HSC Public Health Agency

agenda

Title of Meeting	139th Meeting of the Public Health Agency Board
Date	16 December 2021 at 1.30pm
Venue	Via Zoom

standing items

1 1.30	Welcome and apologies		Chair
2 1.30	Declaration of Interests		Chair
3 1.30	Minutes of Previous Meeting held on 18 November 2021		Chair
4 1.35	Matters Arising		Chair
5 1.40	Chair's Business		Chair
6 1.45	Chief Executive's Report		Chief Executive
7 2.00	Finance Report	**PHA/01/12/21**	Director of Finance
8 2.15	Update on COVID-19		Chief Executive

committee updates

9 2.30	Update from Chair of Governance and Audit Committee	**PHA/02/12/21**	Mr Stewart

items for noting

10 2.30	NI Assembly All Party Group on Reducing Harm Related to Gambling Inquiry Report: The Future Regulation of Gambling in Northern Ireland	**PHA/03/12/21**	Dr Bergin

11 Finance — Chair

3.00

- Ring Fenced Elements of the PHA Budget
- Elements of the PHA Budget for which PHA Board has Discretion
- Reallocation of Underspent Elements of the Annual Budget

closing items

12 Any Other Business

3.20

13 Details of next meeting:

Thursday 20 January 2022 at 1.30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

HSC Public Health Agency

minutes

Title of Meeting	138th Meeting of the Public Health Agency Board
Date	18 November 2021 at 1.30pm
Venue	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast

Present

Mr Andrew Dougal	-	Chair
Mr Aidan Dawson	-	Chief Executive
Dr Stephen Bergin	-	Interim Director of Public Health (*via video link*)
Mr Stephen Wilson	-	Interim Director of Operations
Alderman Phillip Brett	-	Non-Executive Director
Mr John Patrick Clayton	-	Non-Executive Director (*via video link*)
Ms Anne Henderson	-	Non-Executive Director
Mr Robert Irvine	-	Non-Executive Director
Ms Deepa Mann-Kler	-	Non-Executive Director (*via video link*)
Professor Nichola Rooney	-	Non-Executive Director
Mr Joseph Stewart	-	Non-Executive Director (*via video link*)

In Attendance

Dr Aideen Keaney	-	Director of Quality Improvement
Ms Geraldine Teague	-	Lead Allied Health Professionals Consultant (*on behalf of Mr Morton*) (*via video link*)
Ms Tracey McCaig	-	Interim Director of Finance, HSCB (*via video link*)
Mr Brendan Whittle	-	Director of Social Care and Children, HSCB (*via video link*)
Mr Robert Graham	-	Secretariat

Apologies

Mr Rodney Morton	-	Director of Nursing and Allied Health Professionals

123/21 Item 1 – Welcome and Apologies

123/21.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr Rodney Morton.

124/21 Item 2 – Declaration of Interests

124/21.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.

125/21 **Item 3 – Minutes of previous meeting held on 21 October 2021**

125/21.1 The minutes of the Board meeting held on 21 October 2021 were **APPROVED** as an accurate record of that meeting.

126/21 **Item 4 – Matters Arising**

115/21.8 Deficit in PHA Board Spend

126/21.1 Ms McCaig confirmed that the deficit against PHA Board spend is as a result of there being an overlap between the outgoing and incoming Chief Executives and would smooth out as the year progresses.

127/21 **Item 5 – Chair's Business**

127/21.1 The Chair said that he continues to be concerned about gambling and this was an issue he raised at the meeting in June. He noted that many soccer clubs in England had sponsorship deals with gambling companies and this has led to young people becoming heavily involved with gambling. He advised that the NHS in England has set up a number of clinics for gambling addiction and he asked whether representation should be made in order to offer such a clinic in Northern Ireland. Dr Bergin said that this would need a joined up approach and a stepped or tiered model, similar to other addiction services. He added that this would require additional investment. He noted that in due course specialist practitioners would be needed. The Chair noted that it would take time for any relevant legislation to go through the Northern Ireland Assembly and he is aware that budgets are already stretched. He pointed out that very few new programmes are started up without new money and given the pressures on the HSC he suggested there needs to be a review of what is currently funded and see if that funding could be used in a more agile fashion. Professor Rooney commented that the discussion should not always be about services but should be about causes and the public health approach to dealing with such issues. The Chair agreed that this is an issue which has been raised before and is a major concern to him.

127/21.2 Ms Henderson suggested that gambling is not strategically a priority area at the moment. She noted that at the last PHA staff engagement session, she was concerned that a recent survey found that many staff are not aware of the strategic vision of the organisation. She noted that PHA spends £10m on flu, £11m on Protect Life 2, £8m on drugs and alcohol services and £5m on obesity, and although COVID-19 has given PHA a bigger profile and portrays it as a nimble and responsive organisation, she feels there is a need to get a better grip of what the priorities of the organisation are. She added that there is a perception that PHA is about improvement, and she said that it has a good website, but there should be a discussion about vision, especially if staff do not feel they know what the organisation's vision is. The Chair agreed that this is an issue that has been raised.

127/21.3 The Chief Executive said that there must be more time devoted to planning for the next year. He said that the PHA has been in business continuity mode and as such identifying such time has been difficult. He added that there must be an intensive focus on inequalities in health and on the wider determinants of health.

127/21.4 Mr Clayton queried whether it would be possible with the upcoming election to the Northern Ireland Assembly to ensure the public should be informed about the issues in public health and in particular the link between COVID-19 and health inequalities. The Chief Executive pointed out that it is PHA's role to respond to policies developed by the Department and to seek to influence these.

127/21.5 Ms Henderson questioned whether it was appropriate to spend £10 million on flu and how this might reduce health inequalities. The Chief Executive pointed out that this allocation is ring fenced by the Department to provide a vaccination service for flu each year. Miss Henderson expressed the need to get a sense of the priorities of PHA. The Chair stated that there is an urgent need to identify those areas where the PHA does in fact have discretion. Dr Bergin clarified that there is a range of vaccination programmes which are determined and prescribed at UK level by an expert committee which advises the Secretary of State for Health who in turn advises the four chief medical officers as well as health ministers in the devolved institutions.

127/21.6 Ms McCaig suggested that it might be fruitful to have a discussion in a workshop to see how funds flow through the organisation on an annual basis.

127/21.7 Mr Wilson referred to the discussion on the Ministerial Group on Public Health. He advised that there was an extant Group which existed prior to the collapse of the Northern Ireland Assembly but it has not met since the Assembly restarted. The Chair commented that Government departments were not likely to work together effectively unless there is a group of ministers pressing the officials in each Department to advance the cause of public health.

127/21.8 Miss Henderson suggested that it would be beneficial to have a 10 minute slot as the next few meetings on a different topic area in order to get a better understanding of the baseline. The Chief Executive said that he would discuss this at AMT **(Action 1 – Chief Executive)**.

128/21 Item 6 – Chief Executive's Report (PHA/01/11/21)

128/21.1 The Chief Executive advised that for today's meeting, he was presenting a progress report against PHA's Business Plan. He reported that PHA continues to work in business continuity mode due to COVID-19 and therefore has not made progress with regard to business planning.

128/21.2 The Chief Executive said that there is an escalating number of cases of

COVID-19 and that testing capacity is Northern Ireland is at its limit. He advised that the number of daily positive cases is now around 1,700 having been at around 1,000 over the last few weeks. He reported that this increase has resulted moving the status of the Contact Tracing Service (CTS) to "red" and that the Department has been informed. H. He advised that the disease is most prevalent in the 11-30 year old age group.

128/21.3 The Chief Executive advised that PHA is awaiting the outcome of the discussions at Northern Ireland Executive level. He said that as well as the introduction of COVID-19 passports, the Chief Medical Officer (CMO) has indicated that there may be a suite of other measures which will have an impact. He explained that he has informed the Department that PHA has brought all of its staff back to their normal duties and he has no plans at present to redeploy them back to contact tracing, and although he is reluctant to do so because other areas of work are falling behind, he is not ruling it out.

128/21.4 The Chief Executive reported that PHA is presently focusing on nosocomial spread and working with the Department, HSCB and the Southern Trust to look at measures to help decongest hospitals in the Southern Trust. The Chair sought clarity as to the definition of nosocomial spread. The Chief Executive explained that this is when an individual acquires an infection while in hospital.

128/21.5 The Chair said that he was pleased to see that staff had been repatriated back to their normal duties and asked if the CTS is currently recruiting. The Chief Executive confirmed that recruitment is ongoing, but pointed that as funding is only confirmed until 31st March 2022, and that other organisations are able to offer people longer terms contracts, it is becoming more difficult to attract candidates. He noted that PHA has offered overtime opportunities to its own staff who have been previously been involved in contact tracing. The Chair expressed concern that PHA could lose many of its contact tracing staff, and a huge amount of time and effort would be needed to recruit new staff with the appropriate skills. The Chief Executive advised that he has raised this matter with the CMO.

128/21.6 Mr Clayton welcomed the report and said that it was useful in terms of giving the wider strategic context. He noted that he would have welcomed some additional narrative around the KPIs about contact tracing. He asked about the vaccination programme, and PHA's role in terms of targeting areas of low uptake. Given the spread in hospital settings, he asked whether PHA has raised the issue of low uptake with the Trusts and with the independent sector.

128/21.7 The Chief Executive said that he proposed to take members through the areas of the Report where actions were rated as "amber", one of which relates to vaccination uptake. He advised that PHA is continuing to identify those areas where there is low uptake and to target specific

communities. He said that this work is led by Mr Maurice Meehan and he would report each week to the Vaccination Programme Board, following which mobile vaccination centres would be set up in areas of low uptake.

128/21.8 The Chief Executive advised that the Vaccine Management System (VMS) had been the subject of discussions with the Department earlier this week and he assured members that it is a safe system and that PHA has issued strong statements to counter what is being said about the system's security.

128/21.9 Mr Clayton asked for more information about unvaccinated staff in Trusts and the independent sector and if PHA is targeting those staff to improve uptake in the same way as it targets other population groups. The Chief Executive advised that the information on VMS is on a population basis and does not go into specific sectors. However, he said that RQIA is looking at care homes and it is the responsibility of Trusts to identify any unvaccinated staff. He added that PHA has indicated that it will work with Trusts and has informed Trusts of its concern. He pointed out that there is a gap in terms of the information because staff may have gone to their local GP or pharmacy to get their vaccine instead of through the Trust. Dr Bergin said that from an information perspective, PHA would like to get to the same situation that exists with the flu vaccine, where detailed information is available regarding staff vaccination rates.

128/21.10 Ms Mann-Kler thanked the Chief Executive for the Report which she said was helpful. She noted that there may have been a similar type of report in the past which was also aligned to reporting on Programme for Government (PfG) and used Outcomes Based Accountability (OBA) to demonstrate where PHA is having an impact. She said that it would be beneficial to get more information on the areas rated "amber" on a monthly basis. In terms of COVID-19, she asked what role PHA will have in terms of vaccine passports, and where PHA sits in the debate on mandatory vaccines for HSC staff. She asked whether PHA's messaging around encouraging vaccination uptake is subtle enough to differentiate between people who are vaccine hesitant and those who are anti-vaxxers. She added that it would be useful to understand what the data are showing in terms of attitudes to vaccination uptake. With regard to the booster programme, she noted that there has been a lot of media coverage about people not being invited to get their booster and she also asked about second vaccines for 17/18 year olds.

128/21.11 The Chief Executive said that this is a first cut of this type of report and he is keen to hear feedback and if there are any other areas on which members would like to receive information. He said that he will work to get the report more polished. In terms of the 8 areas rated "amber", he advised that work on infection prevention control will progress. For HSCQI, he noted that as many of Dr Keaney's staff had been redeployed this work is behind schedule, but Dr Keaney is working on a

recovery plan. He advised that PHA has been working with the Simon Community and Queen's University to progress the work in relation to the homeless health hubs. He again referenced the redeployment of HSCQI as a factor in not progressing the work of scoping QI across the HSC. He noted that although PHA is awaiting a policy direction from the Department in relation to its Corporate Plan, PHA should be commencing work to look at its own strategic direction going forward. In relation to the outworking of the review of PHA, he advised that an exercise to recruit a Project Manager had been unsuccessful, and that COVID-19 has also resulted in some of the work not being progressed. However, he reported that the work of the information strategy subgroup is progressing with 3 new staff having been brought in, and he said that he would bring a paper on its work to the Board in the new year **(Action 2 – Chief Executive)**. He noted that there is a lot of vacant posts but that Ms McCaig and her team will work with PHA to look at this from an accounting perspective. He noted there has been a suggestion about having a Board workshop to look at HR and data.

128/21.12 The Chief Executive said that, in terms of mandatory vaccination, the Minister has put a paper out to public consultation. He explained that the vaccine will not be mandatory for all current staff, but for new staff, or if current staff move post. He noted that one of the Trade Unions is opposed to the move, but is content that it went out to public consultation. He said that the issue of vaccine hesitancy is a particular one among young females who have expressed concerns about fertility. He noted that this concern remains as it was part of some of the early messaging. Mr Wilson advised that the majority of PHA's messaging goes out to the whole population and is not nuanced, but through partner organisations or selected media, messages are put out to target audiences. He added that PHA is constantly gaining insights about the nuances that it needs to embed and just this week, there was feedback in terms of the sensitivities around myth busting and how people react to that. He advised that there has only been a 50% uptake in the 16/17 year old age group and among 12/15 year olds, some schools have returned low numbers in terms of uptake so PHA will continue to work with Trusts to get additional pop up clinics in place and put out targeted messages through social media. He said that PHA is being as agile as it can be. He noted that there will always be 10% of the population which will be anti-vax or very hesitant and so PHA will not spend a lot of time responding to that group but will focus its efforts on the other 90% and aim to help those hesitant people make a positive decision in terms of getting a vaccine.

128/21.13 Ms Mann-Kler asked about the vaccine passports and the role of PHA. She asked whether PHA is following the yellow card scheme. She noted that the Royal College of Obstetrics has noted 30,000 women reporting changes to their menstrual cycle which may link to vaccine hesitancy and asked if PHA is looking into this and making those connections. Mr Wilson advised that the yellow card scheme operates within the health protection team and consequently PHA's messaging to

young females has changed. He added that Public Health England has published resources which PHA is looking to adapt for Northern Ireland. In terms of vaccine passports, the Chief Executive noted that this policy decision was only made yesterday and to date PHA has had no conversations with the Department regarding this. He said that if there was going to be any impact for PHA, he would inform the Board.

128/21.14 Mr Stewart said that he was pleased to see that in the absence of guidance from the Department, PHA is continuing to focus on its Business Plan at the present time and that will ensure the organisation is well placed and won't have to produce a Plan in a rush.

128/21.15 The Chair commented that there is a lot of confusion around the vaccine passport so there needs to be clear targeted messages. He said that the objective is not only to get more people vaccinated, but to keep them out of hospital.

128/21.16 Professor Rooney asked, apart from the COVID-19 pandemic, do staff normally have to be vaccinated in any case against other illnesses. The Chief Executive said that certain professional groups have to be vaccinated as part of their contract, but he noted that the flu vaccine is not mandatory.

128/21.17 The Chair thanked the Chief Executive and the Directors for compiling this Report with its new format.

129/21 Item 7 – Finance Report (PHA/02/11/21)

129/21.1 Ms McCaig presented the Finance Report and noted that this month a formal executive summary has been included. She advised that as at the end of September there is a year to date surplus of £0.5m which has reduced from £1m at the end of August. She explained this change is due to health improvement expenditure coming back in line, planned campaign expenditure being slightly ahead of schedule and a slight decrease in the management and administration underspend.

129/21.2 Ms McCaig advised that in the programme budget, there is a projected underspend of £0.5m. She highlighted the Nicotine Replacement Therapy (NRT) budget and said that demand this year for NRT has reduced compared to previous years and she suggested that during COVID-19 response this may not have been promoted as with previous years and smoking cessation may be focusing on other areas. She explained that this is referred to as a COVID-19 downturn and will be offset against COVID-19 expenditure. She advised that she has liaised with the Department regarding this and in effect, PHA will receive £500k less COVID-19 funding once its business case for Contact Tracing has been approved.

129/21.3 Ms McCaig said that there remains a projected surplus at the yearend of £800k. She reiterated that there is a surplus in the management and

administration budget.

129/21.4 Ms McCaig highlighted some risks. She said that programme expenditure will continue to be reviewed so there may be an additional slippage which may accrue during the year.. She noted that there was an additional £1m spend against COVID-19 during September. She said that in terms of the impact of the COVID-19 response, there is an issue as to whether PHA's partners can support the organisation in managing slippage by way of short term projects as they would have done previously.

129/21.5 Ms McCaig advised that the capital expenditure budget does not show a lot of spend at present, but Dr Janice Bailie manages this budget well and the profile is generally towards the end of the year.

129/21.6 Ms McCaig reported that PHA's prompt payment performance continues to be the best in the HSC.

129/21.7 Ms Henderson said that she would be keen to delve more into the Trust spend as she commented that it is all showing break even. She suggested that there may be SLAs which have been in place for some time. She noted that given there are only four months until the yearend, and although the underspend did not concern her, she felt it would be useful for the Board to have some visibility in terms of the areas which the AMT has identified as being priorities to benefit from the underspend The Chief Executive advised that there have been some discussions around this, and that some funding will be put towards getting behavioural science input and that will roll into next year. He added that there has been some expenditure in relation to digital and information systems. He noted that with staff returning to their normal duties, there will be difficulty in terms of getting current money spent before there can be consideration about how to spend additional money. The Chair stated that the Board would be keen to see some options and have input into the decision making on this issue. He noted that in previous years when PHA was developing its Business Plan, it would have done so in conjunction with the Department prior to presentation to the Board, but the Board should have more input. The Chief Executive suggested that it may be useful to have a workshop early in the new year to look at strategic direction **(Action 3 – Chief Executive)**.

129/21.8 Mr Irvine said that as a Councillor he is aware that PHA funds Local Councils and although it is not clear in this Report he would welcome seeing a small table highlighting the programme areas of spend. Ms McCaig said that this would be challenging for the Finance team to produce as the finance system would not record in this way, but she agreed that if any decisions were brought to the Board, any element of Council spend could be made clear.

129/21.9 Ms McCaig said that in relation to Trust expenditure, a suite of reports is currently being prepared for sharing with members. She said each

individual investment is monitored by budget holders and she would be happy to discuss this in more detail outside the meeting. She explained that PHA's role is to consider its priorities and approve investments, not to ensure that Trusts are breaking even. In terms of the surplus, she explained that the Chief Executive has a responsibility for ensuring that the budget breaks even with a tolerance of ±0.25% (around £300k) so an underspend is an issue. She reiterated the point that because of the pandemic, PHA's partners are unlikely to be able to assist PHA with further spend. She said that there may not be time to bring proposals back to the Board because of the speed at which things can happen, but the planning cycle for 2022/23 will be commencing which will consider the overall priorities for the PHA.

129/21.10 The Chair recalled that when he had previously asked for details of the breakdown of the funding to the Trusts he was informed by the then Director of Finance that this would cause redundancies. He stated categorically that neither he nor the Board had any intention to cause such an outcome but merely wished to know how the money was being spent. Ms McCaig said that with regard to Trust expenditure, PHA's role is to ensure that the outcomes on the activity that it funds are achieved, so it is less about spend and more to do with ensuring PHA is getting what it has commissioned. In response to a question from Ms Henderson Ms McCaig stated that there may not be other opportunities to fund initiatives outside the organisation which are within PHA's priority areas but because of COVID-19, it will be difficult for PHA's partners to spend money. Ms Henderson suggested that as there is an urgency on this, any options could be shared with members via e-mail. The Chief Executive agreed with the point that it will prove difficult for PHA's partners to spend further money and as Accounting Officer, it is his responsibility to ensure that money is spent judiciously and properly.

129/21.11 The Chair noted that a 3-year Comprehensive Spending Review has just been completed and he asked if this meant that there will finally be a 3-year budget. Ms McCaig advised that a process has commenced within Departments and PHA has been inputting to that in terms of highlighting what it sees as inescapable pressures. She said that although it is technically a 3-year process, bids will still have to be made each year and a prioritisation exercise done, but it is a helpful move as it allows for slightly longer term planning. The Chair asked if there is good interaction between the finance staff in each of the ALBs and the Department in preparation for this major change. Ms McCaig replied that there has been good communication with the professional and policy leads at the Department. She said that she would update members further on this at a future meeting when the budget is released at draft stage by the Minister **(Action 4 – Ms McCaig)**.

129/21.12 The Board noted the Finance Report.

At this point Mr Irvine left the meeting.

130/21 **Item 8 – Update on COVID-19**

130/21.1 This was covered under Item 6 above.

131/21 **Item 9 - Outcomes and Impacts of HSC R&D Funding**

Dr Janice Bailie joined the meeting for this item.

131/21.1 Dr Bailie thanked members for the invitation to attend the meeting and showcase the work of the Research and Development (R&D) team. She said that as there were some new members she would begin by briefly explaining the role of R&D.

131/21.2 Dr Bailie advised that the R&D division was first established in 1994 as part of the Central Services Agency and transferred into PHA in 2009. She explained that R&D's work is not to deliver research *per se*, but to deliver on the R&D Strategy for the HSC. She said that the work of the division covers the whole spectrum of research. She advised that the division manages funding awards for programmes within Trusts, universities and the charitable sector and ensures that any schemes are in line with good practice elsewhere. In 2020/21, she said that the fund administered by R&D was £19.5m.

131/21.3 Dr Bailie said that the R&D division supports quality research that aims to have a positive impact on the delivery of health and social care. She showed where R&D division in PHA sits within the overall R&D infrastructure in Northern Ireland, and said that through the use of Researchfish the division can capture information on the outcomes and the impact of the work that it funds. She explained that over the last number of years there has been an average of an 8.4 fold return on investment.

131/21.4 Dr Bailie advised that R&D provides an annual subscription of around £3.2m to the National Institute of Health Research (NIHR). She said that helps build R&D's reputation and she hoped to continue to grow that success.

131/21.5 Dr Bailie took members through some case studies showing the successes of R&D funding.

131/21.6 Dr Bailie gave an overview of CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) and advised that over 3,000 participants have been recruited to assist with this work. She gave a synopsis of some of the trials in which the team is involved.

131/21.7 Dr Bailie reported that during the COVID-19 pandemic the R&D division provided input in three ways; contributing to workstreams in PHA and wider consortia; commissioning funding schemes and supporting urgent UK-wide public health and surveillance studies.

131/21.8 In conclusion Dr Bailie said that evidence shows that research active hospitals provide better care and outcomes; that investment in R&D is essential; that there is a fourfold return on investment; that good communication is needed to ensure stories are shared and heard; involving patients and carers is key, and that research changes lives. She shared with members the story of one man whose participation in drug trials saved his life and whose story featured in the media and on NVTV.

131/21.9 The Chair thanked Dr Bailie for her comprehensive overview of the work carried out by a small group of people with a small budget.

131/21.10 Mr Stewart asked how the return on investment is calculated and what measures are in place to ensure that research being carried out does not duplicate work done elsewhere. Dr Bailie explained that the formula to work out return on investment is a published formula used by Professor Stephen Hanney which takes account of both financial and spillover benefits. She said that many of the figures she quoted are purely financial, but there are benefits in kind. In terms of duplication of work, Dr Bailie advised that all UK-wide funders work together to ensure there is no duplication. She added that when an evaluation of paperwork is undertaken, PHA relies on peer review processes and takes great pain to ensure that the appropriate peer reviewers are used. She said that PHA always seeks to ensure that any research is novel and of high quality. The Chair said that from his experience of using peer reviewers, the aim is always to ensure that only high quality research is funded and in case of uncertainty, it is better to hold back funds until a number of more worthwhile projects is put forward for evaluation. He commented that in a recent worldwide survey it was shown that the ratio of return on investment is 4.6 and that was the reason why, even during the extremely severe austerity budget of 2012, the UK Government did not cut the R&D budget as there was a recognition that with R&D there is always a very positive payback.

131/21.11 Professor Rooney said that she is a great supporter of research, but asked what the impact would be on public health research if a decision was made that the R&D function should be hosted elsewhere. Dr Bailie said that R&D has now spent more than half of its lifetime in PHA and from her perspective, PHA has been an ally and protected R&D from having its budget cut. She advised that R&D funds public health research and there is now a Centre for Public Health Research led by Professor Frank Kee at Queen's University which is now getting funding through a range of UK-wide avenues. She added that PHA also works with Ulster University and the All-Ireland Institute for Public Health and there is a joint conference run each year. She said that there are benefits for R&D being hosted within PHA and that during the pandemic R&D worked with different parts of PHA and with colleges and the value of this work can be demonstrated through of the outcomes of the projects.

131/21.12 The Chair advised that he has been involved with R&D since its early days and that PHA is the appropriate host for this function. He noted that its role is to look at R&D across the whole HSC and having it in PHA adds to the organisation's kudos. He said that relationships with the academic institutions are important and that he would like to see more collaboration between PHA and Queen's and Ulster University. He noted that previously some staff working in public health would have spent half-time in Queen's Department of Epidemiology and half-time in health and social care.

At this point Ms Mann-Kler left the meeting.

131/21.13 Dr Bergin said that R&D is a critical part of the public health directorate.

131/21.14 The Chair emphasised that it is really important that people recognise the true value of research and development. He said that the research funded by PHA is not pure or basic scientific research but it is translational and brings direct benefits to patients.

131/21.15 The Chief Executive said that the information and intelligence functions of PHA are key and when PHA is commissioning services, it should be doing so using an evidence-based approach and R&D and health intelligence should be working together. He said that PHA should ensure that its evidence underpins how services are commissioned and going forward this information should be provided to the new integrated care systems. He added that when funding should be spent judiciously and efficiently and based on evidence and research and PHA may already have that research information or that research may have to be commissioned.

131/21.16 Ms Henderson said that the presentation was very uplifting with good news stories picked by the media. She asked about public health research in terms of people's habits. Dr Bailie advised that CHITIN, which is an EU-funded programme, has brought in over €10m of funding for the HSC and it has carried out research in public health areas, for example walking and nutrition, and this may be of interest to the Board.

131/21.17 The Chair thanked Dr Bailie and congratulated her and her team for the outcomes they have achieved from their research over recent years. He said that this work is greatly valued.

131/21.18 The Board noted the presentation on the outcomes and impacts of HSC R&D funding.

132/21 Item 10 – Communication with the Public

132/21.1 The Chair asked if PHA is communicating effectively with the public as he felt that many people are not getting the right messages and he suggested using the exterior of the building in Linenhall Street to promote messages. He said he had been asked by a Board member

why the exterior of the building on Linenhall Street is not used to promote messages. He added that the public needs consistent messages and this is not always possible with different messages being broadcast in the media from different parts of the UK. He said that the public is also confused because the messages change.

132/21.2 Ms Henderson noted that PHA has been very reactive to recent news stories and did not miss an opportunity. Professor Rooney commented that in Northern Ireland at present the number of cases and the vaccine uptake rates are the worst in the UK. The Chair commented that the booster programme is not going well. Mr Wilson explained that a strategic decision to prioritise the booster programme in care homes. He added that in terms of the messaging, recent surveys have shown that people are aware of where they can get a vaccine, although he commented that the NI Direct website can be difficult to navigate.

132/21.3 Mr Wilson said that he would be happy to take time at a workshop to outline PHA communications programme going forward. He added that COVID-19 has given PHA huge public exposure and should be used as a springboard going forward. He advised that there have been meetings with BSO to look at using the windows in Linenhall Street for public health messaging. Ms Henderson asked if PHA could pay people to become public health champions. Mr Wilson advised that PHA could use influencers, but noted that the organisation is not always in control of what message they put out. He said that influencers have been approached. Adding to the comment about putting messages on the outside of the building, the Chief Executive noted that there is a limit in terms of how much of its budget PHA can use and agreed that it would be useful to spend a bit of time looking at this. The Chair commented that BBC should be approached about public service advertising, but Mr Wilson explained that this is managed centrally through London and the Cabinet Office. However, he advised that PHA is trying to get BBC on board with its messaging on vaccination as part of social norming day on 2 December.

132/21.4 Professor Rooney asked if Local Councils have public health champions. The Chair reported that in a previous role he had successfully recruited Mayors and Chairs of Local Councils to become health champions during their year of office. Mr Wilson advised that Local Councils would support PHA through community planning and if there are key healthcare issues identified that need to be addressed, for example mental health and physical activity, then partnerships would be put in place.

133/21 Item 11 – Any Other Business

133/21.1 With there being no other business, the Chair thanked members for their time and drew the meeting to a close.

134/21 **Item 12 – Details of Next Meeting**

Thursday 16 December 2021 at 1:30pm

Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 7BS

Signed by Chair:

Date:

Finance Report
October 2021

Tracey McCaig
Director of Finance

December 2021

Section A: Introduction/Background

1. The PHA Financial Plan for 2021/22 was approved by the PHA Board in the June 2021 Board meeting, which described the opening financial position of the organisation and reported an anticipated breakeven position within 2021/22.

2. The Financial Plan identified a number of areas of projected slippage and how this was to be used to address in-year pressures and priorities.

3. This executive summary report reflects the latest position, as at the end of October 2021 (month 7). Supplementary detail in the format of previous reports is provided in Annex A.

Section B: Update – Revenue position

4. The PHA has reported a year to date surplus, at October 2021, of £0.5m (£0.5m at September 2021).

5. In respect of the year to date surplus of £0.5m:
    - The profiled budget for PHA Programme expenditure is on track overall, although expenditure ahead of profile in the Campaigns area (£0.4m) and Health Protection (£0.1m) is being offset by underspends against budget in Service Development & Screening (£0.1m) and also Health Improvement (£0.3m). These are timing issues only, and no impact is expected on the overall Programme budget for the year.
    - Budgetholders have been reminded to keep all programme budgets under close review, and report any expected slippage or pressures at an early stage.
    - An underspend in the area of Management & Admin, primarily in the areas of Nursing & AHP and Operations, which reflects a high level of vacant posts in each area. Efforts are on-going to fill these posts as soon as possible. It should be noted that the year to date surplus also includes an underspend in relation to SBNI (£0.14m), which is a ringfenced budget area and any underspend in this regard is notified and returned to DoH.

6. The updated position is summarised in the table below.

PHA Summary financial position - Oct 2021

	Annual Budget £'000	Year to date budget £'000	Year to date Expenditure £'000	Year to date variance £'000	Projected year end Surplus / (Deficit) £'000
Health Improvement	11,857	6,917	6,917	0	
Health Protection	7,317	4,268	4,268	0	
Service Development & Screening	13,177	7,686	7,686	0	
Nursing & AHP	5,127	2,991	2,991	0	
Centre for Connected Health	1,563	912	912	0	
Other	23	13	13	0	
Programme expenditure - Trusts	**39,065**	**22,788**	**22,788**	**0**	**0**
Health Improvement	28,405	15,809	15,533	276	
Health Protection	14,707	10,051	10,144	(93)	
Service Development & Screening	4,002	1,237	1,097	140	
Research & Development	3,211	1,700	1,700	0	
Campaigns	1,421	301	680	(379)	
Nursing & AHP	3,253	99	81	17	
Centre for Connected Health	326	108	83	25	
Quality Improvement	200	98	0	98	
Other	(473)	0	0	0	
Programme expenditure - PHA	**55,052**	**29,404**	**29,320**	**84**	**135**
Subtotal Programme expenditure	**94,116**	**52,192**	**52,107**	**84**	**135**
Nursing & AHP	5,120	2,929	2,510	419	
Quality Improvement	593	344	342	2	
Operations	4,119	2,402	2,214	188	
Public Health	16,117	9,347	9,309	38	
PHA Board	328	183	210	(27)	
Centre for Connected Health	407	237	240	(3)	
SBNI	771	457	317	140	
Subtotal Management & Admin	**27,454**	**15,899**	**15,142**	**757**	**1,063**
Trusts	535	312	312	0	
PHA Direct	8,004	4,300	4,600	(300)	(500)
Subtotal Covid-19	**8,539**	**4,612**	**4,912**	**(300)**	**(500)**
Trusts	0	0	0	0	
PHA Direct	272	0	0	0	
Subtotal Transformation	**272**	**0**	**0**	**0**	**0**
Trusts	0	0	0	0	
PHA Direct	424	92	92	0	
Other ringfenced	**424**	**92**	**92**	**0**	**0**
TOTAL	**130,805**	**72,793**	**72,252**	**541**	**698**

N.B. Table may be subject to minor rounding differences

7. The forecast year end position is a surplus of £0.7m (£0.8m at month 6), and is being largely driven by vacant posts in the Nursing and Operations Directorates. Following a mid-year review of all Programme planned expenditure:
   - Covid related downturn has been projected in the Smoking Cessation budget, with a projected surplus of £0.5m for the year;
   - Following the mid-year review, other pressures have been identified within the Programme budget, these are being gathered and considered. Some expenditure in this regard has been initially assumed in the forecast position, subject to full consideration by the Agency Management Team and the necessary formal approvals.
   - Contact Tracing Centre expenditure of a total of £9m has been projected, with a net requirement being advised to DoH of £8.5m, as a result of the identified NRT Covid downturn of £0.5m, which is being kept under close review in coming months as a significant amount of the budget is profiled in the latter half of the financial year.
   - The position in respect of Management and Admin has been further updated to reflect the impact of movements in senior posts within Public Health, including Consultants moving to posts in Public Health England and the expected start dates of some senior posts within Public Health being delayed. A financial risk relates to the level of annual leave taken in the financial year, including leave carried forward from 2020/21, and the impact on the accrual being carried in this regard. This is being closely monitored through the HRPTS system and impacts being considered.

Section C: Risks

8. **Internal Programme expenditure outturn.** As in each year, Programme expenditure needs to be monitored closely to ensure that planned expenditure is met. The PHA senior team has conducted a mid-year review of expenditure plans to identify any potential easements or inescapable pressures which may need to be addressed in-year. The reported position reflects the mid-year review, however this will be subject to ongoing in-year monitoring.

9. **Funds not yet Allocated to Trusts.** There remains some funding not yet allocated to Trusts due to the requirement for the completion and approval of necessary business cases. Given the passage of time the risk that Trusts will not be able to fully spend the funds before year-end has grown, and therefore PHA may not be able to allocate this funding in full. Budget holders have been reminded to prioritise the allocation of remaining funding to ensure this risk is minimised and this is being kept under close review.

10. **Management and Administration expenditure outturn.** This is closely monitored by the Finance team, in conjunction with PHA management, to ensure that the forecasted financial position is updated on a monthly basis. However, given current plans and timelines for recruitment, the level of slippage highlighted is incorporated into consideration for reapplication to other priorities or pressures through the ongoing review process.

11. **Ring-fenced funding - Covid.** The position assumes that all areas of expenditure funded via Covid funding will breakeven, with the exception of the Contact Tracing Centre, where Covid downturn within PHA has been identified to offset Covid funding required. Currently the majority of Covid expenditure relates to the Contact Tracing Centre, however it is anticipated that expenditure will commence in other areas in the coming months. A business case for additional funding in respect of the Contact Tracing Service has been finalised for issue to the DoH for additional funding in this area. Regular reviews are undertaken on all areas relating to Covid ring-fenced funding, to identify any areas of risk and close liaison will continue with the DoH.

12. **Covid response impact on PHA.** It has been a challenging period for PHA, not least from the focus on the operational nature of the Contact Tracing Service and other Covid impacts to normal service provision. Staff members have been diverted internally to support the service, which has impacted the PHA's ability to fully conduct its business as usual operational requirements.

13. Due to the complex nature of Health & Social Care, there will undoubtedly be further challenges with financial impacts which will be presented in year. PHA will

continue to monitor and manage these with DoH and Trust colleagues on an ongoing basis.

Section D: Update - Capital position

14. The PHA has a current capital allocation (CRL) of £13.1m. The majority of this (£12.6m) relates to Research & Development (R&D).

15. The main movements since the last Finance report

- an additional allocation of £0.358m has been received for the Congenital Heart Disease Professorship Network to be set up across Ireland. This is being managed by the PHA R&D team.
- A significant amount of the R&D allocation to Trusts has been progressed (£4.8m),

16. The overall summary position is reflected in the following table.

Capital Summary	Total CRL £'000	Year to date spend £'000	Full year forecast £'000	Forecast Surplus / (Deficit) £'000
HSC R&D:				
R&D - Other Bodies	5,092	1,328	5,092	0
R&D - Trusts	7,898	4,778	7,898	0
R&D Capital Receipts	(350)	(82)	(350)	0
Subtotal HSC R&D	12,640	6,023	12,640	0
CHITIN Project:				
CHITIN - Other Bodies	2,176		2,176	0
CHITIN - Trusts	262		262	0
CHITIN - Capital Receipts	(2,439)		(2,439)	0
Subtotal CHITIN	0	0	0	0
Other:				
IT	92	92	92	0
Congenital Heart Disease Network	358		358	0
Subtotal Other	450	92	450	0
Total HSCB Capital position	**13,090**	**6,115**	**13,090**	**0**

17. R&D expenditure is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

18. CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position.

19. There is currently a small allocation for IT expenditure within PHA, £0.09m, however some additional funding is expected in this area which is contained within the Contact Tracing Business Case.

20. The Capital position will continue to be kept under close review throughout the financial year.

Recommendation

21. The PHA Board are asked to note the PHA financial update as at October 2021.

HSC Public Health Agency

Public Health Agency

Annex A - Finance Report

2021-22

Month 7 - October 2021

PHA Financial Report - Executive Summary

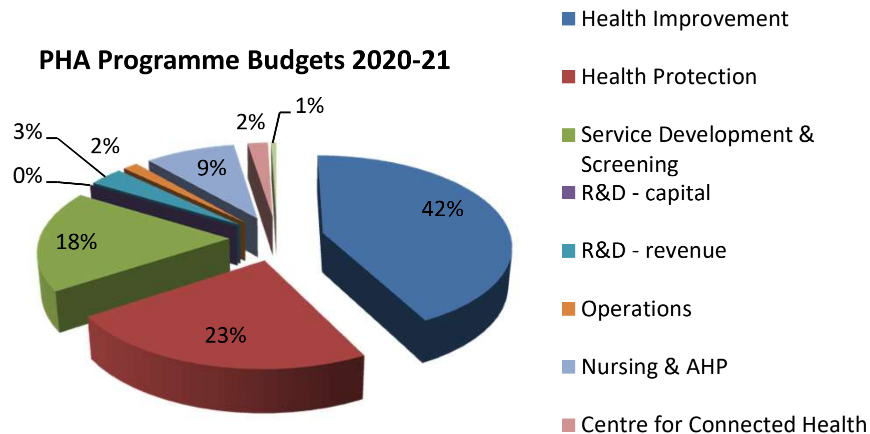
Year to Date Financial Position (page 2)

At the end of month 7 PHA is reporting an underspend of £0.5m against its profiled budget (£0.5m at month 6). This underspend is primarily the result of underspends on Administration budgets (page 6), offset by some expenditure ahead of profile on Programme budgets.

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

Programme Budgets (pages 3&4)

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

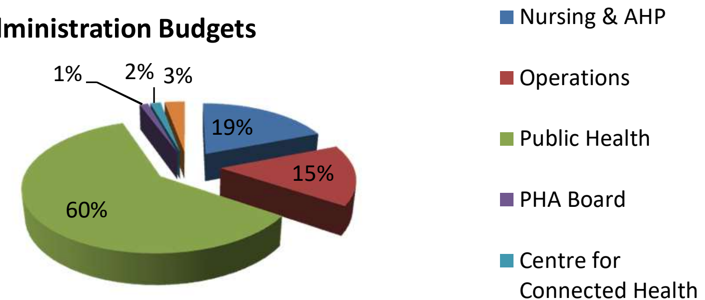


Administration Budgets (page 5)

Approximately half of the Administration budget relates to the Directorate of Public Health, as shown in the chart below.

A significant number of vacant posts remain within PHA, and this is creating slippage on the Administration budget.

Management is proactively working to fill vacant posts and to ensure business needs continue to be met.



Full Year Forecast Position & Risks (page 2)

PHA is currently forecasting a surplus of £0.7m for the full year (£0.8m in month 6 report), arising from identified slippage on Administration budgets.

The Administration and Programme budgets are being continually reviewed in order to update the full year forecast. It is also assumed that any slippage identified in Ringfenced areas will be retracted by DoH. After staffing resources were diverted to assist in PHA's response to the Covid-19 surge, most staff have now been phased back. It is hoped that this will mitigate the risk regarding underspends arising in Programme and Ringfenced areas.

Public Health Agency
2021 -22 Summary Position - October 2021

	Annual Budget: Programme Trust £'000	Annual Budget: Programme PHA Direct £'000	Annual Budget: Ringfenced Trust & Direct £'000	Annual Budget: Mgt & Admin £'000	Annual Budget: Total £'000	Year to Date: Programme Trust £'000	Year to Date: Programme PHA Direct £'000	Year to Date: Ringfenced Trust & Direct £'000	Year to Date: Mgt & Admin £'000	Year to Date: Total £'000
Available Resources										
Departmental Revenue Allocation	39,065	55,021	9,236	26,213	**129,533**	22,788	29,373	4,704	15,223	**72,088**
Assumed Retraction	-	-	-	-	**-**	-	-	-	-	**-**
Revenue Income from Other Sources	-	31	-	1,242	**1,273**	-	30	-	675	**706**
Total Available Resources	39,065	55,052	9,236	27,455	**130,806**	22,788	29,404	4,704	15,899	**72,794**
Expenditure										
Trusts	39,065	-	535	-	**39,600**	22,788	-	312	-	**23,100**
PHA Direct Programme *	-	54,917	9,200	-	**64,117**	-	29,320	4,692	-	**34,012**
PHA Administration	-	-	-	26,391	**26,391**	-	-		15,142	**15,142**
Total Proposed Budgets	39,065	54,917	9,736	26,391	**130,109**	22,788	29,320	5,004	15,142	**72,253**
Surplus/(Deficit) - Revenue	-	135	(500)	1,064	**698**	-	84	(300)	757	**541**
Cumulative variance (%)						***0.00%***	***0.29%***	***-6.37%***	***4.76%***	***0.74%***

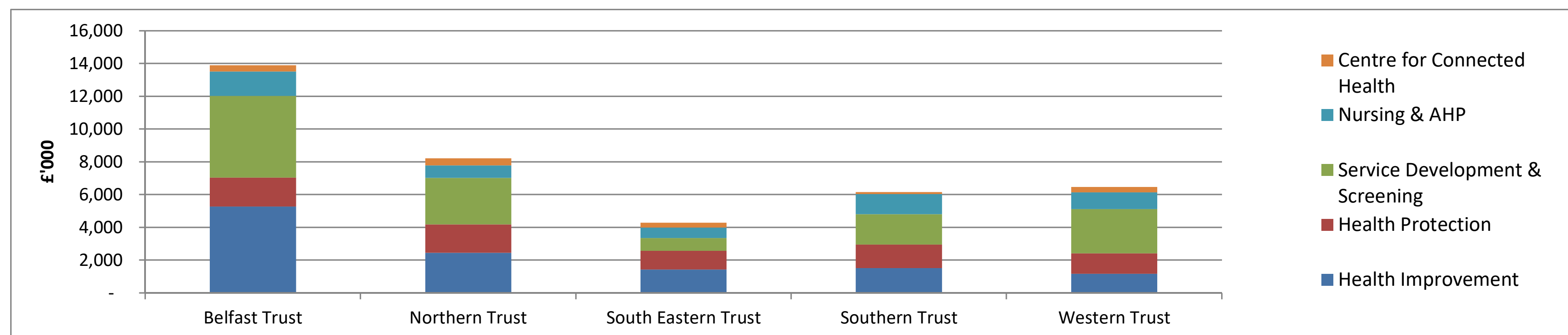
The year to date financial position for the PHA shows an underspend of £0.5m, which is the result of underspend on Admin budgets, Programme Budgets and Ring fenced budgets.

A year-end underspend of £0.7m is currently forecast (slight decrease from £0.8m in month 6 report), primarily caused by vacancies in Admin budgets. This forecast position may be subject to change through the year and will be kept under review to identify any significant movements. For example, this would include any in-year impact to PHA’s normal operations from its ongoing response to Covid-19 surges (such as support to the Contact Tracing service).

** Please note that a number of minor roundings may appear througout this report.*
** PHA Direct Programme includes amounts which may transfer to Trusts later in the year*

October 2021

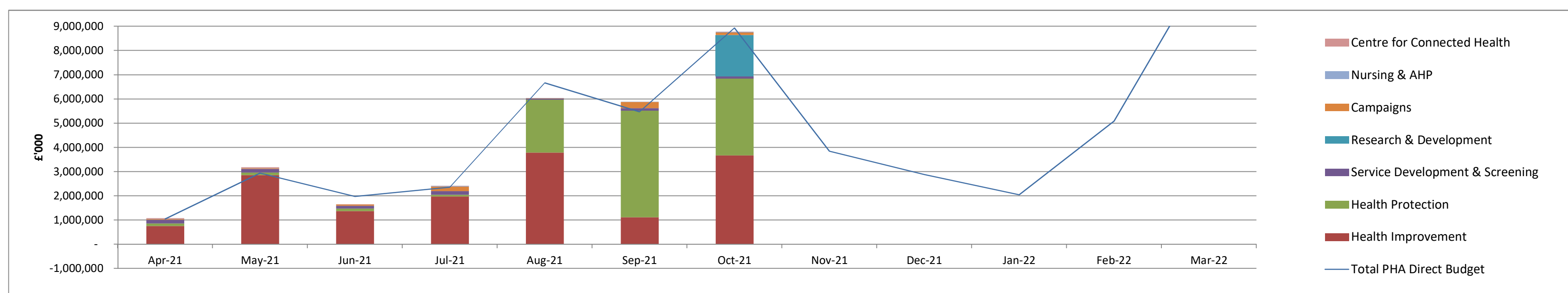
Programme Expenditure with Trusts



Current Trust RRLs	Belfast Trust £'000	Northern Trust £'000	South Eastern Trust £'000	Southern Trust £'000	Western Trust £'000	Total Planned Expenditure £'000	YTD Budget £'000	YTD Expenditure £'000	YTD Surplus / (Deficit) £'000
Health Improvement	5,274	2,454	1,425	1,525	1,179	**11,857**	6,917	6,917	-
Health Protection	1,773	1,729	1,148	1,429	1,239	**7,317**	4,268	4,268	-
Service Development & Screening	4,985	2,851	781	1,864	2,696	**13,177**	7,686	7,686	-
Nursing & AHP	1,483	751	643	1,223	1,026	**5,150**	3,004	3,004	-
Centre for Connected Health	375	434	298	118	338	**1,563**	912	912	-
Total current RRLs	**13,891**	**8,219**	**4,295**	**6,158**	**6,478**	**39,064**	**22,788**	**22,788**	-
Cumulative variance (%)									***0.00%***

The above table shows the current Trust allocations split by budget area. Budgets have been realigned in the current month and therefore a breakeven position is shown for the year to date as funds previously held against PHA Direct budget have now been issued to Trusts.

PHA Direct Programme Expenditure



	Apr-21 £'000	May-21 £'000	Jun-21 £'000	Jul-21 £'000	Aug-21 £'000	Sep-21 £'000	Oct-21 £'000	Nov-21 £'000	Dec-21 £'000	Jan-22 £'000	Feb-22 £'000	Mar-22 £'000	Total £'000	YTD Budget £'000	YTD Spend £'000	Variance £'000	
Profiled Budget																	
Health Improvement	884	2,625	1,357	1,788	4,478	740	3,937	1,901	1,081	754	4,347	4,512	**28,405**	15,809	15,533	276	*1.7%*
Health Protection	77	100	87	85	2,142	4,476	3,085	1,677	1,475	513	100	891	**14,707**	10,051	10,144	(93)	*-0.9%*
Service Development & Scree	51	158	470	192	29	235	102	130	244	253	142	1,996	**4,002**	1,237	1,097	140	*11.3%*
Research & Development	-	-	-	-	-	-	1,700	-	-	-	-	1,511	**3,211**	1,700	1,700	-	*0.0%*
Campaigns	10	10	20	227	10	5	19	83	22	444	223	349	**1,421**	301	680	(379)	*-125.9%*
Nursing & AHP	4	22	4	1	10	0	56	20	50	72	31	2,982	**3,253**	99	81	17	*17.6%*
Centre for Connected Health	20	20	43	11	5	4	5	5	11	10	175	18	**326**	108	83	25	*23.3%*
Quality Improvement	-	-	-	58	-	7	34	31	1	-	66	3	**200**	98	-	98	*100.0%*
Other	-	-	-	-	-	-	-	-	-	-	-	(473)	**(473)**	-	-	-	*100.0%*
Total PHA Direct Budget	**1,046**	**2,935**	**1,981**	**2,363**	**6,674**	**5,467**	**8,938**	**3,847**	**2,883**	**2,045**	**5,084**	**11,788**	**55,052**	**29,404**	**29,320**	**84**	
Cumulative variance (%)																***0.28%***	
Actual Expenditure	**1,128**	**3,228**	**1,693**	**2,462**	**6,060**	**5,924**	**8,824**	**-**	**-**	**-**	**-**	**-**	**29,320**				
Variance	**(82)**	**(293)**	**288**	**(98)**	**613**	**(456)**	**113**						**84**				

The year-to-date position shows a small underspend position of approximately £0.1m. There are a number of overspends and underspends at present netting off to create the underspend at this point in the financial year. The Campaigns areas is showing a significant overspend position at present due to prioritisation of a number of urgent media campaigns, however this is a timing issue only and the budget is expected to achieve a breakeven position for the year.

The negative budget in the Other line is due to a planned over-commitment of the Programme budget agreed at the start of the year to absorb anticipated underspends in the Administration budget.

October 2021

Public Health Agency
2021-22 Ringfenced Position

	Annual Budget				Year to Date			
	Covid £'000	Transformation £'000	Other ringfenced £'000	Total £'000	Covid £'000	Transformation £'000	Other ringfenced £'000	Total £'000
Available Resources								
DoH Allocation	8,539	272	258	**9,069**	4,612	-	9	**4,621**
Assumed Allocation	-	-	166	**166**		-	83	**83**
Total	8,539	272	424	**9,236**	4,612	-	92	**4,704**
Expenditure								
Trusts	535	-	-	**535**	312	-	-	**312**
PHA Direct	8,504	272	424	**9,200**	4,600	-	92	**4,692**
Total	9,039	272	424	**9,736**	4,912	-	92	**5,004**
Surplus/(Deficit)	**(500)**	**-**	**-**	**(500)**	**(300)**	**-**	**-**	**(300)**

PHA has received a COVID allocation of £8.5m to date, £5.0m of which is for Contract Tracing. PHA is working with DoH to assess the costs of expanding the Contact Tracing service, and further funding is expected for this. More detail on the COVID funding allocations PHA has received is provided in page 9 of this report.

Transformation funding has been received for a Suicide Prevention project totalling £0.3m. This project is being monitored and reported on separately to DoH, and it is assumed that any underspends identified will be retracted by DoH and a breakeven position will be achieved for the year.

Other ringfenced areas include Safe Staffing and EITP. Staff are presently being recruited regarding Safe Staffing and it is assumed that any underspends identified will be retracted by DoH and a breakeven position will be achieved for the year.

PHA Administration

2021-22 Directorate Budgets

	Nursing & AHP £'000	Quality Improvement £'000	Operations £'000	Public Health £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000
Annual Budget								
Salaries	4,962	582	2,990	15,792	252	365	505	**25,447**
Goods & Services	159	10	1,129	325	76	42	266	**2,007**
Total Budget	**5,120**	**593**	**4,119**	**16,117**	**328**	**407**	**771**	**27,454**
Budget profiled to date								
Salaries	2,836	339	1,743	9,155	147	213	294	**14,728**
Goods & Services	93	5	659	191	36	24	163	**1,171**
Total	**2,929**	**344**	**2,402**	**9,347**	**183**	**237**	**457**	**15,899**
Actual expenditure to date								
Salaries	2,444	292	1,513	9,235	179	227	297	**14,186**
Goods & Services	66	50	701	74	31	13	20	**956**
Total	**2,510**	**342**	**2,214**	**9,309**	**210**	**240**	**317**	**15,142**
Surplus/(Deficit) to date								
Salaries	392	48	230	(79)	(32)	(15)	(3)	**542**
Goods & Services	26	(46)	(42)	117	4	11	143	**215**
Surplus/(Deficit)	**419**	**2**	**188**	**38**	**(27)**	**(3)**	**140**	**757**
Cumulative variance (%)	*14.30%*	*0.62%*	*7.82%*	*0.41%*	*-15.03%*	*-1.31%*	*30.70%*	***4.76%***

PHA’s administration budget is showing a year-to-date surplus of £0.8m, which is being generated by a number of long standing vacancies along with the impact of many staff continuing to work primarily from home. This is driving reduced expenditure in areas such as travel and courses. Senior management continue to monitor the position closely in the context of the PHA's obligation to achieve a breakeven position for the financial year. The full year surplus is currently forecast to be £1.1m.

The SBNI budget is ringfenced and any underspend will be returned to DoH prior to year end.

Public Health Agency
2021-22 Capital Position

	Capital Resource Limit (CRL) £'000	Year to Date Expenditure £'000	Full Year Forecast Expenditure £'000	Forecast Surplus / (Deficit) £'000
HSC Research & Development				
R&D - Other Bodies	5,092	1,196	5,092	-
R&D - Trusts	7,898	4,778	7,898	-
R&D - Capital Receipts	(350)	-	(350)	-
	12,640	**5,974**	**12,640**	**-**
CHITIN Project				
CHITIN - Other Bodies	2,176	49	2,176	-
CHITIN - Trusts	262	-	262	-
CHITIN - Capital Receipts	(2,439)	-	(2,439)	-
	-	**49**	**-**	**-**
Total R&D Position	**12,640**	**6,023**	**12,640**	**-**
Other PHA Capital				
ICT	92	-	92	-
Total Other Capital Position	**92**	**-**	**92**	**-**
Total PHA Capital Position	**12,732**	**6,023**	**12,732**	**-**

The PHA's opening Capital Resource Limit (CRL) of £12m relates to the regional allocation for HSC Research & Development (R&D). This is managed through the R&D Division within PHA, and funds essential infrastructure for research such as information databanks, tissue banks, clinical research facilities, clinical trials units and research networks. The element relating to 'Trusts' is allocated throughout the financial year, and the allocation for 'Other Bodies' is used predominantly within universities – both allocations fund agreed projects that enable and support clinical and academic researchers.

CHITIN (Cross-border Healthcare Intervention Trials in Ireland Network) is a unique cross-border partnership between the Public Health Agency in Northern Ireland and the Health Research Board in the Republic of Ireland, to develop infrastructure and deliver Healthcare Intervention Trials (HITs). The CHITIN project is funded from the EU's INTERREG VA programme of €8.84m, and the funding for each financial year from the Special EU Programmes Body (SEUPB) matches expenditure claims, ensuring a breakeven position.

There is also currently a small allocation of £92k for ICT capital expenditure within PHA.

PHA Prompt Payment

Prompt Payment Statistics

	October 2021 Value	October 2021 Volume	Cumulative position as at October 2021 Value	Cumulative position as at October 2021 Volume
Total bills paid (relating to Prompt Payment target)	£14,249,406	627	£45,505,252	3,952
Total bills paid on time (within 30 days or under other agreed terms)	£10,176,661	618	£41,353,828	3,893
Percentage of bills paid on time	**71.4%**	**98.6%**	**90.9%**	**98.5%**

Prompt Payment performance for October shows that PHA achieved the 95.0% on volume but was substantially below the target on value. The year to date shows that on value PHA is achieving its 30 day target of 95.0% but on value it has fallen to 90.9%. The fall in October was due to a delay in paying Flu Vaccine Invoices of £3.9m. Prompt payment targets will continue to be monitored closely over the 2021-22 financial year.

The 10 day prompt payment performance remains very strong at 89.7% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2021-22 of 70%.

PHA COVID-funded Expenditure to Month 7

	Annual Budget £'000	Spend to 30 October 2021 £'000	Balance to Spend at 30 October 2021 £'000	*Notes*
Contact Tracing Centre	5,028	4,115	913	*1*
Screening	560	-	560	
Vaccine Roll Out Programme	595	409	186	
Infection Prevention Control Nursing	550	312	238	
NI Advanced Care Planning	450	9	441	
AHP Elective Care Support	41	-	41	
Band 8s Overtime	50	-	50	
Respiratory / ICU Surge Support Team	93	-	93	
Care home outreach support	61	-	61	
Schools Support Team	116	67	49	
Additional Flu Response	573	-	573	
HSCQI	150	-	150	
Vaccine Data Science Support	272	-	272	
	8,539	**4,912**	**3,629**	

Notes

1. *A business case reflecting the estimated Covid funding requirement for the Contact Tracing Centre has been prepared and being internally approved before submission to DoH. DoH colleagues have been appraised of the additional revenue requirement and funding identified, subject to the necessary approvals.*

HSC Public Health Agency

minutes

Title of Meeting	Meeting of the Public Health Agency Governance and Audit Committee
Date	7 October 2021 at 10am
Venue	12/22 Linenhall Street

Present

Mr Joseph Stewart	-	Chair *(via video link)*
Ms Deepa Mann-Kler	-	Non-Executive Director *(via video link)*

In Attendance

Mr Stephen Wilson	-	Interim Director of Operations
Ms Karen Braithwaite	-	Senior Operations Manager (Delivery) *(via video link)*
Ms Tracey McCaig	-	Interim Director of Finance, HSCB *(via video link)*
Mr David Charles	-	Internal Audit, BSO *(via video link)*
Mr Roger McCance	-	NIAO *(via video link)*
Mr Robert Graham	-	Secretariat

Apologies

Mr John Patrick Clayton	-	Non-Executive Director
Ms Andrea Henderson	-	Assistant Director of Finance, HSCB
Ms Jane Davidson	-	Head Accountant, HSCB
Ms Christine Hagan	-	ASM

		Action
39/21	**Item 1 – Welcome and Apologies**	
39/21.1	Mr Stewart welcomed everyone to the meeting. Apologies were noted from John Patrick Clayton, Ms Andrea Henderson, Ms Jane Davidson and Ms Christine Hagan.	
40/21	**Item 2 - Declaration of Interests**	
40/21.1	Mr Stewart asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	
41/21	**Item 3 – Minutes of previous meeting held on 11 June 2021**	
41/21.1	The minutes of the previous meeting, held on 11 June 2021 were **approved** as an accurate record of that meeting.	

42/21 **Item 4 – Matters Arising**

31.21/5 Contact Tracing Service IA Recommendation

42/21.1 Mr Stewart advised that the PHA Chair has written to the Deputy Chief Medical Officer regarding the recommendation in the audit on the contact tracing service about the relationship between the PHA Board and the Department, and also roles and responsibilities. He said that a response is awaited.

31/21.8 Workforce Plan

42/21.2 Mr Stewart reported that he has raised this matter with the PHA Chair who will in turn raise it with the Chief Executive. He added that he had invited the Chief Executive to today's meeting, but he was unable to attend due to speaking commitments at the NICON conference.

43/21 **Item 5 – Chair's Business**

43/21.1 Mr Stewart said that with regard to the future finance function post the closure of HSCB, PHA had received a letter from the Permanent Secretary and that that the correspondence was not satisfactory. He explained that while the Permanent Secretary was content for a Director of Finance for PHA to recruited, no additional staff resources would transfer to PHA and these would be subsumed within the new Group.

43/21.2 Mr Stewart said that he and the PHA Chair had met with Ms Martina Moore and the Chief Executive and that the Chief Executive will discuss this matter with the Chief Executive of HSCB to determine what interim arrangement can be put in place before responding to the Permanent Secretary's letter. He noted that none of the potential options outlined in the paper to the Minister were met in the correspondence, hence further discussion is needed. Ms McCaig assured members that she and the Chief Executive are striving to come up with options and that work is continuing.

43/21.3 Ms Mann-Kler asked if there was awareness of the reasons behind the Permanent Secretary's outlined approach. Mr Stewart suggested that PHA may be more successful if it put forward its own proposals. However, he expressed concern that one of the reasons was that there is no money for the additional resources, but in his view, the total cost of this would be in the region of £300k-£400k which is small in the context of the overall HSC budget. Ms Mann-Kler said that without an understanding of the reasons, it is likely that any

further proposals will be knocked back. She asked if there was an opportunity to do any work behind the scenes. Ms McCaig said that she felt that the Permanent Secretary was trying to be helpful and that any reasonable options will be considered, but funding is an issue. She said that she remained positive about a solution being found. She added that she will be reviewing the options and meeting with Mrs Paula Smyth to discuss this and reiterated that she was confident that if PHA submitted a proposal the Department would work with them.

43/21.4 Mr Stewart advised that following the last meeting, the Non-Executive Directors had held a separate meeting with representatives from Internal and External Audit and that this was a positive and useful meeting.

44/21 Item 6 – Internal Audit

Progress Report [GAC/29/10/21]

44/21.1 Mr Charles advised that as at 1 September 2021, Internal Audit had delivered 20% of its audit days and had issued 100% of draft reports within four weeks, and that one of these reports was finalised within five weeks of issue. He said that he was presenting two reports today, one on the recruitment of vaccinators, and the other being the mid-year follow up. He added that fieldwork has commenced on two further audits, one on performance management and one on board effectiveness. He said he was confident that by the end of the year Internal Audit will have delivered on its work programme.

44/21.2 Mr Charles moved onto the report about the audit on the recruitment of vaccinators which had been undertaken following a request by the Committee.

44/21.3 Mr Charles advised that the governance arrangements for the vaccination programme sit with the Department of Health with the Chief Medical Officer (CMO) as the Senior Responsible Officer (SRO). He added that a number of groups were set up to oversee the establishment and rollout of the vaccination programme with a number of PHA staff working in those groups. Given the immediate need to recruit staff, he explained that the “Hirelab” model of recruitment was used with 582 staff recruited. He reported that in January 2021 the primary care model for vaccination delivery commenced and the timeline from that point on is contained within the report.

44/21.4 Mr Charles reported that a satisfactory level of assurance

was being provided for this audit. He said that there was a recognition that this work was not in line with PHA's statutory functions, but under the direction of the Department with subsequent correspondence from the Department confirming this. He noted that once PHA had begun to recruit vaccinators and had identified the challenges of doing so, it took a number of steps including transferring recruited vaccinators to HSC Trusts. Following receipt of the correspondence from the CMO directing PHA to carry out this work, he advised that a governance framework was developed, and engagement commenced with the Directorate of Legal Services (DLS) which resulted in the development of a Placement Agreement for GP practices that clarified the roles of responsibilities of PHA and the GP practices in terms of issues such as liability and indemnity. He noted that when the Department approached the Assistant Director of Nursing to commence this work in November 2020, the matter was not reported to the Agency Management Team (AMT) until January 2021 and the PHA Board was not informed until February 2021. He said that when requests of this nature are made, there should be a requirement that the AMT and Board are property briefed so that there is visibility and transparency.

44/21.5 Mr Charles said that when the recruitment of vaccinators commenced PHA should have approached other agencies and sought advice from DLS which may have mitigated some of the risks. He noted that when staff were recruited, one of the ways in which the risks were mitigated was through the development of the Placement Agreement which defined roles and responsibilities and clarified the liabilities and indemnities. However, he reported that of the 75 GP practices that these Agreements had been sent to, only 28 had returned them at the time of the audit, but he understood this number had now increased to 60.

44/21.6 Mr Charles advised that Volunteer Now, Ulster GAA and the British Red Cross had provided volunteers at the vaccination centres to help with patient flow. He said that while PHA had paid monthly invoices, he felt that there could be further controls to ensure the spend was appropriate through, for example, the use of signing in and signing out sheets and timesheets. In terms of other key findings, he reported that from a sample of payments to 20 vaccinators, 18 of these were incorrect as they had been underpaid and a small number of dentists had been paid at the Agenda for Change Band 5 rate rather than the medical and dental rate. He noted that while there were regional agreements in place, there are differences in the pay rates. He also reported that at present PHA does not have procedures in place regarding

the equitable allocation of vaccinators to GP practices.

44/21.7 Mr Charles reported that management had accepted all of the recommendations and that these would be followed up at the year end.

44/21.8 Mr Stewart thanked Mr Charles for the report. He said that it was a significant report for PHA and its Board in terms of its relationship with the Department. He added that he had discussed the findings with Mr Charles and Mrs Catherine McKeown earlier this week and invited Ms Mann-Kler to make any comments that she had.

44/21.9 Ms Mann-Kler asked if there had been any discussion in terms of the rating this audit was given as she was surprised that it received a satisfactory level of assurance. Mr Charles explained that the reason it was given this level of assurance was because of the reaction of management when it recognised that there was an issue and that fact that a number of steps were immediately taken, including linking with DLS, developing the Placement Agreements and putting this onto the Corporate Risk Register. He added that a further mitigation was that when over 500 staff were initially appointed, 85% of them were quickly moved off PHA's books which minimised the risk. He said that a series of meetings took place promptly with DLS which resulted in the development of the Placement Agreement which clearly set out the roles and responsibilities for PHA and GP practices and clarified issues around insurance and indemnity. He added that when a sample of 20 vaccinators was taken, it was found that they had all been recruited appropriately and had the right level of qualifications to be able to perform this work. He acknowledged that there was a point at the start where the PHA Board was not sighted on this, but he felt that with the early engagement with DLS, PHA had responded very quickly to mitigate the risks when it became aware that there was an issue.

44/21.10 Ms Mann-Kler said that she still had concerns around governance, oversight and exposure to risk given that PHA was involved in this work from November 2020, but the correspondence from the Department was only received in February 2021, therefore there is a three month gap. She said the fact that the Board had no oversight or knowledge of this instruction that was given to PHA by the Department was significant and that it was such a divergence to the work that PHA would normally do. She expressed surprise as to the length of time it took for AMT to be made aware of the situation.

44/21.11	Ms Mann-Kler noted that at the time of the audit only 20 of the Placement Agreements had been signed, therefore if something had gone wrong, PHA would have been held liable. She added that at present there are still 18 unsigned. She commented that there are still a number of vaccinators on PHA's books and queried their productivity and value for money. She said that she did not understand why PHA was tasked to recruit vaccinators when 85% immediately went to the Trusts where they should have gone in the first place. She expressed concern that this could happen again and that there remains a lack of understanding.
44/21.12	Ms Mann-Kler said that in effect PHA became a nursing agency but there was no regulation or oversight nor was there any discussion about the measures that had to be put in place. She added that she was still unclear about how the initial request happened and she felt that there needs to be a discussion about this with the full Board.
44/21.13	Mr Stewart said that he had hoped that the Chief Executive would be in attendance at today's meeting but that he was unable to be present. He added that he agreed with Ms Mann Kler's comments which mirrored his thoughts exactly said and that this report does need to be discussed at a Board meeting sooner rather than later and suggested that this should happen at the next meeting. He agreed that there should be a clearly agreed process for requests coming from the Department so that everyone is sighted and that this links to some of the findings from the recent report on governance in RQIA in terms of lines of communication. He added that he would be surprised if the Comptroller and Auditor General (C&AG) was not looking at this. He said that there is good guidance in this area issued by the NIAO, but it is difficult for NEDs to adhere to this guidance when these types of matters occur. He suggested that the C&AG should look at how the Department operates. Mr McCance confirmed that this is an area that the C&AG is interested in.
44/21.14	Mr Charles pointed out that the first recommendation in the report is about the need to ensure that when requests come in from the Department there needs to be a mechanism where the Chief Executive, AMT and Board are all informed. He said that formalising this will ensure that AMT and NEDs find out about such requests more quickly. He referred to the audit on contact tracing where there was a similar recommendation for the PHA Chair to engage with the CMO to get clarity about roles and responsibilities. He said that he had gone through the rationale for why a satisfactory level of assurance had been given, but referred to the fact that a meeting took place on 3 March between DLS and the

	then Interim Chief Executive. He added that the spend for PHA was relatively low, which also helped support the level of assurance.	
44/21.15	Mr Stewart said that the status of the Placement Agreements needs to be clarified in terms of how many staff are employed under them, how many are not signed and where the liability lies.	
44/21.16	Mr Wilson undertook to get the information on the status of the Placement Agreements. He said that while he did not wish to gloss over the important issues that were being highlighted, he felt that some context was important. He explained that at that time there was considerable programme of activity taking place in relation to contact tracing with the number of cases escalating and the PHA was facing criticism so there was a focus on stepping up the resource in the contact tracing centre. He added that the governance of the vaccination programme was seen as a matter for the Department and while that does not excuse what happened, he said that an honest mistake had been made and once the issue was raised, the then Interim Chief Executive took steps as she recognised the seriousness of the situation. He said that this report should be brought to the Board for a full and frank discussion as there are lessons to be learnt and taken on board by AMT and then cascaded throughout the organisation.	Mr Wilson
44/21.17	Mr Stewart said that fundamentally this was seen as an informal request for PHA to act outside its statutory remit and as far as PHA's legal position is concerned he said that he is not satisfied that PHA is in the clear. He noted that correspondence had been received from the Department setting out its view but it stated that PHA should seek its own legal opinion. He commented that this matter has now been ongoing for a year and PHA still cannot say whether it should have been doing this work or not. He agreed to follow this up with the PHA Chair and Chief Executive.	Mr Stewart
44/21.18	Ms Mann-Kler thanked Mr Charles and Mr Wilson for their comments and said that she appreciated the context and the pressure that PHA was working under and the need to respond to this request. She added that she felt assured that PHA is looking at this and she supported the view that PHA needed to obtain its own legal advice. She asked how PHA could share the learning from this report with the Department. Mr Stewart said that he had discussed this with the Chief Executive and advised that the Chief Executive holds weekly meetings with the CMO so there may be an opportunity through those meetings. He	

	proposed that at the next Board meeting he would ask the Chief Executive how he intends to take this forward. Ms McCaig suggested that the learning could be shared through the Sponsor Branch as there are ongoing arrangements in place there.	Mr Stewart
44/21.19	Mr Stewart brought the discussion to a close and said that this should be discussed at the Board meeting next week.	
44/21.20	Members noted the Progress Report.	
	Mid-Year Follow up on Outstanding IA Recommendations 2021/22 [GAC/30/10/21]	
44/21.21	Mr Charles advised that a follow up on outstanding audit recommendations is carried out twice a year and the most recent exercise showed that of 52 recommendations, 38 were fully implemented, 13 were partially implemented with 1 not yet implemented. He referred to the table outlining those recommendations which are either partially, or not yet implemented and advised that the oldest relates to the procurement of contracts with voluntary sector organisations. He noted that COVID-19 has slightly delayed procurement processes.	
44/21.22	Mr Charles reported that there are three recommendations relating to population screening programmes which are not yet implemented and these relate to the quality assurance (QA) of newborn screening, a programme of QA visits for newborn screening programmes and an overarching framework for all screening programmes where there are standardised policies and procedures. Again, he cited COVID-19 as a reason for some of this work not yet being completed.	
44/21.23	Mr Charles said that within information governance work is still required to ensure that contracts are GDPR compliant, but he was aware that a new member of staff has been recruited. He advised that from the audit of the contact tracing service, there is an outstanding recommendation that the PHA Chair should get clarity on reporting arrangements, but he understood that following a telephone conversation he had with the PHA Chair last week that an e-mail has been sent to the Department this week.	
44/21.24	Mr Stewart noted that the recommendation on policies and procedures on rota and timesheet management has not yet been implemented. Mr Charles reported that at the time of fieldwork, this had not been taken forward as preparations were ongoing for the fourth surge. Mr Stewart said that not	

having these policies and procedures in place at a time of surge could make the situation worse and added that he would raise this with the responsible officer at the Board meeting.

Mr Stewart

44/21.25 Mr Stewart asked if there was any prospect of progress with the procurement issues. Mr Wilson explained that at the time a new senior planning manager was recruited to focus on this work, but he has been seconded to support the contact tracing centre. Furthermore, he said that there is a number of contracts that need to be progressed, but the health improvement staff involved are also helping to support contact tracing. However, he advised that staff are beginning to be repatriated to their core functions and that he has been talking to Mr Stephen Murray about how to progress this work. Mr Stewart asked about the Procurement Board. Mr Wilson confirmed that the Procurement Board still meets and that PHA will aim to review and revise its work programme in this area and progress work as soon as possible.

45/21 Item 7 – Corporate Governance

HSCQI Directorate Risk Register [GAC/35/10/21]

Dr Aideen Keaney and Ms Dawn Clarke joined the meeting for this item.

45/21.1 Mr Stewart welcomed Dr Keaney to the meeting and thanked her for taking time away from the NICON conference to present this risk register. Dr Keaney said that this was the first time her directorate has had an opportunity to come to the Governance and Audit Committee. She advised that HSCQI is a small team and does not have a planning and project manager so she thanked Ms Clarke for her work in compiling this risk register.

45/21.2 Dr Keaney advised that there are presently five risks on the directorate risk register, two of which are rated as “medium” and three as “high”. She said that the biggest risk relates to staffing. She explained that when HSCQI was formed, staff came from the legacy Safety Forum, but some posts, including her own, were not funded recurrently, but her post is now permanent. She added that a number of posts were identified as being required for the hub team but issues of funding still remain. She said that following the resignation of the Clinical Director a reconfiguration was done, but she continues to work with the Chief Executive and the Director of Finance to work out the best way forward.

45/21.3	Dr Keaney said that there is an HSCQI Alliance, but it is currently in transition with the previous chair having retired, and it is due to meet in November. She said that without support staff, HSCQI's ability to respond is more difficult.
45/21.4	Dr Keaney advised that there is a risk regarding accommodation. She explained that there had been a business case for HSCQI to have its own accommodation, but with the pandemic, that need is less pressing given the virtual nature of working. Mr Stewart commented that there had been a review of accommodation and he asked Dr Keaney if HSCQI's requirements were inputted into that review. Dr Keaney said that they were and it was highlighted as a priority in that report.
45/21.5	Dr Keaney explained that in terms of finance, there is a risk for HSCQI because its programme of work relies on non-recurrent funding and it would be beneficial to have stability. However, she said that she has been liaising with Mr Murray and Mr Andrew Dawson in the Department, and through Ms McCaig, bids have been submitted for HSCQI work aligned to some of the 17 Ministerial priorities.
45/21.6	Dr Keaney said that there is a risk in relation to performance and service improvement. She explained that HSCQI would work with QI leads within the HSC, but with Trusts having competing priorities, their ability to collaborate with HSCQI can be limited at times. However, she hoped that this could be improved through the work of the Alliance.
45/21.7	Dr Keaney advised that HSCQI has worked with an external company on the development of its own website which is being launched at the NICON conference later this morning, therefore this risk may come off the register.
45/21.8	Mr Stewart said that staffing is the main issue for HSCQI and the inability to fully resolve those issues is the biggest concern.
45/21.9	Ms Mann-Kler thanked Dr Keaney for coming to today's meeting. She asked if the right people in the HSC understand the importance of QI work, and if there is anything that the PHA Board can do to help. Dr Keaney said that the role of the Alliance is crucial but noted that it is going through a period of transition with a new Chair coming in. She added that the other key person is Mr Andrew Dawson and she will ensure that he is kept sighted. In terms of PHA Board support, she welcomed that the Board has given HSCQI profile and space to present at meetings and asked that they maintain this interest. She said that she

	would welcome the Board's participation in QI training and awareness which will be taken forward as part of the new PHA Corporate Strategy. Ms Mann-Kler said that she would like to have the opportunity to learn more about that.
45/21.10	Mr Stewart thanked Dr Keaney and Ms Clarke for their attendance at today's meeting.
	At this point Dr Keaney and Ms Clarke left the meeting.
44/21	**Item 6 – Internal Audit (continued)**
	Mid-Year Follow up on Outstanding IA Recommendations 2021/22 [GAC/30/10/21] (continued)
44/21.26	Ms McCaig returned to the discussion on the need to implement the recommendation regarding procedures for rotas and timesheets in the contact tracing centre. She said that as Director of Finance she would wish to see that issue resolved as soon as possible, but she appreciated the circumstances within which PHA is working.
44/21.27	Ms McCaig noted that implementation of 77% of recommendations is not the position in which PHA would normally expect to find itself so there is a need for some focus on this area once staff return to normal working practices. Mr Charles said that from carrying out follow up review across all the Trusts, there has been a struggle in terms of progressing the implementation of audit recommendations, and although there is a link to COVID-19, it is important that recommendations are implemented to enhance the control environment. Mr Stewart acknowledged that without staff it is difficult, but if staff are too busy delivering a service and controls aren't seen as important, then that is a different situation. Ms McCaig commented that if problems are not fixed now, they will escalate further down the line.
44/21.28	Members noted the Mid-Year Follow up on Outstanding IA Recommendations 2021/22
	Shared Services Audits [GAC/31/10/21]
44/21.29	Mr Charles advised that a satisfactory level of assurance had been given following the most recent audit of accounts payable, a service on which PHA is reliant. He said that controls are operating as designed for both POP and FPM invoice management and there was no significant diminution of controls with staff working from home.

44/21.30	Ms McCaig said that while she was happy to see that a satisfactory level of assurance had been given, she had seen the full report and there was a number of recommendations that had been made, and it was not the first time these recommendations had been made. She advised that she has asked her team to respond, but noted that she did not see anything that would impact significantly on PHA business. She added that she would also raise this at the next meeting of the Assistant Director group.
44/21.31	Members noted the Shared Services Audits.
	Mid-Year Assurance Statement to the Public Health Agency from the Head of Internal Audit [GAC/32/10/21]
44/21.32	Mr Charles said that the Mid-Year Assurance Statement summarised the audits that have already been discussed at today's meeting.
44/21.33	Members noted the Mid-Year Assurance Statement to the Public Health Agency from the Head of Internal Audit.
	Internal Audit General Report [GAC/33/10/21]
44/21.34	Mr Charles said that this Report is a summary of the totality of Internal Audit work across the HSC in 2020/21. He commented that due to COVID-19 it was a unique year and in the first quarter Internal Audit effectively stood down from assurance work and did more consultancy work.
44/21.35	Mr Charles reported that the majority of assurances provided across all audits in the HSC were satisfactory and this figure had increased from 2019/20. He suggested that a reason for this may have been that there were less audits in patient facing areas as traditionally new work areas would have more limited assurances. He advised that the main areas where limited assurances were provided were consistent with previous years, e.g. payments to staff and management of systems. He advised that the number of priority one recommendations was less than in previous years.
44/21.36	Mr Charles said that Internal Audit carried out more non-assurance work, helping out with fraud risk assessments, assurance templates and work with nursing homes and domiciliary care organisations.
44/21.37	Mr Charles noted that there was a slight drop in the percentage of fully implemented audit recommendations. He advised that 2,136 recommendations had been fully

	implemented, 834 partially implemented and 30 not implemented. Of those not implemented, he said that 3% relate to 2016/17 with the vast majority relating to 2019/20.	
44/21.38	Mr Stewart commented that from his experience, if a date for implementation is agreed by management then management should be aiming to work towards that date and by not doing so, they are failing to meet their own target. He said that there is a lot of learning from this Report and suggested that it would be useful to share it with the PHA Board as a whole.	Mr Stewart
44/21.39	Members noted the Internal Audit General Report.	
45/21	**Item 7 – Corporate Governance (continued)**	
	Corporate Risk Register (at 30 June 2021) [GAC/34/10/21]	
45/21.11	Mr Wilson advised that this Corporate Risk Register reflects the position as at 30 June 2021. He acknowledged that the Committee is now considering this three months later and therefore there is a need to review the scheduling of meetings to ensure more timely updates. He said that there have not been many significant changes to the Register and at AMT last week, it was agreed that there will be a thorough review of the Register to see how some of the older actions can be progressed. He advised that in this review, one new risk has been added which relates to the Lifeline information management system, and that one risk, that relating to COVID-19 allocations, has had its rating reduced from "medium" to "low".	
45/21.12	Mr Stewart said that on the basis that the information in the Register is out of date he proposed not going through each risk individually, but he asked for more information about the new risk given that Lifeline was an issue that had previously exercised the Board.	
45/21.13	Mr Wilson advised that when the Lifeline service was TUPE'd over from the previous provider to the Belfast Trust there was always an issue about the information management system, and this has been under discussion for some time. He said that the key issue at present is that the current platform is longer supported and while there is a Direct Award Contract in place with Etain who support the system, there is a need to look at options during the period before it can be moved onto the Encompass platform. He said that PHA, ITS and Etain are looking at options.	
45/21.14	Mr Stewart asked if there is a target date for Encompass,	

	but Mr Wilson said that he was not aware of a target date, and that it is the subject of discussions. He said that there would be more information available following the next review of the Register. He advised that he had spoken to Ms Fiona Teague who informed him that a new member of staff has been brought in to lead on this work, but she is helping to support contact tracing.	
45/21.15	Mr Stewart said that because of the constant references during the meeting to staff being unable to take forward work because they are supporting contact tracing, he would be asking the Chief Executive for a full update on when staff would be repatriated to their normal duties. Mr Wilson advised that this has already been discussed at AMT and the aim is to have all staff repatriated by the end of October, and that a prioritisation process is currently being agreed.	
45/21.16	Ms Mann-Kler asked why this new risk is only appearing on the Register now when it appears to have been an issue since October 2018. Mr Wilson explained that it is because there is now an issue in terms of a lack of support for the platform. Ms Mann-Kler asked if there is any risk to people who use the system. Mr Wilson said he needed more information and undertook to provide a further update at the Board meeting.	Mr Wilson
45/21.17	Members **APPROVED** the Corporate Risk Register as at 30 June 2021.	
46/21	**Item 8 – Update from External Audit**	
	Report to those Charged with Governance [GAC/36/10/21]	
46/21.1	Mr McCance said that members have seen the draft Report to those Charged with Governance which confirmed that PHA's accounts had been certified with an unqualified audit opinion and no recommendations. He extended his thanks to the Finance team for their help during the audit.	
46/21.2	Mr Stewart thanked Mr McCance on behalf of the Committee and said that he was pleased to have NIAO support on a range of matters.	
46/21.3	Members noted the Report to those Charged with Governance.	
	NIAO Report into the Provision of Mental Health Services in Northern Ireland	
46/21.4	Mr McCance noted that the Committee has not always had	

sight of NIAO Reports and he delivered a presentation on two recent Reports, one on Addiction Services, and one of Workforce Planning for Nurses and Midwives.

46/21.5 Beginning with the Report on Addiction Services which was published in June 2020, Mr McCance said that there were several key messages. He advised that the level of harm caused by substance abuse is rising, as is the cost to treating it with no budget to meet the costs, resulting in poor outcomes for service users. He said that there has been a significant increase in the number of drug-related deaths. He added that the cost to the public sector of alcohol misuse is approximately £900m, of which approximately 25% is to the HSC. He reported that in contrast, the spend to treating addiction is low, at £16m.

46/21.6 Mr McCance reported that there were concerns about some of the data as the Substance Misuse database has only been published once so this raised questions as to how a determination can be made about whether expenditure in this area represented value for money. He advised that the waiting list target is 9 weeks in Northern Ireland but some Trusts have found it difficult to meet this target. He added that the number of alcohol-related deaths in Northern Ireland in 2017 was 17.4 per 100,000 population which is an increase from 12.2 in 2013.

46/21.7 Mr McCance advised that the number of deaths related to prescription drug misuse is also increasing which raises issues for the HSC as pharmacies are prescribing higher amounts of diazepam in Northern Ireland compared to other UK regions. He added that the number of pregabalin prescriptions is also increasing.

46/21.8 Mr McCance said that there needs to be a joined up approach to tackle these issues as the costs are becoming unsustainable. He felt that there should be a focus on the impact that services can have on people's lives.

46/21.9 Mr McCance moved onto the Report on Workforce Planning for Nurses and Midwives. He commented that the demand for care is rising significantly and that workforce planning needs to be a long term process. He added that the population is ageing and there is a growing number of people with long terms conditions. However, he reported that there are more than 2,000 nursing vacancies across Northern Ireland which represents 11% of the workforce. He said that a saving of £1m has been made by reducing the number of nursing training places but this has resulted in an increased spend on temporary and agency nurses, hence

	the need for longer term planning. He noted that a similar culture to that of working as a locum doctor is now being seen within nursing.	
46/21.10	Mr McCance pointed out that the ageing nursing workforce means that the percentage of staff who will leave their posts within the next five years is increasing. He said that although a new Strategy was launched in 2018 it takes several years to become a fully trained nurse, and therefore transformation is essential.	
46/21.11	Mr McCance gave members an overview of other health-related areas where NIAO is carrying out review work, including mental health services, PPE, pre-school immunisation, waiting lists and smoking. He advised that the Reports on PPE and pre-school immunisation are currently with the Department. He explained that the programme of work is reviewed twice a year.	
46/21.12	Mr McCance advised that the Report on Addiction Services will be the subject of a Public Accounts Committee Inquiry and that later this month the Permanent Secretary and CMO will be attending that Committee.	
46/21.13	Mr Stewart thanked Mr McCance for the presentation and expressed his frustration at the short term thinking and incorrect assessment of what is value for money.	
46/21.14	Ms Mann-Kler said that so many of these reports affect the work of PHA and that there are valuable lessons. She asked how it ties in with the work of the PHA Board. Mr Stewart suggested that Reports could be shared with Mr Graham who could circulate them to members.	
46/21.15	Ms Mann-Kler asked why the some of the data in the Addiction Services report only goes up to 2017. Mr McCance explained that the fieldwork for this Report was carried out prior to COVID-19 and some of the figures were based on the latest data that was available from NISRA. He added that it is a dynamic situation and there has been a new Strategy. In terms of learning, he said that any learning is put into Circulars which are sent to HSC bodies by the Department, but he was content to share other Reports with PHA. Mr Stewart suggested that the slides from today's meeting could be shared with the wider Board and could provoke some discussion at its next meeting. He added that the Committee would wish to be kept informed about the C&AG's Reports.	Mr McCance / Mr Graham

47/21	**Item 9 – PHA Mid-Year Assurance Statement [GAC/37/10/21]**
47/21.1	Mr Stewart said that the Mid-Year Assurance Statement was being presented for approval. Mr Wilson pointed out that was some repetition in the document that needed to be amended.
47/21.2	Subject to amendment, members **APPROVED** the Mid-Year Assurance Statement which will be brought to the Board meeting on 21 October.
48/21	**Item 10 – Draft Governance and Audit Committee Self-Assessment [GAC/38/10/21]**
48/21.1	Mr Stewart said that he has reviewed this and asked if members were content to approve.
48/21.2	Members **APPROVED** the Governance and Audit Committee Self-Assessment.
49/21	**Item 11 – SBNI Declaration of Assurance [GAC/39/10/21]**
49/21.1	Mr Stewart said that he had no issues regarding the SBNI Declaration of Assurance.
49/21.2	Members noted the SBNI Declaration of Assurance.
50/21	**Item 12 – Any Other Business**
50/21.1	As there was no other business Mr Stewart thanked members for their attendance and drew the meeting to a close
51/21	**Item 13 – Details of Next Meeting**
	Friday 3 December 2021 at 10:00am
	Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast.
	Signed by Chair:
	Joseph Stewart
	Date: 3 December 2021

HSC Public Health Agency

item 10

Title of Meeting	PHA Board Meeting
Date	16 December 2021
Title of paper	NI Assembly All Party Group on Reducing Harm Related to Gambling Inquiry Report: The Future Regulation of Gambling in Northern Ireland
Reference	PHA/03/12/21
Prepared by	Maurice Meehan
Lead Director	Stephen Bergin
Recommendation	For **Approval** ☐ For **Noting** ☒

1 Purpose

The PHA Board is asked to note the content of this paper relating to the NI Assembly All Party Group on Reducing Harm Related to Gambling. Inquiry Report: The Future Regulation of Gambling in Northern Ireland. Belfast; 2021.

2 Background Information

Problem gambling is considered to be a growing significant health and social issue in Northern Ireland. Northern Ireland has the highest estimated rate of problem gambling at 2.3% compared to other regions in the United Kingdom (1.1% in Wales, 0.7% in Scotland and 0.5% in England) and one of the highest rates when compared internationally with countries which used similar surveys (1).

A stronger focus on prevention and reduction of gambling-related health inequalities across the life-course could reduce gambling harm to the individual and to the wider community. The PHA supports the All Party Group on Reducing Gambling Related Harm commitments.

PHA is not currently mandated by DOH to take forward commissioning priorities on the All Party Group Report and note the likely requirement of further needs assessments, survey prevalence data and research on Gambling Related Harms.

Representation on Addictions Services is the responsibility of HSCB.

3 Key Issues

The PHA has been asked to contribute to an Oral Hearing by the All Party Group on 14th December 2021 and the Board is asked to note the proposed key messages from PHA at this time. These are;

- PHA notes the population health concerns being raised by the All Party Group and the new Report.
- PHA supports increasing policy and research on Gambling Harms at UK and International level (see in paper various sources/references)
- Currently the policy mandate, as specified by DOH policy leads for Mental Health, Substance Use Strategy and Protect Life, for specific PHA commissioning or other interventions does not extend to gambling related harm.
- PHA acknowledge the Department for Communities 2017 NI Survey on Gambling Behaviour, but notes that overall there is currently insufficient NI-level evidence available at this time to inform immediate commissioning, or other interventions by the PHA. This insufficient evidence includes gambling and gambling related harms and prevalence-related data.
- PHA welcomes the recommendation of specific research in this area to inform any subsequent consideration of interventions and actions within HSC and Programme for Government.
- PHA welcomes the emphasis on the responsibility of various government departments to consider the legislation and regulatory implications of gambling related harms.

A more detailed briefing paper is set out below.

Briefing Paper

Gambling Harms

Gambling harms are defined as 'the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society' (2-4). These harms are diverse and can include financial harms, relationship breakdown, psychological distress, decrements to health, cultural harm, reduced performance at work or study and criminal activity. It is not only the gambler who is harmed- it is estimated that approximately six people in their life, most commonly family including children, will also be negatively impacted (5). The scale and nature of these harms are increasingly being recognised (6). The harmful effects from gambling may be short-lived but can persist, having longer term and enduring consequences that can exacerbate existing inequalities. Among children, these harms potentially affect future development and parental gambling can lead to adverse childhood events (ACEs) (7).

The social, environmental, and economic conditions in which people live vary. They contribute to a social gradient in health. The determinants of health together with , legislative and policy developments are fundamental levers that can substantially impact the risk of experiencing gambling harms at a population level, but they exist outside of the control of the individual.

A stronger focus on prevention and reduction of gambling-related health inequalities across the life-course could reduce gambling harm to the individual and also to the wider community. The PHA supports the All Party Group on Gambling Related Harm commitments.

The Institute of Public Health in Ireland suggest in their submission on the All Party Group that Northern Ireland is likely to be particularly vulnerable to the impact of gambling harms due to the high prevalence of mental illness.

Gambling harm exists on a spectrum in relation to mental illness, but at its most severe it can include self-harm and suicide. "There is strong evidence demonstrating the relationship between gambling harms and suicidality, including among young people. A cross-sectional online survey conducted in the UK demonstrated a significant relationship between suicide attempts and problem gambling even after factors like poor wellbeing, substance misuse and impulsivity had been taken into account (12). Those with lived experience of gambling problems often report feeling suicidal as a result of problem gambling. Evidence suggests that a high proportion of those seeking treatment have attempted suicide (13)."

Problem gambling is more common among those with mental ill health, across a broad set of disorders including anxiety and depressive disorders, obsessive compulsive disorder, phobias, panic disorder, eating disorder, psychosis, attention deficit hyperactivity disorder, post-traumatic stress disorder and substance dependency (14). Pathological gambling is the first non-substance addiction recognised as a mental and behavioural disorder in the WHO International

Classification of Diseases (15). Problem gambling can both contribute to the development of mental ill health, and it can also be a behavioural feature of existing mental illness – something that is experienced on a personal level as a 'vicious cycle'.

Northern Ireland has the highest prevalence of mental illness in the UK, which may make the population particularly vulnerable to problem gambling (16).

Compulsive Gambling

Overview

Compulsive gambling, also called gambling disorder, is the uncontrollable urge to keep gambling despite the toll it takes on your life. Gambling means that you are willing to risk something you value in the hope of getting something of even greater value.

Gambling can stimulate the brain's reward system much like drugs or alcohol can, leading to addiction. Compulsive gamblers may continually chase bets that lead to losses, hiding behaviours, depletion of savings, accumulation of debt, or even resort to theft or fraud to support addiction.

Compulsive gambling is a serious condition that can destroy lives. Although treating compulsive gambling can be challenging, many people who struggle with compulsive gambling have found help through professional treatment.

Symptoms

Signs and symptoms of compulsive gambling (gambling disorder) include:

- Being preoccupied with gambling, such as constantly planning how to get more gambling money
- Needing to gamble with increasing amounts of money to get the same thrill
- Trying to control, cut back or stop gambling, without success
- Feeling restless or irritable when trying to cut down on gambling
- Gambling to escape problems or relieve feelings of helplessness, guilt, anxiety or depression
- Trying to get back lost money by gambling more (chasing losses)
- Lying to family members or others to hide the extent of the gambling
- Jeopardizing or losing important relationships, a job, or school or work opportunities
- Resorting to theft or fraud to get gambling money
- Asking others for bail outs from financial trouble arising from money lost due to gambling

Unlike most casual gamblers who stop when losing or set a loss limit, people with a compulsive gambling problem are compelled to keep playing to recover their money — a pattern that becomes increasingly destructive over time.

Some people with a compulsive gambling problem may have remission where they gamble less or not at all for a period of time. However, without treatment, the remission usually is not permanent.

Causes

Exactly what causes someone to gamble compulsively isn't well understood. Compulsive gambling may result from a combination of biological, genetic and environmental factors.

Risk factors

Although many people occasionally bet, most people never develop a gambling problem. Certain factors are more often associated with compulsive gambling:

- **Mental health disorders.** People who gamble compulsively often have substance abuse problems, personality disorders, depression or anxiety. Compulsive gambling may also be associated with bipolar disorder, obsessive-compulsive disorder (OCD) or attention-deficit/hyperactivity disorder (ADHD).
- **Age.** Compulsive gambling is more common in younger and middle-aged people. Gambling during childhood or the teenage years increases the risk of developing compulsive gambling. However, compulsive gambling in the older adult population can also be a problem.
- **Gender**. Compulsive gambling is more common in men than women. Women who gamble typically start later in life and may become addicted more quickly. But gambling patterns among men and women have become increasingly similar.
- **Family or friend influence**. If family members or friends have a gambling problem, this can increase risks of developing compulsive gambling.
- **Medications used to treat Parkinson's disease and restless legs syndrome**. Drugs called dopamine agonists have a rare side effect that may result in compulsive behaviours, including gambling, in some people.
- **Certain personality characteristics**. Being highly competitive, a workaholic, impulsive, restless or easily bored may increase your risk of compulsive gambling.

Complications

Compulsive gambling can have profound and long-lasting consequences, such as:

- Relationship problems
- Financial problems, including bankruptcy
- Legal problems or imprisonment
- Poor work performance or job loss
- Poor general health
- Suicide, suicide attempts or suicidal thoughts

Prevention

Although there is no proven way to prevent a gambling problem, educational programmes that target individuals and groups who can be identified as being at increased risk, are recommended. Currently the UK Charity Gambling with Lives is introducing an educational programme within schools in NI to raise awareness of the risks of gambling and its related harms. The Education Authority is also active in developing curriculum content that addresses gambling related harms.

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Appendix: Copy of PHA Submission to the Department of Communities

Public Health Agency

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BY EMAIL
The Committee for Communities
Parliament Buildings
Ballymiscaw
Stormont
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BT4 3XX

9 December 2021

Dear Sir/Madam

BETTING, GAMING, LOTTERIES AND AMUSEMENTS (AMENDMENT) BILL

As Chief Executive of the Public Health Agency, I am pleased to provide our submission in response to the Committee's call for evidence on the Betting, Gaming, Lotteries and Amusements (Amendment) Bill.

The Public Health Agency (PHA) was established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland. The PHA is the major regional organisation for health protection and health and social wellbeing improvement. Our role also commits us to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing.

The Public Health Agency welcomes the introduction of the Betting, Gaming, Lotteries and Amusements (Amendment) Bill.

This Bill provides an opportunity to consider regulation of gambling in NI within the context of emerging research highlighting concerns about gambling-related harm at a population-level. This includes the recently published Hodkins and Stephens 'Meta-analysis of problem gambling risk factors in the general population 2021' The impact of COVID-19 on gambling and gambling disorder: emerging data (nih.gov)

This study reviewed 17 published studies internationally and highlights that during the Pandemic Lockdown period the studies correlate increased problem severity gambling among younger age groups and mainly young males.

Based on the Department for Communities' '2017 Gambling prevalence survey' Northern Ireland has the highest estimated rate of problem gambling at 2.3% compared to other regions in the United Kingdom (1.1% in Wales, 0.7% in

Scotland and 0.5% in England) and one of the highest rates when compared internationally with countries which used similar surveys.

Northern Ireland has the highest prevalence of mental illness in the UK, which may make the population particularly vulnerable to problem gambling.

According to the National Institute of Health and Care Evidence (NICE) in 2018, participation in gambling was reported by 57% of men and 51% of women, and estimates of the number of people in the UK who participate in harmful gambling vary widely from 300,000 to 1.4 million (NI equivalent estimates- 9,000 to 42,000). Only a small proportion of people who participate in harmful gambling (approximately 3% in England, Scotland and Wales) are in treatment at any time and in NI as there are no existing Health and Social Care treatment services this number will be limited to GamCare (Gambling Industry funded) Young People Gambling Support Service (YoungPeopleService@gamcare.org.uk) and UK wide Gamblers Helpline.

Gambling disorder, problem gambling and pathological gambling are all terms used to describe gambling that causes harms, problems or distress for the individual and those around them (also referred to as 'affected others'). 'Harmful gambling' is used as an umbrella term to describe any frequency of gambling that results in people experiencing harm.

People who participate in harmful gambling may present with both physical and psychiatric comorbidities (in particular, depression and suicidal ideation).

Compulsive gambling, also called gambling disorder, is the uncontrollable urge to keep gambling despite the toll it takes on your life. Gambling means that you're willing to risk something you value in the hope of getting something of even greater value.

Gambling can stimulate the brain's reward system much like drugs or alcohol can, leading to addiction.

In consideration of the Betting, Gaming, Lotteries and Amusements (Amendment) Bill the Committee of the Department for Communities should take account that the NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) has been asked by the Department of Health in England to develop new clinical guidelines on harmful gambling including identification, diagnosis and management. These Guidelines, once complete, will inform UK wide Addiction services commissioning. (NICE guideline: Gambling identification, diagnosis & management draft scope for consultation December 2021).

Currently in NI there is no coordinated system of early identification and intervention with problem gamblers; primary and secondary healthcare services do not routinely identify or refer gamblers for treatment.

Treatment of harmful gambling is an emerging field, with ongoing research. PHA notes the current relative absence of NI data on problem gambling and gambling related harms. Further data and local research is welcomed to inform policy and commissioning of services.

Complementary information on NI Financial Hardship during Covid Pandemic

Statistics from Family Support Hubs (referral process for families in need of support) show the following;

- 2019/2020 – 7,590 referrals – main reason for referral 403 for financial support = 5%
- 2020/2021 – 8,405 referrals – main reason for referral for financial support 2,299 = 27%

There was an increase of 22% from previous year for referral for families for financial support mainly in relation to food/fuel poverty; food parcels & Christmas presents. There was no specific evidence of financial hardship in relation to gambling within the referrals. (Health and Social Care Board).

However increased opening hours within the proposed draft Bill could exacerbate financial pressures for families which include those with problem gambling.

PHA response to specific Clauses within the draft Bill
Clause 2 - Opening of licensed offices on Sunday and Good Friday.
PHA would highlight concerns that increased availability of gambling through additional opening hours may exacerbate existing harms.
Weekend opening will increase the accessibility of gambling to a wider proportion of society, such as working-age adults, children and young people.

Clause 14 – Industry Levy
In England, 'The Gambling Act 2005' contains a provision in Section 123 for a levy on gambling operators to fund projects to reduce gambling harms. Successive governments have not made use of this provision. In the absence of a mandatory levy, the Gambling Commission requires operators (through the Licence Conditions & Code of Practice) to donate to fund research, education and treatment to reduce gambling harms. The 3-year National Strategy to Reduce Gambling Harms, published by the Gambling Commission in April

2019, refers to the work of GambleAware in commissioning most specialist services for those affected by gambling harms across the UK. The PHA concurs with The Institute of Public Health on the introduction of an industry levy and recommends that this levy is placed on a statutory footing in NI. We agree that the statement relating to a requirement for government to engage with the gambling industry on the levy is removed from the legislation. A levy, uncoupled from the Gambling Industry could be used to fund prevention and treatment service to treat and support people who experience problem gambling in NI independently from the Gambling Industry. Research into gambling Harms in NI should be a priority and could be subject of investment from the Levy.

Clause 15 - Codes of Practice
The PHA also concurs with the Institute of Public Health in proposing that Clause 15 –to give the Department of Communities power to create Codes of Practice, that these Codes should be mandatory and legally enforceable. These should prioritise public health, focus on reducing gambling-related health inequalities and seek to protect children, young people, and vulnerable individuals. From a public health perspective, legislation provides stronger protection to the individual, family, and community.

PHA can confirm it is comfortable for this written evidence submission to be made publicly available by the Assembly Committee.

Yours sincerely

Aidan Dawson
Chief Executive