PHA continuing to support the Trusts on a regional basis to help keep the momentum of this work going.

Following the 2015/16 'Your Experience Matters' survey, during 2016/17 the PHA is now coordinating a regional action plan to help continue to improve the service user experience in mental health services.

During 2016/17, the third edition of the *Recovery* newsletter was published which is dedicated to sharing news and information about mental health recovery work across Northern Ireland.

The newsletter is co-produced by staff and service users and includes personal stories of people on their own recovery journey as well as updates on the work of all local Trusts in this important area.

Following the successful pilot in the South Eastern Trust area in 2015/2016, the Anti-Absconding KPI was rolled out across all 5 Trusts during 2016/2017. Baseline data available for 2016/2017 indicates increasing compliance with the Anti-Absconding bundle across all participating wards.

A second nursing KPI was also developed in 2016/17 for testing across Northern Ireland in the area of therapeutic and psychological Interventions.

Learning Disability

The Regional Learning Disability Healthcare and Improvement Steering Group, led by the PHA's nursing team, continued to make progress through the improvement of the health care and health and social wellbeing of people with learning disabilities.

One significant piece of work was the development of the HSC hospital passport for people with a learning disability in contact with a general hospital.

The passport was developed in partnership with a wide range of individuals with a learning disability, organisations involved in learning disability service provision as well as family and carers.

It provides vital health information about the person and will help staff in hospital settings make reasonable adjustments in order to support safe and effective care for people with a learning disability.

The passport was tested with service users, carers, HSC Trusts, voluntary and independent care providers and will soon be rolled out across Northern Ireland.

Primary care

During 2016/17 the Chief Nursing Officer launched *Now and the Future: A General Practice Nursing Framework for Northern Ireland*. Produced by the PHA with a wide range of partners, the Framework aims to provide guidance to support systems and processes that are required for the development of General Practice nurses.

The Framework highlights the key issues and opportunities for nurses working in General Practice including role definitions, competencies, working within teams and the professional governance arrangements that are required to support nursing registration and practice in Primary Care.

During 2016/17, the PHA worked with partners to increase the availability of a range of education programmes in primary care, including improved spirometry education and new standards for cervical smear taking.

Most recently, the PHA's nursing team has worked in close cooperation with the HSCB, the Department of Health, Ulster University and Down GP Federation to explore and develop a programme for Advanced Nurse Practitioners in Primary Care.

eHealth

Information and technology is indispensable with nurses, midwives and health visitors using it on a daily basis to deliver care and improve services.

It is also used to develop and deliver educational programmes and undertake research.

In order to effectively implement the objectives and realise the outcomes of *eHealth and Care 2015–2020*, nursing will have to work collaboratively inside and outside of the HSC at both the local and regional levels in leadership, practice and education initiatives.

In order to achieve this aim, a nursing and midwifery informatics network was established during 2016/17 to spearhead a comprehensive approach to capacity building amongst nurses, midwives and health visitors across all care sectors and settings.

The network will build on already- established good practice and professional development through the exploration of informatics and its impact on patient care

within a new collaborative environment, shaping the design and development of initiatives in the future.

The Northern Ireland Allied Health Professions eHealth network was established in autumn 2016 and reports through the PHA AHP Leads Forum. The group is made up of Trust members of staff from across a wide range of disciplines and specialties and who are now deemed to be e-health 'champions'.

Some of their achievements to date include the collection of baseline data on all local AHP initiatives, refreshing previous work from the AHP strategy; the establishment of a regional AHP e-health network SharePoint site and ongoing discussions on how best to harness HSC knowledge exchange; Trust nominees interfacing at a local level with the relevant Chief Clinical Information Officer and Trust Clinical Digital Councils; PHA representation on the National Allied Health Professions Information Strategy Team for the four nations.

Unscheduled care

The Nursing and AHP Directorate provides professional input and support to the HSCB/PHA Unscheduled Care Programme Team and to both the regional and local Unscheduled Care Network.

In conjunction with the HSCB, we have taken forward a range of initiatives:

- Development and implementation of regionally-agreed principles for discharge from hospital – Home is the first and best place for care –incorporating a 'plan on a page' process for discharge. This includes a revised assessment process that meets the needs of patients, professionals and the regulator for the safe transfer of care.
- We have secured resources and a commitment from all Trusts to participate, in partnership with LCGs, in the National Audit of Intermediate Care. This will support robust peer benchmarking and service redesign to help reduce reliance on acute hospitals.
- We have led an extensive engagement on intravenous antibiotic use including prescribing, review and governance to support admission avoidance and earlier discharge from hospital.
- Development of a suite of quality indicators to demonstrate standards of care and inform priorities for improvement both regionally and locally.

Quality Improvement using Project ECHO

The HSC Safety Forum was successful in gaining a place on the Project ECHO programme (Extension of Community Healthcare Outcomes), led jointly by the HSCB and NI Hospice.

Distance tele-mentoring, via the ECHO programme, uses a 'hub and spoke' approach and has enabled support for 14 quality improvement teams in all six HSC Trusts (spokes) without staff having to leave their place of work.

Improvement experts at the 'hub' have been able to support teams mainly using collaborative discussion and expert teaching.

Projects include; improving the use of the Sepsis6; optimising use of early warning scores; better care for looked-after children; safer maternity care; improving reliability of paramedic care; improvement in CAMHS services.

AHP professional issues

In partnership with HSC Trusts, the AHP team led a project to develop an HSC AHP assurance framework.

This provides professional assurance that systems and processes are in place in HSC Trusts to support AHPs to deliver safe, effective and high quality care to people who use health and social care services in Northern Ireland.

The key performance and assurance roles and responsibilities are: Corporate control; safety and quality; finance; and, operational performance.

Trusts have now completed the first round of monitoring and the next steps will include:

- Ensuring that processes are put in place so that assurances apply to the 12 AHP professions in all Trusts. (This includes the additional five contracted professions).
- Engagement with Local Commissioning Groups (LCGs) in relation to any issues raised about staffing levels.
- Working with Trusts with the aim of finding solutions to gathering evidence of percentage compliance with training and supervision. Trusts currently report that they do not capture this detail at Trust level
- Working with Trusts to meet the full requirements of the regional AHP supervision policy.

Implementation of the AHP strategy

The PHA has worked closely with the DoH, Trust AHP leads and professional heads of service to ensure work outlined within the 2012–2017 AHP strategy *Improving health and wellbeing through positive partnerships* has been implemented.

This includes a range of activities to meet the 40 actions outlined within the following themes:

- Promoting person-centred practice and care;
- Delivering safe and effective care;
- Maximising resources for success; and
- Supporting and developing the AHP workforce.

Delivering care

During 2016/17 the PHA in partnership with other HSC organisations and the DoH, led and progressed the project plan for '*Delivering Care. A framework for nursing and midwifery workforce planning to support person centred care in Northern Ireland*'.

This policy initiative aims to support the provision of quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

The PHA, in partnership with the Northern Ireland Practice and Education Council for Nursing and midwifery (NIPEC) and HSC Trusts, has successfully led the development of the recommended workforce models and monitoring requirements across nursing through the implementation of delivering care to build a skilled and competent nursing workforce for acute medicine and surgery, emergency departments, district nursing and health visiting.

The latter phases which have been progressed during 2016/17 are now waiting on policy endorsement from the DoH for implementation of:

- Phase 2 – Type 1 emergency departments;
- Phase 3 – district nursing; and
- Phase 4 – health visiting.

OLDER PEOPLE

People who are older have a wealth of life experiences, skills and knowledge. They contribute significantly to society and the economy, yet this contribution is often overlooked.

Within the Nursing and AHP Directorate we aim to value, respect and protect people who are older and to work in partnership with others to ensure they have long, healthy and happy lives wherever they live, recognising that advanced age can bring an increased likelihood of dependency, disability, chronic disease and illness.

During 2016/17, the PHA established an Older Peoples Coordination Group that has four specific areas of focus that will be taken forward into 2017/18. These are namely, prevention of incontinence; prevention of loneliness and social isolation; prevention of falls; and, dementia/mild cognitive impairment.

Prevention of incontinence

To identify and address the specific challenges presented in Northern Ireland by urinary incontinence, a scoping exercise has been undertaken across the five Health and Social Care Trusts in relation to service provision.

This work will inform a regional action plan which aims to promote excellence in the identification, assessment and management of urinary incontinence.

Prevention of loneliness and social isolation

During 2016/17 the AHP team, working in partnership with Trusts, Age NI, service users and Translink started to develop AHP public health approaches to reducing loneliness in older adults.

Some research findings highlight that older people are in the grip of a 'loneliness epidemic'.

AHPs are well placed to promote independence and provide general health and wellbeing advice, offer early intervention techniques and advice and support to prevent physical and mental ill-health as older adults form a large proportion of their caseloads and they frequently support clients in their own home.
This work includes:

- Development of an aide memoir for AHPs to use in their daily contact with older people to help identify loneliness and signpost them to useful agencies accordingly;
- Collation of signposting information for AHPs to give to older people as appropriate, for example, useful contacts;
- Development of a short leaflet/bulletin on AHP advice for older people with tips on remaining healthy and independent in order to reduce the chance of isolation though ill physical and/or mental health;
- Work with Translink, Age NI and others in supporting people with skills to improve confidence in getting out and about in their communities and, as a result, reduce social isolation.

The agenda for tackling loneliness and isolation will be further built upon during 2017/18.

Prevention of falls

The PHA leads a falls group that has been established to coordinate public health's approach to the prevention and management of falls. This spans primary/community care, unscheduled, acute care and independent sector.

The work plan for 2017/18 includes nursing and AHP's contribution to falls prevention within an ageing society.

Dementia/mild cognitive impairment

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 Northern Ireland project which runs from 2014–2017.

Important work undertaken during the year includes:

- Funding from the Delivering Social Change dementia project allowed a focus on Delirium and work was undertaken through the Safety Forum to introduce a range of delirium resources across 10 pilot wards.
- Delirium training was been provided to 1,050 individuals including staff from the community and voluntary sector, Trusts, carers and people with dementia.
- A delirium awareness animation app was produced and has had over 2,200 views. The improvement work was presented at the Patient Safety Congress and European Delirium Association conferences and was awarded runner up in the HSE and Dublin City University Dementia Elevator Award for Innovation in Dementia Care Improvement 2016.
- A new dementia section was developed on nidirect. This has received over 20,000 page views in seven months and has become the most accessed health and wellbeing section on the site.
- The '*Still Me*' dementia awareness campaign was launched in autumn. This was the first public information campaign from a public body to use people living with a dementia in TV advertising, demonstrating the results of excellent co-production and co-design. There have been over 15,000 page views.

Cancer

- In conjunction with HSCB, investment was made during 2016/17 to expand the Cancer Nurse Specialist workforce to ensure they are equipped with the right skills, opportunities and supervision arrangements to improve the experience of patients living with cancer.

  In January 2017 an Upper Gastrointestinal (GI) Regional Forum was established for Cancer Nurse Specialists and a work plan is being finalised. The Acute Oncology Nursing Service (AONS) also developed a range of pathways to provide a consultation, communication and liaison service.

DIRECTOR'S REPORT – OPERATIONS

Staff within the Operations Directorate provide expertise across a broad range of business activities, essential to the efficient running of the organisation, including Communications, Health Intelligence, Planning, Governance and Operational Services.

Working closely with colleagues throughout 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.

Communications

Critical to the performance of any organisation is good communication. A central role of the Operations Directorate is to ensure that effective communication is undertaken at all times through the dissemination of effective messages and information, internally and externally, in a timely manner that is tailored for our target audiences.

In today's fast-moving, technological and digital era we consistently look to ensure that the right messages are getting to the right target audiences through exploiting the most suitable mix of traditional and emerging communication channels.

Social media

During 2016/17, we continued to grow our social media presence using infographics, video and photographs. A noteworthy development was our new video, highlighting the dangers of blind cords for young children in collaboration with local councils in Northern Ireland which earned much positive recognition.

A number of media outlets, including across England and Australia picked up on the video message and such has been the viral success of the video that it has been seen by millions of people on Facebook. There have been over four million views through an Australian media outlet alone and the video has been shared hundreds of thousands of times to date.

Other videos developed internally by the Communication's team have also been rolled out through social media and secured strong levels of engagement. For example, the Choose to Live Better campaign was augmented with in-house videos showing how to prepare a number of the healthy recipes contained on the campaign website.

The incorporation of infographics into our social media channels also assisted in strengthening engagement with targeted audiences as they enabled key messaging to be distilled into 'bitesize', engaging images, which increased the likelihood of people sharing them on their own social media accounts and increasing the 'viral' nature of the posts.

This has enabled the PHA to engage directly with the public on a range of important issues through third party support. As a result of wider efforts to develop the use of

social media, the two main channels used by the agency – 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 5,353 on 1 April 2016 to 7,338 on 31 March 2017 and Facebook followers increased from 9,905 on 1 April 2016 to 14,571 on 31 March 2017.

Public relations

We 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.

We also continued the important work of proactively engaging with the media and journalism students to promote appropriate reporting of mental health issues and to raise awareness of sources of support for individuals or families experiencing mental health problems or for those at risk of suicide and/or self-harm.

This work 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.

Public information campaigns

A number of new mass media campaigns were developed and implemented in 2016/17 including campaigns on dementia awareness, positive mental health and tackling obesity.

Dementia

The dementia awareness campaign, launched in September 2016, was developed in partnership with the Department of Health, the Executive Office and Atlantic Philanthropies.

Comprising two phases, the campaign, entitled '*Still Me*', aimed to raise awareness of the signs of dementia as well as to reduce stigma and fears surrounding the condition.

It included mass media advertising across multiple channels and was supported by Public Relations (PR), social media and information hosted on the nidirect website.

The primary target audience included people aged 60 years and over as being in this group is a major risk factor for dementia. The secondary target audience then focussed on those aged 45 and over, comprising family members, friends and siblings who could play an important role in recognising signs of dementia and encouraging friends or family to see their GP.

A further broad campaign aim was to get the general public to challenge negative perceptions and attitudes about dementia.

The campaign featured a number of people living with dementia who all volunteered through the Alzheimer's Society, Age NI or Dementia NI so as to help raise awareness of dementia and encourage greater support for those living with the condition.

Change your mind campaign 2016/2017

A new campaign encouraging people to ask, listen and talk about mental health entitled '*Change your mind*' was also launched during the year.

The campaign, launched by the PHA in partnership with Inspire (formerly NIAMH) and Comic Relief, aims to encourage the public to offer support to those who may be struggling with their mental health. The campaign ran from 12 September 2016 to 30 November 2016.

The campaign also formed part of a wider programme, partly funded by Comic Relief, of work in schools and workplaces, to help reduce stigma around mental health.

The first phase of the campaign partly aimed to reduce the stigma around mental health problems by highlighting how common they are.

The message was communicated through radio, outdoor and digital advertising and highlighted that one in five people in Northern Ireland will experience a mental health problem at any one time. It also highlighted that the other four will have a friend, family member or colleague who will, and has asked the question, "So, isn't it time we dealt with the stigma together?"

The second phase, entitled '*Helping others*', focused on how people can support friends or family to deal with a mental health problem through asking, listening and talking.

The campaign ran on TV; radio; Sky TV; outdoor; video on demand; and digital, directing people to the information resource website www.changeyourmindni.org

Obesity

A new campaign entitled *'What will your step count be today?*' launched and ran in June 2016, February 2017 and March 2017 addressing the issue of overweight and obesity as highlighted in the framework *A fitter future for all*.

The campaign aimed to encourage people to think about the number of steps they take each day and motivate those who are overweight or obese to track and try to do more.

All advertising featured the slogan *'What will your step count be today?'* as tracking your number of daily steps is a simple way of becoming more physically active. Encouraging people who were predominantly sedentary to move more was key to the campaign message.

The campaign featured TV advertising which highlighted the various ways to increase your step count, outdoor and digital advertising including Facebook, Google search and mobile. Significant updates were also made to the website developed to support the obesity campaign *choosetolivebetter.com* with resources to encourage people to take the next step and be more active.

Further to this activity, the '*Extras*' campaign ran during January 2017 and February 2017 with the aim of encouraging all those who are overweight or obese to consider cutting out the extras in an effort to reduce weight gain and manage their weight.

We also continued to roll out our smoking '*One in two*' campaign which highlighted that one in two smokers will die of a tobacco-related disease and therefore aiming to motivate and encourage smokers to make a quit attempt.

Other highlights during 2016/17, included mass media campaigns for sexual health and organ donation; winning two silver awards for the breast cancer phase of the 'Be Cancer Aware' campaign at the Chartered Institute of Public Relations (CIPR) PRide Awards in October 2016; and, development work being started on a new breastfeeding campaign which will be produced and implemented later in 2017.

We also worked collaboratively with the HSCB on the development, launch and delivery of a new campaign, '*Stay Well This Winter*'.

The campaign, using different media, aimed to encourage people to get the flu vaccine, advise them how to use health services appropriately over the winter period and clarify the role of the GP out-of-hours service.

Initial research has indicated a very high level awareness of the campaign and the issues it raised.

Website development

During 2016/17 emphasis continued on supporting the 26 websites the PHA has in place and facilitating the content management of all sites; ensuring multiple platform accessibility; and integration for mobile technologies such as smartphones and tablets to further engage our audiences.

The HSC R&D website was further enhanced during 2016/17 and the site for infection control was completed.

Work continued on the process of developing the Health and Social Care element of the nidirect website. A new '*Living Well*' section was agreed and the content for this section will reflect key areas of PHA responsibilities including smoking cessation, mental health promotion, obesity prevention and drugs and alcohol awareness.

Support materials and design

Whilst meeting the demands for new communication channels, the PHA have also ensured that they do not compromise on the quality or availability of more traditional formats. These include publications and resources to support programmes such as immunisation or screening where informed consent is required, or for health and social wellbeing improvement projects across our communities.

With emerging priorities added throughout the year, in excess of 200 publications were produced by the PHA Communication's team.

The *'Cook it!'* community nutrition training manual, which required a complete revision to reflect the new *Eatwell guide* and to extend the programme to our growing black and minority ethnic communities is an excellent example of full publications support ranging from writing, editing, design and print procurement as well as collaboration with many individuals and experts internally and externally.

This project included a full suite of support materials which had to be translated into a number of languages to take into account the different foods and cultures of our increasingly diverse society.

Several important new areas of work undertaken this year were on eye health in the workplace and the new hospital passport for clients with a learning disability.

Eye health in the workplace resources produced included an information poster for display to employees on workplace noticeboards with more detailed information contained in an accompanying factsheet for employers.

The new hospital passport for clients with a learning disability, and accompanying guidance to help with completing the passport, are important communication tools and vital safeguards to prevent risk when individuals with a learning disability use general hospital settings.

The implementation of the dementia strategy progressed during the year in partnership with the HSCB and to support this work the PHA produced a number of resources for people with dementia and their carers'. This work will continue in 2017/18.

The *Focus on alcohol* resource and the supporting '*alcohol wheel*' (which allows people to calculate units in popular alcoholic drinks) were both redesigned.

These revisions are in line with the new alcohol guidelines issued by the UK Chief Medical Officers and now provide information on the new weekly guidelines on regular drinking and advice on single episodes of drinking and alcohol in pregnancy.

The PHA has continued to update our internal guidance documents available in the PHA communication toolkit to assist those developing other support materials to allow us to focus our limited capacity on key communication priorities.

Internal communication

The PHA continued to work during the year to develop and progress its internal communications work, strategy and action plan which will ensure all PHA business is supported by efficient and effective internal communication systems and processes.

As a result of feedback from an internal communications audit, the PHA introduced a new weekly internal newsletter 'inPHA' in June 2016 which helps to ensure all staff are kept up to date about important organisational news and developments as well as having a lighter, non-corporate side which includes staff news and achievements.

Another new medium for communication internally was introduced in June 2016 in the form of a digital screen located on the 4th floor in Linenhall Street. The screen has a specially designed template which displays PHA-produced campaign videos, internal corporate videos, the PHA's live Twitter feed which incorporates graphics and video and a local RSS news feed.

Connect, the PHA's intranet site, continued to be one of the primary internal communications channels with repositories of important organisational information and regular updates provided to staff as well as carrying daily features on staff-related activities and achievements.

Health Intelligence

The PHA's Health intelligence service brings together the latest data, information and evidence to underpin decision making, priorities and programmes. The health intelligence professionals bring understanding of the available epidemiological and demographic data, best practice and clinical guidance and work closely with a wide range of disciplines within and outside the PHA. Much of what the PHA do in these areas is in a supportive role and rarely published under the PHA name.

During 2016/17, the health intelligence function contributed to a range of reports, workshops and presentations on topics as diverse as cancer; dementia; breastfeeding; obesity; smoking; sexual health; and, mental health and has supported the PHA's extensive programme of public information campaigns.

Comprehensive briefs were produced on births; breastfeeding; homelessness; and, suicide as well as the yearly tobacco report.

Specific evaluations of effectiveness and outcomes were completed on major health improvement programmes including *Food in Schools*, the suicide prevention helpline and the sudden death protocols.

New evaluations began on regional initiatives such as One Stop Shops; Therapeutic Horticulture; New Entrants services; the Choose to Lose weight management programme; and, the Strengthening Families programme. Development began on the system to support physical activity referrals in partnership with the councils to promote exercise at a local level.

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.

The supporting tables around public health, 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 Child Health System (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 via the PHA website and made available to partner agencies.

The PHA 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 and corporate plan.

Following the publication of the *Making Life Better* strategy, the PHA worked with the Northern Ireland Statistics and Research Agency (NISRA), Department of Health (DoH), 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 is practical across the breadth of the determinants of health, for example, 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 level and then District Council level. In addition, support has been provided to more detailed discussions with individual councils around outcome and performance measures for community planning.

Operational Services

The PHA is committed to having robust governance arrangements in place as a firm foundation for taking forward business. During 2016/17, the PHA continued to review and update
corporate and information governance arrangements so that they remain relevant and appropriate, as well as providing advice and support to staff across the organisation to assist in their practical application.

This included maintaining the policy register, ensuring that policies are reviewed and updated on a timely basis, carrying out the annual review and revision of the standing orders, 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.

As well as keeping the PHA Business Continuity Plan under regular review to ensure that it remains up to date and accurate, the PHA also focused on ensuring that staff are aware of the existence of the plan, and that they know what to do should an

incident occur. 'Agency Business Continuity – As easy as ABC' was the message during Business Continuity Awareness week, reminding staff of the key facts about PHA Business Continuity, and how they can find out information should an incident occur when they are not in the office.

Significant work was carried out during 2016/17 to ensure that PHA facilities continue to provide a safe and healthy work environment for staff and that they are compliant with the Northern Ireland Asset Management Strategy.

With the expiration of a commercial lease for a small suite of offices in Omagh town centre, a new home was found in April 2016 for staff on the nearby Tyrone and Fermanagh Hospital site.

In Belfast, the commercial leases for both Ormeau Baths and Alexander House came to an end in February 2017. Following discussions with the DoH and the Department of Finance (DoF), a business case for alternative accommodation was developed, identifying a vacant public sector lease in Linum Chambers, Bedford Street, as the most suitable new accommodation.

Operations staff worked closely with DoF Properties Division to refurbish the accommodation at Linum Chambers and to relocate approximately 60 staff to the fresh and modern working environment.

The moves in both Omagh and Belfast have enabled the PHA to reduce the number of commercial leases and maximise the use of existing facilities in line with DoH and DoF asset management requirements. Additionally, this has also enabled these staff to be connected to the same Voice Over Internet Protocol (VOIP) telephony system as other PHA, HSCB and Business Services Organisation (BSO) staff, enabling improved and more efficient telecommunications internally and externally.

Planning and Performance

During 2016/17, the PHA continued to progress implementation of its Procurement Plan for the provision of health and wellbeing services. The PHA also continued to work closely with colleagues in the BSO Procurement and Logistics Service (PaLS) and Directorate of Legal Services (DLS) and other HSC organisations, to further develop and embed social care procurement.

2016/17 also saw the development of the new PHA *Corporate Plan 2017–2021* at the request of the Department of Health. The plan has been informed by engagement with both staff and external stakeholders and is in line with the Northern Ireland Executive's draft *Programme for Government Framework 2016–2021* and *Making Life Better: a whole system strategic framework for public health 2013–2023* (DoH) as well as taking account of local Government-led community planning.

Following a 12-week consultation period, which included several stakeholder engagement workshops and the use of social media, the plan has been reviewed and revised to take account of responses received.

While the *Corporate Plan 2017–2021* recognises the current uncertainties in respect of both organisational structures and budgets, it still sets out the strategic direction for the next four years, identifying the key outcomes and high-level actions that will help to tackle health inequalities, improve health and wellbeing and promote the shift towards prevention and early intervention. We also recognise that these outcomes can only be achieved through continuing to work with a range of partners across all sectors.

With the draft *Programme for Government* emphasising the centrality of Outcomes Based Accountability (OBA), and our extensive work with local councils in developing community plans, the PHA has put in place training for Board members, and senior staff in OBA. We will build on this during 2017/18 and embed it as a core aspect of our work.

Information requests

Freedom of Information (FOI) Requests

FOI requests received from 1 April 2016 to 31 March 2017 = 53

There were no Open Data Requests received from 1 April 2016 to 31 March 2017.

Assembly Questions

The PHA received and responded to 133 written Assembly Questions and 6 oral Assembly Questions during 2016/17.

Personal data-related incidents

No major personal data protection incidents occurred during 2016/17. One incident was notified to the Information Commissioner in line with the agreed process and PHA received confirmation that this did not constitute a data breach.

Financial Performance Report

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

Financial Planning

The PHA prepared a Financial Plan for 2016/17, taking into account the significant budgetary constraints and varied and mounting pressures on services. This Plan was formally approved by the PHA Board in June 2016.

Looking forward into 2017/18, the current financial context significantly limits the additional resources available for health and social care. There continues to be a risk that this will impact on the quality and safety of services which the PHA, along with the sector, continues to try to mitigate. In addition, the political uncertainties and the resultant impact on budgetary, uncertainty adds more pressure to the HSC sector.

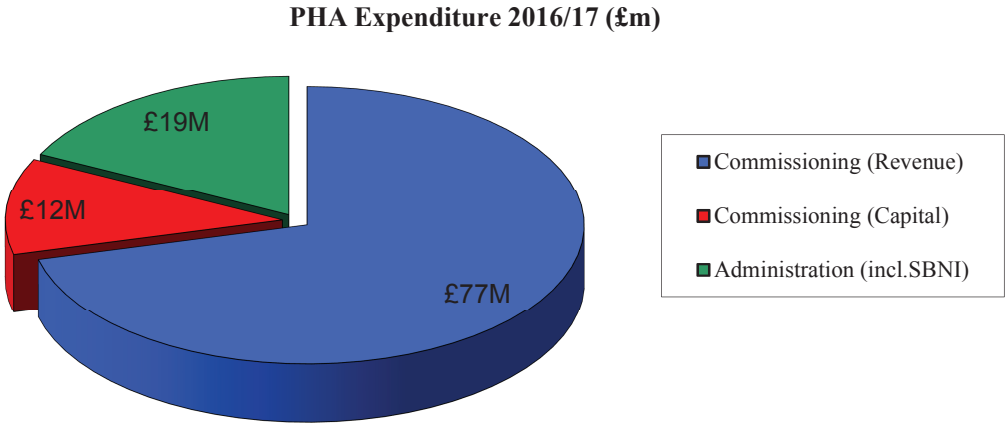
PHA Financial Management and Stability

The PHA received a budget of £13m capital and £109m revenue from the DoH, along with income from other sources of £2m in 2016/17, of which the PHA has a statutory duty to breakeven within +/-0.25% of these resources.

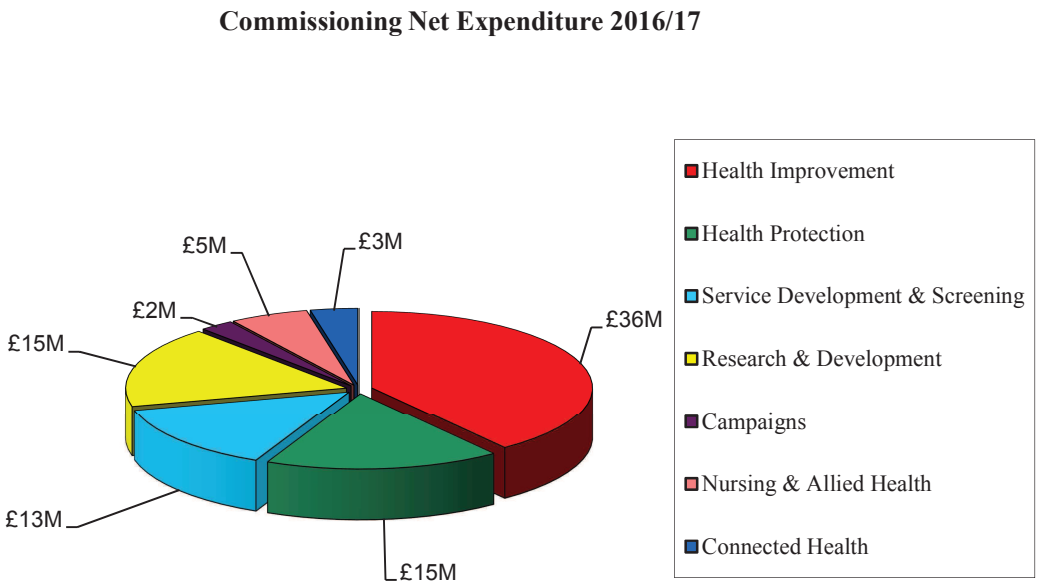
The financial statements presented in this Annual Report and Accounts highlight a small surplus of £75k and this was achieved by significant and diligent effort on the part of PHA Budget holders, supported by the Finance Directorate (HSCB), managing the wide range of pressures and demands across both programme and Management and Administration budgets.

The following charts highlight how the PHA's revenue funds have been utilised during 2016/17.

a. PHA Net Expenditure by area 2016/17



b. Programme Expenditure by Budget Area 2016/17



During the 2016/17 financial year, the PHA continued with the difficult task of managing to successfully deliver its many and complex functions with a significantly reduced budget (reduction of £3.4m since 2015/16). Delivery of these savings, has created a significant and ongoing challenge for the PHA to ensure that core functions continue to be delivered to the standard that its stakeholders would expect.

At the end of 2016/17 PHA has been successful in delivering a wide range of efficiencies to deliver the £2.8m savings.

Prompt Payment Policy

The DoH requires that the PHA pay their non- HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The PHA's payment policy is consistent with these principles and its measure of compliance can be found within Note 14 of the Annual Accounts within this combined document.

The Centre for Connected Health and Social Care

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

The CCHSC continued during the year to contribute to improving health and wellbeing through a number of partnership activities including:

- working with the HSCB on the implementation of the eHealth and Care Strategy for Health and Social Care, ensuring that the strategic aims of the PHA are fully reflected;
- evaluation of the Remote Telemonitoring service carried out by Queen's University Belfast was completed and the report published. The quantitative part of the study does not show any significant impact on the health outcomes of patients who have been monitored however the qualitative study shows support for the telemonitoring service was overwhelmingly positive, particularly from patients and their carers, with reassurance being a particular theme;
- coordinating Northern Ireland's contribution to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) which aims to improve the health of older people in Northern Ireland and across Europe;
- coordination of the EU-funded project called 'Beyond Silos' continued and the project brought to a successful conclusion. In Northern Ireland we contributed to 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, the HSCB, the PHA, universities and industry to pursue European Union (EU) funding opportunities such as Horizon 2020, the EU 3rd Health Programme, Interreg V and other EU funding streams:
- the SUNFRAIL project, funded through the EU 3rd Health Programme, seeks to "Improve the identification, prevention and management of frailty and care of multimorbidity (multiple long-term conditions) in community dwelling persons (over 65)";
- funded through Horizon 2020, the MAGIC project, which started on 1 January 2016, focuses on improving care and outcomes for stroke survivors with an ongoing need for patient information; and
- working in conjunction with the Health Service Executive (RoI) and NHS Scotland to ensure that eHealth initiatives funded through EU Cross-Border Funding Programme (INTERREG VA) were progressed.

Remote telemonitoring within an oncology setting

In the Belfast HSC Trust, dietitians have used remote telemonitoring successfully for head and neck cancer and upper gastro-intestinal (UGI) cancer patients.

Patients with head and neck cancer were routinely monitored regionally for six weeks post-treatment at outpatient clinics, by telephone calls and by home visits from the dietitian.

Remote telemonitoring was introduced to optimise dietitians' time, to reduce travel costs and to enhance patient experience and satisfaction. UGI cancer patients were being reviewed post-surgery by a dietitian at two, four and six week intervals (in addition to consultant reviews at two weeks). Patient surveys indicated that there was too much repetition.

Remote telemonitoring was introduced to reduce repetition of clinic appointments and travel for patients and also to give patients and dietitians reassurance that from a nutritional point of view any post-operative issues would be quickly highlighted.

In both cases remote telemonitoring readings were submitted weekly by patients and reviewed by the dietitians. The results have helped to prioritise workloads, assist in condition monitoring and alerted the medical team to any dramatic weight change.

Patients and staff all feel very positively about the service. It has reduced travel time and costs and allowed dietitians to use their time more effectively by helping with clinical prioritisation.

Sustainability – Environmental, social and community issues

The PHA is committed to protecting the environment and 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.

The PHA 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 use of online-based systems for human resources, procurement, and invoice processing, moving away from paper-based systems; centralised printing devices for the production of printed material (which replaced printing equipment at each workstation); waste paper recycling and video and teleconferencing facilities to reduce travelling.

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 commitments under the plan is included below.

Disabled employees

If a member of staff has become disabled during the period when they are employed by 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.

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.

Gender identity and expression – Employment policy

Taking into account what individuals and groups from the gender identity sector fed back during engagement with these groups last year, we finalised a first draft of an employment policy relating to gender identity and expression.

In January 2017, the PHA launched a 12-week public consultation on the draft Policy and its equality screening, together with our partners across the whole of Health and Social Care (HSC).

Disability Work Placement

For the second year running, the PHA participated in the Disability Work Placement scheme which is facilitated by the Equality Unit and the Health and Social Care Board jointly for the 11 regional HSC organisations.

One person has been with the PHA since December 2016 and is due to complete their 26-week placement in May 2017.

Tapestry – Disability Staff Network

After its initial launch last year, Tapestry, the Disability Staff Network, undertook a broad range of activity during 2016/17.

During the year the network, which meets quarterly, developed its first action plan and a range of actions under three broad themes:

- Raising awareness of the network;
- Raising awareness of disabilities; and
- Becoming an employer of choice which included, for example, a series of coffee mornings to engage with staff across four PHA office locations in November 2016; a staff awareness day on cancer held in January 2017; a 'lunch and learn' session for line managers on reasonable adjustments; and a staff survey on what makes an employer an employer of choice for people with a disability or those who care for someone with a disability.

Ethnicity

Jointly with our 11 regional HSC partners, the PHA held a cultural awareness training session for staff. The training was delivered by the South Belfast Roundtable and covered topics such as migration awareness; an introduction to asylum and refugee issues in the UK and Northern Ireland in particular and cultural awareness.

Looking Forward – The Continuing Work of the PHA

Looking to the future, and in planning work for 2017/18 and beyond, the PHA must take account of the strategic, regulatory and legislative environment in which they operate and the various strategies, issues and statutory requirements which shape and influence our work.

The following list of influencing factors is by no means exhaustive but gives a broad representation of the wider environment within which we work:

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

One of the main changing factors to the environment within which the PHA have been working and will continue to work is regarding reform of the HSC.

Subsequent to former Minister Simon Hamilton's announcement on 4 November 2015 of his intention to remodel the administrative structures of the Health and Social Care system, October 2016 saw the launch of Minister Michelle O'Neill's 10-year vision through the document *Health and Wellbeing 2026 – Delivering together* and her proposals for transformation. Work has been ongoing to develop the new HSC structures in line with the Minister's vision and both the PHA and HSCB have been working very closely with the Department of Health, Trusts and other system leaders

Another key priority for 2017/18 is the implementation of *Making Life Better*.

The PHA has a lead role in its implementation and will seek to take forward its recommendations through specific actions and working closely with DoH and other key partners.

Further developments to the *Making Life Better* programme of action will also be taken forward, internally and regionally, to align our goals with other strategies and policies goals and to strengthen collaboration and coordination for the improved health and wellbeing of our communities.

The PHA will also continue contributions to the important work of local councils, including the community planning processes and will continue to work closely as plans are finalised and action plans are developed.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

A very considerable amount of work and time has been invested over the past year in the development of the PHA *Corporate Plan 2017–2021,* including wide stakeholder engagement and a comprehensive public consultation process.

The Corporate Plan sets out the strategic direction for the PHA for the next four years taking account of Department of Health (DoH) priorities, especially the *Making Life Better* public health framework, the Draft Programme for Government Framework 2016–21, and local government-led community planning, within the context of financial constraints and HSC reform and restructuring.

Five key outcomes have been identified as the priority for the next four years:

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

The final version of the *Corporate Plan 2017-2021*, taking account of stakeholder engagement and consultation responses, will be published early in 2017/18, along with the *Annual business plan 2017/18* which will set out the actions for the first year.

The PHA, like all other HSC organisations and the wider public sector, have faced financial challenges in light of the constrained Northern Ireland budget and the coming period will see further financial challenges.

During 2016/17 the PHA felt the impact of staff reductions through the outworking of the Voluntary Exit Scheme and working with a reduced workforce will be felt as we move forward.

Valerie Watts
Chief Executive (Interim)

Date 13 June 2017

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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 30 years, he has been a Non-Executive Director of organisations spanning the private, public and voluntary sectors.

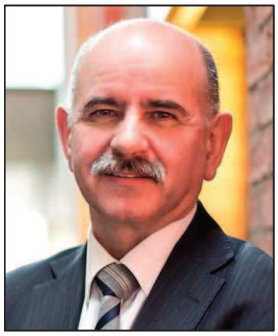
He is a former Trustee and Chair of the HR Committee of the UK Health Forum, a former Trustee and Treasurer of the World Heart Federation and a former Chair of the Chartered Institute of Personnel and Development in Northern Ireland.

Valerie Watts

Valerie Watts took up post as interim Chief Executive of the PHA on 17 October 2016. She was appointed Chief Executive of the Health and Social Care Board in July 2014 and has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital where she oversaw competitive tendering for ancillary support services. Valerie has worked in local government since 1989.

Most recently, she was Chief Executive of Aberdeen City Council (2011–2014) and former Town Clerk and Chief Executive of Derry City Council (2009–2011) where she was instrumental in securing the UK City of Culture for 2013 and developing a strategic economic master plan for the North West.

Dr Eddie Rooney



Dr Eddie Rooney was Chief Executive of the PHA since its inception in 2009 until his retirement on 14 October 2016.

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.

Edmond McClean

Edmond McClean was appointed Deputy Chief Executive (interim) of the PHA at the end of October 2016 and has continued as the PHA's Director of Operations heading 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.

Councillor Billy Ashe

Billy Ashe is currently a Councillor for Mid and East Antrim Borough Council, of which he is a former mayor. He was also previously mayor of Carrickfergus and Coordinator of a Carrickfergus-based community project.

Brian Coulter OBE

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 39 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.

Julie Erskine

Julie, a former acting chair of the PHA and non-executive board member since the inception of the PHA in 2009, finished her term on 30 November 2016.

Julie is now Chair of the Business Services Organisation.

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 Department of Health.

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 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.

Thomas Mahaffy

Thomas is currently a board member of the Northern Ireland Anti-Poverty Network, the Northern Ireland Human Rights Consortium, the Participation and Practice of Rights Project and convenes the Rights in Community Care Group.

He is employed by the trade union UNISON as Head of Organising and Development with responsibilities including union employer partnerships, equality, human rights and tackling health inequalities.

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 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 virtual reality, neon and light installations, painting, drawing and photography.

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.

She was appointed to her post when the HSCB was established in April 2009 and previously trained and practiced as a social worker.

Subsequently she led the management and development of many aspects of social care in Northern Ireland. She is also a Board Member of Children in Northern Ireland (CiNI) and Northern Ireland Trustee for the Social Care Institute for Excellence (SCIE).

Related party transactions

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

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 Deputy Chief Executive (Interim) / Director of Operations, and on the PHA website at www.publichealth.hscni.net/lists-and-registers

Audit Services

The PHA's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2017 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 she is aware of has been passed to the external auditors.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health 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 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; and
- 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 as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Ms Valerie Watts of the Public Health Agency as the Interim 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.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

As 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 the finance function) and in taking forward the health and wellbeing agenda.

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

2. Compliance with Corporate Governance Best Practice

The Board of the PHA applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of the PHA does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by internal and external audits and through the operation of the Governance and Audit Committee, with regular reports to the PHA Board.

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

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

3. Governance Framework

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

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

The PHA Board comprises a Non-Executive Chair, seven Non-Executive members, the Chief Executive and three Executive Directors. One Non-Executive Member stepped down in December 2016 and this vacancy has not yet been filled. As a result there have only been six Non-Executive members between December 2016 and March 2017.

The PHA Board meets regularly, usually monthly, with the exception of July. The Board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are in place to appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. During 2016/17 the PHA Board met on nine occasions. All meetings were quorate.

NAME	NUMBER OF ATTENDANCES
A Dougal	8
V Watts	4 (out of 4 meetings since taking up post)
E Rooney	4 (out of 5 meetings prior to leaving post)
E McClean	9
C Harper	7
M Hinds	9
B Ashe	7
B Coulter	7
L Drew	9
J Erskine	7 (out of 7 meetings prior to leaving post)
T Mahaffy	7
D Mann-Kler	8
P Porter	5

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 2016/17 the GAC met on four occasions, and all meetings were quorate.

The Remuneration and Terms of Service Committee advises the PHA Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee normally meets at least once every six months. During 2016/17 the Committee met on two occasions. The meetings were quorate.

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 had a five year Corporate Strategy for 2011–2015 setting out its purpose, vision, values and strategic goals. This Corporate Strategy was extended to cover the 2016/17 year on the advice of DoH, while a new Corporate Plan for the period 2017–2021 was being developed. An Annual Business Plan is prepared taking account of any DoH guidance and priorities, as well as PHA priorities, for the year ahead. The Corporate Strategy/Plan is developed with input from the PHA Board and staff from all Directorates and engagement with wider stakeholders throughout the year. The PHA Annual Business Plan for 2016/17 was approved by the PHA Board on 16 March 2016 and by the DoH on 6 April 2016.

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 or 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 DoH 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 DoH) which incorporates a "5x5" Risk Matrix is used, along with a Risk Analysis Tools Impact Table which gives details 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 level and Corporate level Risk Registers.

To ensure the robustness of the PHA's system of internal control, fully functioning Risk Registers at both Directorate level 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 risks 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 the 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 2016/17, guidance and support was provided to staff who are actively involved in reviewing and co-ordinating the review of the Directorate and Corporate Risk Registers. A system has been established whereby the Senior Operations Manager meets with the planning and project managers supporting each Directorate and Division at the end of each quarter to ensure feedback and consistency in the review of the Risk Registers, and to share and learn from good practice.

All staff are required to complete the PHA risk management e-learning programme on an annual basis. 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), 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 assessed and control measures are identified and reviewed as required. Where appropriate information risks are incorporated in the Corporate or Directorate Risk Registers.

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and IT Security continues to be rolled out to all staff. The SIRO and IAO's attend specialised training. 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 2016/17. The PHA achieved the following levels of compliance for 2016/17:

Standard	DoH 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)	91%	✓
Environmental Cleanliness	75% - 99% (Substantive)	N/A	-
Environment Management	75% - 99% (Substantive)	83%	-
Financial Management *(Core Standard)*	75% - 99% (Substantive)	88%	✓
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 and Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	85%	✓
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)	90%	-
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 2016/17 Internal Audit reviewed the following systems:

System reviewed	Assurance received
Financial Review	Satisfactory
Travel Expenses	Limited
Management of Health and Social Wellbeing Improvement Contracts	Satisfactory (vol orgs – 5 satisfactory; 1 limited)
Risk Management	Satisfactory
Centre for Connected Health	Satisfactory – control over CCH; Limited – corporate oversight and review of outcomes
Learning from Serious Adverse Incidents and from Falls 2016/17	Satisfactory

Internal audit also carried out the year end Controls Assurance verification and 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 the PHA.

Two priority one weaknesses in control were identified in the PHA Management of Health and Social Wellbeing Contracts Audit. One related to an external investigation of a procurement issue in a voluntary organisation the PHA was funding. However, the issue did not relate to any PHA funded project. Of the three recommendations relating to this finding, two have been fully implemented and one partially implemented. The second priority one finding related to the procurement of health and social wellbeing improvement contracts. This has been partially implemented.

Two priority one findings were also identified in one of the voluntary/community organisations visited and audited by Internal Audit, resulting in limited assurances. This relates to the same external investigation noted above and is being addressed by the organisation; progress will be audited by Internal Audit.

Two priority one weaknesses were identified in respect of travel expenses (including use of HRPTS and management of car parking and taxis). All four recommendations, relating to car parking arrangements and travel claims have been fully implemented. Two priority one weaknesses were identified in respect of the Centre for Connected Health and Social Care. Two recommendations relating to the governance and oversight of European funding have been partially implemented. The second weakness related to CCHSC objectives; the implementation date for this recommendation has not yet passed.

One priority one weakness was identified in the financial review audit, relating to spend being incurred before approval of Direct Award Contracts (DAC). While the implementation date for this recommendation has not yet passed, actions are being taken to action this.

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued on 31 March 2017, found that, of the 57 recommendations with an implementation date of 31 March 2017 or earlier, 81% were fully implemented, and 19% were partially implemented. Work will continue during 2017/18 to address the 11 partially implemented recommendations.

RQIA

The RQIA Review of the Diabetic Eye Screening programme was published in May 2015. A modernisation programme was established and action plan developed. Significant progress has been made with actions in place, or on track, to address all the recommendations in the RQIA report.

External Audit

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2016, 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

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

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

While issues remain with performance against the 4 hour and 12 hour ED standards, on the advice of the Health and Social Care Board (HSCB) this is no longer considered as an internal governance divergence. The PHA continues to work with the HSCB to take forward the unscheduled care agenda. The HSCB reports on performance through their normal mechanisms.

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

Business Services Transformation Project/Shared Services

The Business Services Transformation Program (BSTP) introduced new HSC wide computer systems in 2012/13 and implemented Shared Services for Accounts Payable, Receivable, Payroll and Recruitment.

While BSO has made significant progress in the control environment there remains priority 1 audit recommendations for Payroll and Recruitment Shared Services with unacceptable and limited levels of assurance being received from the Internal Auditor in 2016/17. While the issues raised in these audit reports have limited impact on PHA, it is of some concern that progress on issues identified in prior years has not been made. Additionally, during 2016/17 new system stability issues relating to the Human Resources, Payroll and Travel system have been identified which resulted in contingency measures being used to ensure staff were paid and a recalculation of employers' superannuation across the HSC. An action plan has been developed by BSO to attempt to address the control and system stability issues, which will be closely monitored by all HSC organisations throughout 2017/18.

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 2016/17 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.

The outlook for 2017/18 is increasingly constrained, particularly in respect of resource funding. In a statement to the House of Commons on 24 April 2017 the Secretary of State for Northern Ireland outlined an indicative Budget position for NI departments. This position was based on the advice of the Head of the NI Civil

Service (NICS) in conjunction with the NICS Board. The purpose of this statement was to provide clarity to departments as to the basis for departmental allocations in the absence of an Executive, so that Permanent Secretaries can plan and prepare to take more detailed decisions in that light. The departmental allocations set out by the Secretary of State provide the basis on which departments are now planning for 2017/18. However, the Secretary of State was clear that the indicative budget position did not constrain the ability of an incoming Executive to adjust its priorities during the year. He also advised that some £42 million Resource DEL and £7 million Capital DEL was left unallocated in order to maintain flexibility for a new Executive to allocate resources to meet further priorities as they deem appropriate. Therefore, while there is the potential for an incoming Executive to adjust these plans and also to allocate the unallocated resources, individual departments cannot anticipate any additional funding at this stage until such decisions are made.

Across the HSC sector it is expected that the significant financial challenges faced will intensify and extensive budget planning work to support the 2017/18 financial plan is ongoing between the PHA and Department of Health (DoH). However, as with other financial years the PHA remains committed to achieving financial break-even.

Management of Contracts with the Community and Voluntary Sector

The 2016/17 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 remains in respect of the procurement of services. Limited progress has been made in progressing the Procurement Plan during 2016/17 due to a number of factors including staff capacity and waiting for the new DoH Protect Life Strategy to enable mental health tenders to be progressed. The PHA has however awarded a further eight contracts during 2016/17 with a value of circa £430k and preparatory work on a number of other tenders is being progressed.

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 still a new area for the wider HSC, and the PHA continues to work closely with colleagues in HSCB, BSO, the HSC Trusts and the DoH, 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 DoH funding gap. In order to meet this significant budget reduction, during 2016/17, 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).

As the end dates of staff leaving under VES were phased in with effect from January 2016 through to June 2016, the full impact of these reductions only became clear during the year. The loss of the knowledge and experience of the staff and of the posts has impacted on how the PHA undertakes its business, not least of all in the area of social care procurement. The PHA has undertaken measures to ensure that core and essential work is maintained, including some internal restructuring, and prioritisation of work. The PHA has continued to liaise with DoH.

This was further exacerbated by a further reduction of 10% of the management and administration budget (£1.6m) for 2016/17. Additionally, while the budget for 2017/18 has not been received yet, there is potential for a further reduction in the management and administration budget. The Interim Chief Executive has written to the DoH advising of the very significant negative impact on PHA core functions should there be a further budget reduction in 2017/18. The PHA will continue to work closely with the DoH in this regard.

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

There are no new issues to report.

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 2016/17.

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 (DoH), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, where permitted by DoH, agreeing the discretionary level of performance related pay.

A Circular on the 2016/17 Senior Executive pay award had not been received from the DoH by 31 March 2017, therefore related payments have not been made to Executive Directors.

The 2015/16 Senior Executive's pay award was set out in DoH circular HSC(SE) 1/2016 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 2016/17. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

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

Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2016/17.

Membership of the Remuneration and Terms of Service Committee:

A Dougal (OBE) - Chair
Cllr W Ashe – Non-Executive Director
Ald P Porter – Non-Executive Director (from 01/11/16)
J Erskine – Non-Executive Director (left 30/11/16)

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

Senior Employee's Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA were as follows, it should be noted that there were no bonuses paid to any Director during 2016/17 or 2015/16.

Non Executive Members (Table Audited)

	2016/17				2015/16			
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 Dougal (commenced 01/06/15)	30-35	0	-	30-35	25-30	0	-	25-30
J Erskine (left 30/11/16)	5-10	0	-	5-10	10-15	0	-	10-15
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	5-10	0	-	5-10
D Mann-Kler (commenced 01/03/16)	5-10	0	-	5-10	0-5	0	-	0-5
J Harbison (left 28/04/15)	0	0	-	0	0-5	0	-	0-5
J Leslie (20/04/15 to 18/09/15)	0	0	-	0	0-5	0	-	0-5
M Karp (left 07/04/15)	0	0	-	0	0-5	0	-	0-5

Executive Members (Table Audited)

	2016/17				2015/16			
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 (Retired 14/10/16) (1)	60-65	200	11,000	75-80	115-120	200	22,000	140-145
Director of Public Health Medicine C Harper	145-150	0	21,000	165-170	145-150	0	14,000	155-160
Director of Operations & Deputy Chief Executive* E McClean (*since 01/11/16) (2)	80-85	400	39,000	120-125	80-85	300	14,000	90-95
Director of Nursing M Hinds	100-105	0	13,000	115-120	100-105	0	14,000	115-120

Notes

1) Valerie Watts was appointed as Interim Chief Executive from 17/10/16 and has dual responsibility for the PHA and the Health and Social Care Board. All remuneration has been reported under the post holder's substantive post in the HSCB.

2) The post holder was appointed as the Deputy Chief Executive from 01/11/16.

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 2015/16.

	2017	2016
Highest Earner's Total Remuneration (band in £000)	145-150	145-150
Median Salary (£)	34,875	36,666
Median Total Remuneration Ratio	**4.2**	**4.0**

Pensions of Senior Management (Table Audited)

	2016/17				
Name	**Total accrued pension at age 60 and related lump sum £000**	**Real increase in pension and related lump sum at age 60 £000**	**CETV at 31/03/17 £000**	**CETV at 31/03/16 £000**	**Real increase in CETV £000**
Chief Executive E P Rooney (Retired 14/10/16) (4)	10-15 pension	0-2.5 pension	-	213	-
Director of Public Health Medicine C Harper (3a)	40-45 pension 120-125 lump sum	0-2.5 pension 5-7.5 lump sum	795	738	34
Director of Operations & Deputy Chief Executive E McClean (since 01/11/16) (2) & (5)	25-30 pension 80-85 lump sum	0-2.5 pension 5-7.5 lump sum	-	565	-
Director of Nursing M Hinds (3b)	20-25 pension 60-65 lump sum	0-2.5 pension 2.5-5 lump sum	439	401	26

Notes (also see above for notes 1 and 2)

(3) CETV at 31/03/16 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:

(a) 716 to 738
(b) 391 to 401

(4) As CETV is an end of year calculation and post holder retired on 14/10/16, figures are not applicable.

(5) CETV calculation not applicable at 31/03/17 for this post holder.

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 and chooses to transfer their benefits accrued in their former scheme.

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

The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefits accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It 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

Staff Costs

PHA staff costs comprise:

	2017			2016
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	12,445	502	12,947	14,423
Social security costs	1,369	55	1,424	1,309
Other pension costs	1,821	73	1,894	2,098
Total staff costs reported in Statement of Comprehensive Net Expenditure	**15,635**	**630**	**16,265**	**17,830**
Less recoveries in respect of outward secondments			(342)	(452)
Total net costs			**15,923**	**17,378**

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 DoH. 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:

	2017			2016
	Permanently employed staff	Others	Total	Total
Commissioning of Health and Social Care	288	11	**299**	**322**
Less average staff number in respect of outward secondments	(4)	0	**(4)**	**(5)**
Total net average number of persons employed	**284**	**11**	**295**	**317**

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	
	2017	2016	2017	2016	2017	2015
<£10,000	0	0	0	2	**0**	**2**
£10,000-£25,000	0	0	0	5	**0**	**5**
£25,000-£50,000	0	0	0	13	**0**	**13**
£50,001-£100,000	0	0	1	13	**1**	**13**
£100,001-£150,000	0	0	0	4	**0**	**4**
Total number of exit packages by type	**0**	**0**	**1**	**37**	**1**	**37**
Total resource cost £000s	**£0**	**£0**	**£61**	**£1,979**	**£61**	**£1,979**

Redundancy and other departure costs have been paid in accordance with the provisions of the 2016/17 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 2016/17 or 2015/16.

Retirements due to ill-health

During 2016/17 there was 1 early retirement from the PHA, agreed on the grounds of ill-health. These costs are borne by HSC pension scheme and not included in PHA Accounts.

Staff Composition

The staff composition, broken down by male/female and whole time equivalent as at 31 March 2017, was as follows:

Gender	Headcount	Whole Time Equivalent
Female	240	224.7
Male	60	59.5
Grand Total	**300**	**284.2**

**Comparative figures from 2015/16 Headcount 323, WTE 304.4.*

Staff Gender Breakdown within PHA 2016–17 Senior Management (excl. Board Members)*		
	Headcount	**WTE**
Female	30	27.8
Male	15	14.5
Grand Total	**45**	**42.3**

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

***The interim Chief Executive is included in the figures within the 2 tables above.*

****Comparative figures from 2015/16 Headcount 50, WTE 46.3*

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2016 – 31 March 2017 is 2.8%. (2015/2016 4.35%)

There were 15,291 hours lost due to sickness absence or, the equivalent of 51 hours lost per employee. Based on a 7.5 hour working day, this is equal to 6.8 days per employee.

This is 4.1 days lower than the national average of 10.1 days per employee for the Health Sector (*CIPD Absence Management Report 2016*).

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 (BSO HR Shared Services) 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 had no expenditure on External Consultancy during 2016/17 (2015/16 £14k).

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 2016/17 or 2015/16.

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 2016/17 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments

Type of loss and special payment	2016/17		2015/16
	Number of Cases	£	£
Losses arising from overpayments			
Pay, allowances and superannuation benefits	1	480	0
TOTAL	**1**	**480**	**0**

Special Payments

There were no other special payments or gifts made during the year (2015/16 – none).

Other Payments and Estimates

There were no other payments made during the year (2015/16- none).

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 2017, the PHA is not aware of any remote contingent liabilities, and there were none in 2015/16.

Valerie Watts
Chief Executive (Interim)

Date 13 June 2017

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 2017 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise the Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows 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 2017 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 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 and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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 guidance.

Report

I have no observations to make on these financial statements.

KJ Donnelly

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

15 June 2017

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2017

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

FOREWORD

These accounts for the year ended 31 March 2017 have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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 91 to 123) 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 DoH.

Paul Cummings

Director of Finance

Date 13 June 2017

I certify that the annual accounts set out in the financial statements and notes to the accounts (page 91 to 123) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Andrew Dougal

Chairman

Date 13 June 2017

Valerie Watts

Chief Executive (Interim)

Date 13 June 2017

PUBLIC HEALTH AGENCY

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2017

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.

	NOTE	2017 £000	2016 £000
Income			
Income from activities	4.1	980	707
Other income (excluding interest)	4.2	679	662
Deferred income	4.3	0	7
Total operating income		1,659	1,376
Expenditure			
Staff costs		(16,265)	(17,830)
Purchase of goods and services	3	(50,800)	(47,548)
Depreciation, amortisation and impairment charges	3	(161)	(148)
Provision expense	3	(370)	5
Other expenditures	3	(3,060)	(4,441)
Total operating expenditure		(70,656)	(69,962)
Net Expenditure		**(68,997)**	**(68,586)**
Finance income	4.2	0	0
Finance expense	3	0	0
Net expenditure for the year		(68,997)	(68,586)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(13,769)	(12,844)
South Eastern Health & Social Care Trust		(4,427)	(3,861)
Southern Health & Social Care Trust		(6,324)	(5,848)
Northern Health & Social Care Trust		(8,281)	(7,906)
Western Health & Social Care Trust		(6,779)	(6,282)
NIAS Health & Social Care Trust		0	(5)
NI Medical & Dental Training Agency		(132)	(107)
Total RRL issued		(39,712)	(36,853)
Total Commissioner resources utilised		(108,709)	(105,439)
Revenue Resource Limit (RRL) received from DoH	24.1	108,784	105,617
Surplus / (Deficit) against RRL		**75**	**178**

OTHER COMPREHENSIVE EXPENDITURE	2017 £000	2016 £000
Items that will not/may be reclassified to net operating costs	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2017	**(68,997)**	**(68,586)**

The notes on pages 95 to 123 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of FINANCIAL POSITION as at 31 March 2017

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

	NOTE	2017 £000	£000	2016 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	540		352	
Intangible assets	6.1/6.2	178		157	
Total Non Current Assets			718		509
Current Assets					
Inventories	10	0		0	
Trade and other receivables	12	493		579	
Other current assets	12	15		27	
Cash and cash equivalents	11	419		310	
Total Current Assets			927		916
Total Assets			**1,645**		**1,425**
Current Liabilities					
Trade and other payables	13	(6,987)		(7,773)	
Provisions	15	(375)		(5)	
Total Current Liabilities			(7,362)		(7,778)
Total assets less current liabilities			**(5,717)**		**(6,353)**
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			**(5,717)**		**(6,353)**
Taxpayers' Equity and other reserves					
Revaluation reserve		36		36	
SoCNE reserve		(5,753)		(6,389)	
Total equity			**(5,717)**		**(6,353)**

The financial statements on pages 91 to 123 were approved by the Board on 13 June 2017 and were signed on its behalf by:

Signed  (Chairman) Date 13 June 2017

Signed  (Chief Executive - Interim) Date 13 June 2017

PUBLIC HEALTH AGENCY

STATEMENT of CASH FLOWS for the year ended 31 March 2017

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	2017 £000	2016 £000
Cash flows from operating activities			
Net surplus after interest/Net operating cost	SoCNE	(68,997)	(68,586)
Adjustments for non cash costs	3	549	161
(Increase)/decrease in trade and other receivables	12	98	356
Increase/(decrease) in trade payables	13	(786)	759
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	1	(87)
Movements in payables relating to the purchase of intangibles	13	0	(23)
Net cash outflow from operating activities		(69,135)	(67,420)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(309)	(5)
(Purchase of intangible assets)	6	(64)	(26)
Net cash outflow from investing activities		(373)	(31)
Cash flows from financing activities			
Grant in aid		69,617	67,485
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements			
Net financing		69,617	67,485
Net increase (decrease) in cash & cash equivalents in the period		109	34
Cash & cash equivalents at the beginning of the period	11	310	276
Cash & cash equivalents at the end of the period	11	**419**	**310**

The notes on pages 95 to 123 form part of these accounts.

PUBLIC HEALTH AGENCY

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2017

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

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2015		**(5,304)**	**36**	**(5,268)**
Changes in Taxpayers' Equity 2015/16				
Grant from DoH		67,485	0	67,485
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(68,586)	0	(68,586)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2016		**(6,389)**	**36**	**(6,353)**
Changes in Taxpayers' Equity 2016/17				
Grant from DoH		69,617	0	69,617
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(68,997)	0	(68,997)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	16	0	16
Balance at 31 March 2017		**(5,753)**	**36**	**(5,717)**

The notes on pages 95 to 123 form part of these accounts.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

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

The accounting policies follow International Financial Reporting Standards (IFRS) 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 Buildings, Plant & Machinery, Information Technology, and Furniture & Fittings.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;

- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

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

Valuation of Land and Buildings

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

Assets under Construction (AUC)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use.

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
Leasehold property	Remaining period of lease
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 2016/17 or 2015/16.

1.9 Inventories

The PHA had no inventories as at 31 March 2017 or 31 March 2016.

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 DoH is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The PHA did not hold any investments in either 2016/17 or 2015/16.

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 2016/17 or 2015/16.

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 2016/17 or 2015/16.

1.15 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2016/17 or 2015/16.

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 relationship with the DoH, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the PHA is not exposed to the degree of financial risk faced by business entities.

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

- Currency risk

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

- Interest rate risk

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

- Credit and liquidity risk

Since the PHA receives the majority of its funding from the Department of Health, 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 DoF's discount rates of -2.70% (1-5 years), -1.95% (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 2017 or 31 March 2016.

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 2017. 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 the benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the DoH.

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 2016/17 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 2016/17 or 2015/16.

1.23 Government Grants

The PHA had no government grants in 2016/17 or 2015/16.

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 2017. Due to changes in the template, there have been amendments to the layout and display of some figures.

1.27 Impact of implementation of ESA2010 on research and development expenditure

Following the introduction of the 2010 European System of Accounts (ESA10), there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure. In order to reflect this new treatment which was implemented from 2016/17, additional disclosures have been included in the notes to the accounts.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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:

		2017	2016
Summary	**NOTE**	**£000**	**£000**
Commissioning	2.1	87,078	81,213
FHS	2.2	2,378	2,392
Agency Administration	2.3	18,584	21,044
Safeguarding Board NI	2.4	669	790
Total Commissioner Resources utilised		**108,709**	**105,439**

2.1 Commissioning

		2017	2016
Expenditure	**NOTE**	**£000**	**£000**
Belfast Health & Social Care Trust	SoCNE	13,769	12,844
South Eastern Health & Social Care Trust	SoCNE	4,427	3,861
Southern Health & Social Care Trust	SoCNE	6,324	5,848
Northern Health & Social Care Trust	SoCNE	8,281	7,906
Western Health & Social Care Trust	SoCNE	6,779	6,282
NIAS Health & Social Care Trust	SoCNE	0	5
NI Medical & Dental Training Agency	SoCNE	132	107
Other	3.1/3.2	48,346	45,074
		88,058	81,927
Income			
Income from activities	4.1	980	714
Commissioning Net Expenditure		**87,078**	**81,213**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

FHS Net Expenditure	3.1	**2,378**	**2,392**

2.3 Agency Administration

		2017	2016
Expenditure	**NOTE**	**£000**	**£000**
Salaries and wages		15,861	17,350
Operating expenditure	3.2	2,853	4,195
Non-cash costs	3.3	386	13
Depreciation	3.3	163	148
		19,263	21,706
Income			
Staff secondment recoveries	4.2	342	452
Operating income	4.2	337	210
		679	662
Administration Net Expenditure		**18,584**	**21,044**

2.4 Safeguarding Board NI

Expenditure			
Salaries and wages		404	480
Operating expenditure	3.2	265	310
		669	790
Safeguarding Board NI Net Expenditure		**669**	**790**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 3 - OPERATING EXPENSES

3.1 Commissioning:	**2017**	**2016**
	£000	**£000**
General Medical Services	2,378	2,392
Other providers of healthcare and personal social services	38,587	36,143
Capital grants to voluntary organisations	0	0
Research & development capital grants	9,759	8,931
Miscellaneous	0	0
Total Commissioning	**50,723**	**47,466**

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	12,947	14,423
Social security costs	1,424	1,309
Other pension costs	1,894	2,098
Supplies and services - general	75	82
Establishment	1,662	3,611
Transport	8	10
Premises	1,162	672
Rentals under operating leases	212	130
Total Operating Expenses	**19,384**	**22,335**

3.3 Non cash items:		
Depreciation	119	115
Amortisation	42	33
Loss on disposal of property, plant & equipment (including land)	1	2
Provisions provided for in year	370	(5)
Auditors remuneration	16	16
Total non cash items	**549**	**161**
Total	**70,656**	**69,962**

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

Reclassification of R&D as commissioning expenditure (previously operating expenses) has changed the expenditure analysis above from the prior year.

During the year the PHA paid its share of regional audit services (£1,261) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and this amount is included in operating costs above.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 4 - INCOME

4.1 Income from Activities	2017	2016
	£000	£000
R&D	980	707
Total	**980**	**707**

4.2 Other Operating Income	2017	2016
	£000	£000
Other income from non-patient services	337	210
Seconded staff	342	452
Total	**679**	**662**

4.3 Deferred income	2017	2016
	£000	£000
Research & development income released	0	0
Income released from conditional grants	0	7
Total	**0**	**7**

TOTAL INCOME	**1,659**	**1,376**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 5.1 - Property, plant & equipment - year ended 31 March 2017

	Buildings (excluding dwellings) £000	Assets under Construction £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2016	0	0	10	706	72	788
Additions	30	182	0	96	0	308
Transfers	152	(182)	0	0	30	0
Disposals	0	0	0	(111)	0	(111)
At 31 March 2017	**182**	**0**	**10**	**691**	**102**	**985**
Depreciation						
At 1 April 2016	0	0	0	415	21	436
Disposals	0	0	0	(110)	0	(110)
Provided during the year	3	0	1	108	8	119
At 31 March 2017	**3**	**0**	**1**	**413**	**29**	**445**
Carrying Amount						
At 31 March 2017	**179**	**0**	**9**	**278**	**73**	**540**
At 31 March 2016	**0**	**0**	**10**	**291**	**51**	**352**
Asset financing						
Owned	179	0	9	278	73	540
Carrying Amount						
At 31 March 2017	**179**	**0**	**9**	**278**	**73**	**540**

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 (2016 - £nil).

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 5.2 - 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 1 April 2015	**0**	**318**	**59**	**377**
Asset financing				
Owned	10	291	51	352
Carrying Amount				
At 31 March 2016	**10**	**291**	**51**	**352**
Asset financing				
Owned	0	318	59	377
Carrying Amount				
At 1 April 2015	**0**	**318**	**59**	**377**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 6.1 - Intangible assets - year ended 31 March 2017

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2016	62	148	210
Additions	0	64	64
At 31 March 2017	**62**	**212**	**274**
Amortisation			
At 1 April 2016	28	25	53
Provided during the year	13	30	43
At 31 March 2017	**41**	**55**	**96**
Carrying Amount			
At 31 March 2017	**21**	**157**	**178**
At 31 March 2016	**34**	**123**	**157**
Asset financing			
Owned	21	157	178
Carrying Amount			
At 31 March 2017	**21**	**157**	**178**

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 (2016 - £nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 6.2 - 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 1 April 2015	**47**	**94**	**141**
Asset financing			
Owned	34	123	157
Carrying Amount			
At 31 March 2016	**34**	**123**	**157**

NOTE 7 - FINANCIAL INSTRUMENTS

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

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2016/17 or 2015/16.

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 2016/17 or 2015/16.

NOTE 10 - INVENTORIES

The PHA did not hold any inventories as at 31 March 2017 or 31 March 2016.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 11 - CASH AND CASH EQUIVALENTS

	2017 £000	2016 £000
Balance at 1st April	310	276
Net change in cash and cash equivalents	109	34
Balance at 31st March	**419**	**310**

The following balances at 31 March were held at	2017 £000	2016 £000
Commercial banks and cash in hand	419	310
Balance at 31st March	**419**	**310**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2017 £000	2016 £000
Amounts falling due within one year		
Trade receivables	158	176
VAT receivable	266	279
Other receivables - not relating to fixed assets	70	124
Trade and other receivables	**493**	**579**
Prepayments and accrued income	15	27
Current part of PFI and other service concession arrangements prepayment	0	0
Other current assets	**15**	**27**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**493**	**579**
TOTAL OTHER CURRENT ASSETS	**15**	**27**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**508**	**606**

The balances are net of a provision for bad debts of £nil (2016 £nil).

NOTE 13 - TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2017 £000	2016 £000
Amounts falling due within one year		
Other taxation and social security	0	0
Trade capital payables - property, plant and equipment	91	92
Trade capital payables - intangibles	46	46
Trade revenue payables	5,539	4,250
Payroll payables	335	705
BSO payables	357	635
Other payables	560	2,039
Accruals and deferred income	59	6
Trade and other payables	**6,987**	**7,773**
Other current liabilities	**0**	**0**
Total payables falling due within one year	**6,987**	**7,773**
Amounts falling due after more than one year		
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**6,987**	**7,773**

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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:

	2017 Number	2017 Value £000s	2016 Number	2016 Value £000s
Total bills paid	5,903	58,348	5,860	56,627
Total bills paid within 30 day target or under agreed payment terms	5,560	56,564	5,440	55,278
% of bills paid within 30 day target or under agreed payment terms	**94.2%**	**96.9%**	**92.8%**	**97.6%**
Total bills paid within 10 day target	4,840	52,185	4,833	51,117
% of bills paid within 10 day target	**82.0%**	**89.4%**	**82.5%**	**90.3%**

14.2 The Late Payment of Commercial Debts Regulations 2002

The PHA did not pay any compensation or interest for payments made late in 2016/17 (2015/16 £nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2017

	Other £000	2017 £000
Balance at 1 April 2016	5	5
Provided in year	370	370
(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 2017	**375**	**375**

Comprehensive Net Expenditure Account charges	**2017 £000**	**2016 £000**
Arising during the year	370	0
Reversed unused	0	(5)
Cost of borrowing (unwinding of discount)	0	0
Total charge within Operating expenses	**370**	**(5)**

Analysis of expected timing of discounted flows

	Other £000	2017 £000
Not later than one year	375	375
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2017	**375**	**375**

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 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**

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**

NOTE 16 - CAPITAL COMMITMENTS

The PHA did not have any capital commitments as at 31 March 2017 or 31 March 2016.

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	2017 £000	2016 £000
Buildings		
Not later than 1 year	106	131
Later than 1 year and not later than 5 years	381	53
Later than 5 years	0	4
	487	**188**

17.2 Finance Leases

The PHA had no finance leases in 2016/17 or 2015/16.

17.3 Commitments under Lessor Agreements

The PHA had no lessor obligations in either 2016/17 or 2015/16.

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

The PHA had no commitments under PFI or service concession arrangements in either 2016/17 or 2015/16.

NOTE 19 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2017 or 31 March 2016.

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 2017 or 31 March 2016.

NOTE 21 - CONTINGENT LIABILITIES

The PHA did not have any unquantifiable contingent liabilities as at 31 March 2017 or 31 March 2016.

NOTE 22 - RELATED PARTY TRANSACTIONS

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

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 had no third party assets in 2016/17 or 2015/16.

PUBLIC HEALTH AGENCY

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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:

	2017 Total £000	2016 Total £000
DOH (excludes non cash)	96,006	105,456
Other Government Departments	0	0
Non cash RRL (from DOH)	549	161
Total agreed RRL	96,555	105,617
Adjustment for Research and Development under ESA10	12,229	0
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**108,784**	**105,617**

24.2 Capital Resource Limit

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

	2017 Total £000	2016 Total £000
Gross capital expenditure	372	141
Net capital expenditure	372	141
Capital Resource Limit	12,601	141
Adjustment for Research and Development under ESA10	(12,229)	0
Overspend/(Underspend) against CRL	**0**	**0**

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.

	2016/17 £000	2015/16 £000
Net Expenditure	(108,709)	(105,439)
RRL	108,784	105,617
Surplus / (Deficit) against RRL	75	178
Break Even cumulative position(opening)	1,201	1,023
Break Even cumulative position (closing)	**1,275**	**1,201**

Materiality Test:	2016/17 %	2015/16 %
Break Even in year position as % of RRL	0.07%	0.17%
Break Even cumulative position as % of RRL	1.17%	1.14%

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

NOTE 25 - POST BALANCE SHEET EVENTS

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

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 15 June 2017.