# agenda

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| **Title of Meeting** | 148th Meeting of the Public Health Agency Board |
| **Date** | 17 November 2022 at 1.30pm |
| **Venue** | Fifth Floor Meeting Room, 12/22 Linenhall Street |

## standing items

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| 1<br>1.30 | Welcome and apologies | | Chair |
| 2<br>1.30 | Declaration of Interests | | Chair |
| 3<br>1.35 | Minutes of Previous Meeting held on 20 October 2022 | | Chair |
| 4<br>1.40 | Matters Arising | | Chair |
| 5<br>1.45 | Chair's Business | | Chair |
| 6<br>1.55 | Chief Executive's Business | | Chief Executive |
| 7<br>2.10 | Finance Report | **PHA/01/11/22** | Director of Finance |
| 8<br>2.35 | Health Protection Update | | Dr McClean |

## items for approval

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| 9<br>2.45 | ALB Self-Assessment 2021/22 | **PHA/02/11/22** | Chair |

## items for noting

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| 10<br>3.00 | Performance Management Report | **PHA/03/11/22** | Mr Wilson |

## closing items

11 Any Other Business
3.15

12 Details of next meeting:

*Thursday 15 December 2022 at 1.30pm*

*Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*

# minutes

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| **Title of Meeting** | 147th Meeting of the Public Health Agency Board |
| **Date** | 20 October 2022 at 1.30pm |
| **Venue** | Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast |

**Present**

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| Mr Andrew Dougal | - | Chair |
| Mr Aidan Dawson | - | Chief Executive |
| Dr Joanne McClean | - | Director of Public Health |
| Mr Rodney Morton | - | Director of Nursing and Allied Health Professionals |
| Mr Stephen Wilson | - | Interim Director of Operations |
| Mr Craig Blaney | - | Non-Executive Director |
| Ms Anne Henderson | - | Non-Executive Director |
| Mr Robert Irvine | - | Non-Executive Director |
| Professor Nichola Rooney | - | Non-Executive Director |
| Mr Joseph Stewart | - | Non-Executive Director |

**In Attendance**

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| Ms Tracey McCaig | - | Director of Finance, SPPG (*via video link*) |
| Mr Robert Graham | - | Secretariat |

**Apologies**

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| Mr John Patrick Clayton | - | Non-Executive Director |
| Ms Deepa Mann-Kler | - | Non-Executive Director |
| Dr Aideen Keaney | - | Director of Quality Improvement |
| Mr Brendan Whittle | - | Director of Social Care and Children, SPPG |
| Ms Vivian McConvey | - | Chief Executive, PCC |

**98/22** **Item 1 – Welcome and Apologies**

98/22.1 The Chair welcomed everyone to the meeting. Apologies were noted from Mr John Patrick Clayton, Ms Deepa Mann-Kler, Dr Aideen Keaney, Mr Brendan Whittle and Ms Vivian McConvey.

98/22.2 The Chair advised that this was Mr Morton's last PHA Board meeting, and he wished to put on record the appreciation of the Board to Mr Morton for his work leading the Nursing, Midwifery and AHP directorate in PHA and his contribution to the Board and the Agency Management Team (AMT). He said that Mr Morton joined PHA at a difficult time when the pandemic had shaken the HSC, but that he had led his team valiantly carrying out tremendous work in areas such as care homes and

vaccinations. He added that Mr Morton had been a key link between PHA and HSCB. He thanked Mr Morton for his efforts and wished him every success for the future.

**99/22 Item 2 – Declaration of Interests**

99/22.1 The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared. Mr Dawson indicated that he would be making references to Public Inquiries in his Chief Executive's Business.

**100/22 Item 3 – Minutes of previous meeting held on 15 September 2022**

100/22.1 The minutes of the Board meeting held on 15 September 2022 were **APPROVED** as an accurate record of that meeting, subject to a minor amendment proposed by Ms McCaig in paragraph 90/22.9.

**101/22 Item 4 – Matters Arising**

*88/22.2 Equality Training*

101/22.1 Professor Rooney asked about training for Board members. Mr Graham explained that members can use their laptops to access a range of courses on the HSC eLearning website. He undertook to send members a list of courses which would be mandatory **(Action 1 – Mr Graham)**.

**102/22 Item 5 – Chair's Business**

102/22.1 The Chair advised that the Registrar General's Report has been published and that there were interesting findings, but noted that they may not be a true indication of trends due to COVID. He said that the reduction in the number of teenage pregnancies should be highlighted as a success as should the decrease in the number of young people smoking. He also noted the decline in the number of heart attacks.

102/22.2 The Chair reported that the number of deaths from coronary heart disease for those under 75 years in Northern Ireland had a crack declined by more than 60% in the last 30 years. However, he added that as the number of heart deaths declined the number of deaths from cancer and Alzheimer's disease and associated illnesses increased.

102/22.3 The Chair reported the average age of death still showed a gap between males and females, but this is narrowing.

102.22.4 The Chair said that he had read an article on addiction and the data in it should be used to highlight the need for additional resources in this area.

102.22.5 The Chair referred to an article on the contribution that health makes to

the economy and undertook to share this article with members **(Action 2 – Chair).**

**103/22 Item 6 – Chief Executive's Business**

103/22.1 The Chief Executive reported that since the last meeting PHA has met with the Solicitors regarding Module 2c of the COVID Inquiry which focuses on senior decision making at Government level. He added that PHA will be receiving a Section 9 request with a 6-week response time.

103/22.2 The Chief Executive advised that on Monday 23 October, PHA will be submitting its written statement to the Urology Inquiry and he thanked those staff who had taken time to respond and the governance team for compiling the response. He said that there is a considerable amount of time required to catalogue and name the documents in a particular format. He acknowledged the support and advice from the Directorate of Legal Services (DLS).

103/22.3 Professor Rooney asked if there is any element of the response that the PHA Board should be concerned about. The Chief Executive explained that PHA was asked to respond to 48 questions, and he did not foresee any issues, but he noted that the Inquiry could come back with further queries.

103/22.4 Ms Henderson asked how time consuming and intensive this work is. The Chief Executive said that this it is extremely intensive and the burden of work falls on a small number of staff. He added that PHA is in the process of obtaining additional help and supporting DLS as they seek to get additional legal support for PHA. He advised that DLS has appointed a Deputy Director for Inquiries. The Chair commented that this type of work requires focused time and energy and places an increased burden on existing staff.

103/22.5 Mr Blaney asked whether 6 weeks was a sufficient response time for the COVID Inquiry request. The Chief Executive advised that he did highlight to the Solicitors that as winter approaches, PHA will be dealing with a number of matters and that this will be on top of the existing workload. He said that the Solicitors have undertaken to work with PHA to reduce the burden and that having the initial meeting was useful to help answer some of their queries. He pointed out that any responses will have to be drafted by officers who already have a full-time job, and that it was pointed out to the Inquiry that during the pandemic PHA had 2 different Chief Executives and 3 different Directors of Public Health. He said that staff who no longer work in the organisation may have to be approached as the Inquiry may wish to speak to them. The Chair asked if it is possible to approach these individuals to ask if they wish to work with PHA. The Chief Executive noted that the Inquiry has the powers to ensure that they attend. He added that these individuals will have to be provided with support as it can be a daunting experience.

103/22.6 Ms Henderson asked how the burden on PHA compares with that on the Department or other bodies. The Chief Executive explained that one of the reasons for meeting with the Solicitors in advance of any requests coming through was to go through which documentation may come from the Department and to reduce duplication of effort. He advised that for the Urology Inquiry, the greatest impact will be on the Southern Trust. For Module 2c of the COVID Inquiry, he advised that this relates mainly to the Northern Ireland Assembly and the Department, but PHA's turn will come.

103/22.7 The Chief Executive advised that he had attended the Governance and Audit Committee (GAC) meeting last week and following discussion with the Committee Chair, it was agreed that the risk on PHA's Corporate Risk Register regarding procurement would be updated, and perhaps removed and replaced with a new risk. Ms Henderson commented that the risk on procurement needed attention as PHA is falling behind in terms of getting new contracts awarded. The Chief Executive said that the risk remains, but the current risk was written at a time when there was a change of legislation, but as the environment has changed again, with rules around social value procurement and as this is not reflected in the risk, there is a need to ensure that the risk is amended. Mr Stewart said that he agreed with this approach and added that there are other risks on the Register which require reworking.

103/22.8 The Chair said that 3 years ago he had asked for a timeline on the social procurement process and now that the 2 Senior Planning Managers are finally in post and no longer seconded to tracing work he was most anxious to see an action plan without further delay. Ms Henderson said that she would welcome a presentation to the Board as procurement is a key risk. Mr Wilson commented that he is conscious of the antiquity of the risk, but explained that it is a multi-layered risk. He welcomed the opportunity to present an update to the Board, possibly at a workshop, but the Chair said that he wished to see an action plan **(Action 3- Mr Wilson)**. Mr Wilson pointed out that while the 2 Senior Planning Managers are critical to this work, they have to work with other parts of the organisation. Mr Stewart noted that it is well known that public sector procurement can be a lengthy process, and therefore it would be useful to look at what elements of this work PHA has control over, and those where PHA is dependent on others e.g. PALS. The Chief Executive agreed with Mr Stewart and advised that last week he had to sign off on a Direct Award Contract (DAC) because PALS did not have the capacity to undertake a tendering exercise.

103/22.9 Mr Irvine said that procurement is a massive area that PHA contracts through PALS, and like Finance and HR, there are huge demands on BSO, and at some point PHA will need to give consideration as to whether it recruits permanent staff to look at these areas and there is a responsibility for the PHA Board and Chief Executive to look at this. The Chief Executive advised that since the last Board meeting, PHA held a joint senior management team meeting with BSO to discuss current

pressures and to identify how to resolve these going forward. He added that these meetings will take place on a quarterly basis. Mr Wilson reported that BSO has appointed an HR strategic business partner, Ms Karyn Patterson, who works exclusively with PHA. Ms Henderson asked if there is a risk on PHA's Risk Register around PHA not getting the service it needs from BSO. Mr Stewart reiterated that AMT needs to review the risk and bring it back to GAC and added that the current risk on procurement does not reference BSO.

103/22.10 Mr Stewart advised that GAC has agreed to postpone an Internal Audit review on emergency planning and to look instead at recruitment process in an attempt to understand why it takes so long to get an individual into post. He added that, with regard to procurement, it is his understanding that PHA must use PALS for contracts above a certain level. He commented that when contracting with a supplier there should be a tight Service Level Agreement (SLA) with penalty clauses, but that type of contract does not exist when dealing with an in-house supplier.

103/22.11 Ms McCaig advised that there have been risks on the Register previously relating to particular issues with BSO on the delivery of services. On the use of PALS, she said that PHA has to do a lot of work before any procurement goes to PALS, and added that PHA is mandated to use PALS. With regard to recruitment, she advised that she been asked by Internal Audit to contribute to some work that they are carrying out regionally. She noted that in the past any delays have not necessarily always been with the recruitment team, but with PHA itself, and therefore the audit will look at the full end-to-end process.

103/22.12 The Chair asked if issues relating to recruitment can be included as part of Phase 2 of the PHA Review, but the Chief Executive said that many matters relating to recruitment are outside of PHA's control and he did not wish that to be a distraction. The Chair said that there are major delays in recruitment. Ms McCaig explained that there are many elements which are not within PHA's gift to change, but PHA has to ensure that its own procedures are tight. She added that PHA should also have robust performance management arrangements in place with BSO. The Chief Executive commented that while there are some areas where there are difficulties, there are other areas where PHA receives a good service. He said that the level of service from DLS with regard to the Public Inquiries has been exceptional.

103/22.13 Mr Morton said that following the appointment of Ms Patterson, there has been a substantial improvement in recruitment. He added that with regard to the Senior Planning Managers, there has been some upheaval and this can impact on the speed of getting things done. He said that it is important to have individuals who really understand the business. The Chair asked whether PHA is required by legislation to use BSO. Ms Henderson proposed that an action plan should be brought to the December Board meeting. The Chief Executive advised that it is likely that there will be more Shared Services in future so PHA could expend a

lot of energy seeking to extract itself from Shared Services with no result so it is important that PHA focuses on ensuring that its internal processes run smoothly.

103/22.14 The Chief Executive noted that members had seen the EY Report on the Review of PHA at the workshop on Monday. He advised that the Report has been shared with the Minister who is fully supportive of its findings, and subject to finances, is happy to proceed to Phase 2. Mr Irvine asked if the timings in the Report are now operational, but The Chief Executive reiterated that it is subject to confirmation regarding funding. The Chief Executive added that the Permanent Secretary has made it clear that the HSC is £450m overspent and has the potential to overspend the block grant which will have implications going forward. He advised that PHA has been asked to give details of its savings plan which has to be submitted in the next couple of days. He said that there would be more information given on this in the confidential session.

103/22.15 The Chief Executive advised that Dr Jillian Johnston, who has been acting as Assistant Director of Health Protection, will be leaving PHA on secondment to the Department of Health for 9 months. He said that Dr Johnston will be missed and that this secondment will be an excellent opportunity and on her return she will be able to make an ever bigger contribution to the work of PHA in the medium and longer term. The Chair endorsed the Chief Executive's remarks. The Chief Executive said that Dr McClean will consider how that role will be filled. Dr McClean advised that there is an interim arrangement in place.

103/22.16 The Chief Executive said that he also wished to acknowledge the contribution of Mr Morton to the work of PHA and his support to both AMT and to him personally. He added that Mr Morton will be a huge loss to the health system in Northern Ireland and he thanked Mr Morton for his work.

103/22.17 Dr McClean informed members that PHA has submitted evidence to the Infected Blood Inquiry, and she has now been called to appear before the Inquiry on 17 November.

**104/22 Item 7 – Finance Report (PHA/01/10/22)**

104/22.1 Ms McCaig advised that this Finance Report is for the period up to the end of August and follows the cyber security incident. She reported that PHA has a year to date surplus of £1m, but she said that this was not of concern and is a timing issue. She indicated that the projected year end position is a surplus of £91k.

104/22.2 Ms McCaig advised that in the context of the correspondence received from the Permanent Secretary a full review of all budget areas was carried out, particularly the demand-led areas and the management and administration budget. She said that following this review it is likely that the projected year-end surplus will be around £450k, and that this is the

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| | figure that will be reported back to the Department. |
| 104/22.3 | Ms McCaig reported that around £4m of the £13.5m capital budget has been expended, and this is line with normal spending patterns. She advised that some projected underspends on other projects have been identified and this funding will be returned to the Department. |
| 104/22.4 | Ms Henderson said that the Report was very clear, but she asked why the smoking cessation budget is underspent every year. Ms McCaig advised that this is not anyone's fault, but consideration should be given regarding whether some of this funding should be released on a more recurrent basis. Ms Henderson commented that there are other budget lines where it would be useful to do a similar review. Ms McCaig said that the underspend for smoking cessation is smaller than it has been in previous years, but there is a risk that if too much is taken away as slippage that the demand goes up again. She added that it is a difficult one to project. |
| 104/22.5 | The Chair expressed concern that a recent publication by ASH (Action on Smoking and Health) showed that a large number of young people who have never smoked before have taken up vaping. He asked what is meant by "demand-led". Ms McCaig said that this is where the public can go and request help with regard to smoking cessation. She added that demand would go up perhaps after Christmas, or after a campaign. Dr McClean explained that this funding is for Nicotine Replacement Therapy (NRT). She added that the Department's Strategy on smoking has been extended and the Tobacco Strategy Implementation Group, which she will chair, has been re-established. |
| 104/22.6 | Mr Stewart sought clarity on the accrual for annual leave and if this was a provision made for leave that staff did not take. Ms McCaig confirmed this and said that the accrual amount was increased because staff hadn't been able to take leave and this was reviewed with colleagues in HR. She said that some of this accrual has now been released, but the situation will have to be monitored. |
| 104/22.7 | Mr Morton advised that there is an added complexity in that PHA delivers programmes on behalf of the Department so there needs to be a dialogue with the Department if funding were to be swapped between programmes. |
| 104/22.8 | Dr McClean explained that the issue with the shingles vaccine was that people did not take up the vaccine. The Chair asked if people are being encouraged to get the vaccine. He suggested that there may need to be a media campaign because people are not aware of the availability of this vaccine. |
| 104/22.9 | Dr McClean advised that there will be a catch-up exercise for those who did not get their vaccination at the time of the pandemic. |

104/22.10 The Board noted the Finance Report.

**105/22 Item 8 - Terms of Reference for Planning, Performance and Resources Committee (PHA/02/10/22)**

105/22.1 The Chief Executive advised that a draft terms of reference for the proposed Planning, Performance and Resources Committee has been prepared. He drew members' attention to the quorum which is different than other Committees where the quorum is based solely on Non-Executive Directors. He said that the focus of the Committee is primarily on planning and performance, but this can be reviewed after 9 months.

105/22.2 The Chair said that several members had queried the status of the panel that had met to consider slippage bids and he proposed that it would continue as a sub-committee of this Committee.

105/22.3 Mr Stewart said that he welcomed the establishment of this Committee and thanked the Chief Executive for bringing this forward.

105/22.4 The Board **APPROVED** the Terms of Reference for Planning, Performance and Resources Committee.

105/22.5 The Chair expressed a sense of achievement since he first put this proposal forward more than 4 years ago.

**106/22 Item 9 – Health Protection Update**

106/22.1 Dr McClean presented the latest data related to COVID and reported that the latest ONS survey indicated that approximately 1 in 40 people in Northern Ireland tested positive at the time of the last survey. She showed the data relating to wastewater surveillance and community acquired emergency admissions by age. She commented that the rate appears to be slowing and Mr Morton added that this is a national trend.

106/22.2 Dr McClean gave an overview of the number of cases of Respiratory Syncytial Virus (RSV) and advised that these have increased but she believed that they had peaked.

106/22.3 Dr McClean advised that the flu season has commenced and PHA will shortly begin its weekly reporting. She said that a small number of cases is starting to come through, although GP consultation numbers remain low.

106/22.4 Dr McClean reported that the vaccine programme for COVID and flu has commenced and to date 180,000 COVID boosters and 216,000 flu vaccines have been administered with 1.1 million people eligible for the COVID booster, and 1.5 million eligible for the flu vaccine. She advised that the campaign programme for these is starting next week. She noted that the uptake among healthcare workers has been disappointing to date.

106/22.5 Dr McClean advised that PHA had been dealing with an outbreak of eColi in a nursery, but that has now come to an end.

106/22.6 Mr Wilson asked if there are still delay in terms of information being updated on the Vaccine Management System (VMS). Dr McClean said that issues have been largely resolved and the maximum delay should be 1.5 / 2 days. The Chief Executive commented that GPs will likely carry out mass vaccination clinics and then manually update the results later, whereas pharmacies will update the system immediately.

106/22.7 The Chair asked what is being done to encourage uptake among healthcare staff. Dr McClean advised that Trusts are doing a lot of work, including bringing the vaccine to staff. She said that Trusts do promote the vaccine heavily and that there are regular meetings with Trusts. She acknowledged that increasing staff uptake has always been challenging.

**107/22 Item 10 – Update from Chair of Governance and Audit Committee (PHA/03/10/22)**

107/22.1 Mr Stewart said that the minutes of the meeting of 28 July are available for members for noting. He advised that the Committee met again last week and that the Chief Executive has already covered some of the items discussed, including the Corporate Risk Register and the agreement of the Committee to defer the audit of emergency planning to 2023/24 and bring forward an audit of recruitment. He added that the Committee had also considered the final report from External Audit which was a clean report with no recommendations.

107/22.2 Mr Stewart explained that there was a difficulty at the meeting in that the Committee was unable to approve the Mid-Year Assurance Statement because Mr Clayton had declared an interest, due to references in the Statement pertaining to Public Inquiries, and felt he should absent himself from the meeting for that item. He added that this item could not be covered at the meeting so a special meeting was convened as part of the Board workshop Monday where the Statement was approved for consideration today by the Board.

107/22.3 Ms Henderson noted the reference to HSCQI funding in the Statement. Mr Stewart said that HSCQI does not have any recurrent funding. The Chief Executive advised that PHA has asked for a meeting with Sponsor Branch, along with Mr Andrew Dawson and the Deputy Chief Medical Officer to discuss the fact that HSCQI does not have security of funding and had to utilise PHA slippage, which is not an acceptable situation.

107/22.4 The Board noted the update from the Chair of the Governance and Audit Committee.

**108/22 Item 11 – PHA Mid-Year Assurance Statement (PHA/04/10/22)**

108/22.1 The Chief Executive advised that the 2022/23 Mid-Year Assurance

Statement is being presented to members today and if approved, will be submitted to the Department.

108/22.2 Ms Henderson said that the Statement is comprehensive and covers issues such as procurement, an area that the Board will be interested in going forward.

108/22.3 The Board **APPROVED** the PHA Mid-Year Assurance Statement.

**109/22 Item 12 – Annual Quality Report (PHA/05/10/22)**

*Ms Denise Boulter joined the meeting for this item*

109/22.1 The Chair welcomed Ms Boulter to the meeting to present the Annual Quality Report and asked her who the audience is for this Report. Ms Boulter advised that the Report is sent to the Department and it is published on World Quality Day.

109/22.2 Mr Morton advised that the Department holds the PHA and SPPG to account for this Report and it is an instrument of accountability. He said that he wished to pay tribute to the work of Ms Boulter who took on board the feedback from the Board regarding the format of the Report. The Chair said that the Board had not been critical of the format, but Mr Morton explained that he meant that the Report was written with more of a focus on outcomes, and included more infographics.

109/22.3 Ms Boulter said that the Report is largely a positive one, and this Report is for the period 2021/22 and will be last Report prepared in conjunction with HSCB. She reiterated that the Report will be published on World Quality Day, and that the Report is more outcomes focused. She explained that the Report has been designed to be more interactive and that all the links in it are live. She added that the Report is currently undergoing a final proofread and individual authors are being given a final opportunity to review it. She said that she hoped that the Board will be content to approve the Report today for publication on the PHA and Department's websites.

109/22.4 Mr Stewart commented that the text and the graphics relating to falls and pressure ulcers do not tally in that while the narrative indicates these are reducing, the graphs suggest they are on the increase. Ms Boulter thanked Mr Stewart for pointing this out. She advised that she attended a meeting earlier today where there was a discussion around the KPIs being measured in these areas and if the right things are being measured. She said that if there is an upward trend then it is important to know what is being known to address that. Mr Morton agreed that this should be reviewed as the trend line for falls is moving upwards. He said that there is a lot of complexity in this area and falls can be linked to increased frailty and morbidity.

109/22.5 Ms Henderson said that the Report was very interesting and she asked

about PHA's plans to publish it. She said that if PHA has noted a reduction in falls or pressure ulcers it should highlight this instead of simply collating data. With regard to the narrative on waiting list management and the fact that 13,000 patients were found on duplicate lists, she asked if this was good or bad, and if it showed that lists are not being managed. She added that if the information you need to start with is not available then it is difficult to assess what the important priorities are. The Chair commented that the need for data to be cleansed was an issue that was raised at NICON yesterday and suggested that in reality there are far less people on waiting lists than reported. Ms Henderson asked if PHA should be highlighting that managing waiting lists is a critical task. Mr Morton said that this particular example relates to one initiative within primary care. Ms Henderson asked if the outcome being reported here is a good outcome, and Mr Morton said that it was. Mr Morton added that another service could then carry out a similar exercise.

109/22.6 Ms Boulter said that this is an example of a "work in progress", an initiative which can be taken forward into other areas using a quality improvement methodology. She added that this initiative was about cleansing data to ensure they were accurate. The Chair commented that there is a benefit in cleansing data as people who are on waiting lists are despondent and so it is important that the data are accurate. Mr Morton said that waiting list data are critical as they tell the story of inequalities.

109/22.7 The Chair asked about SAIs. Noting that 480 SAIs had been closed during the year, he asked who is responsible for the duty of care to families. He also asked whether there are targets set for SAIs because a lot of pain endured by families is because there are often long waits completing these and families are not kept informed. Ms Boulter advised that there is an obligation to inform families if an SAI is being conducted and 2 Trusts have appointed Family Liaison Officers, with the other Trusts seeking to follow suit. She said that engagement with families has improved. The Chair commented that there may be a strong case to have a third party to liaise between the adversarial parties. the trust on the one hand and the family and the other. Mr Morton explained that Trusts have an obligation to engage with families when formulating the terms of reference of any SAI. He added that as well as the Trusts nominating a Family Liaison Officer, they can advise families of the role of the Patient Client Council (PCC) as an advocacy body. The Chair asked if families are informed of PCC's advocacy role and Ms Boulter confirmed that they are. He asked if PCC are advised of every SAI, but Ms Boulter said that they would not be. Ms Boulter advised that RQIA has recently carried out a review of SAIs and the whole process will be reviewed. It was **AGREED** that Ms Boulter would forward a copy of the Report to Mr Graham to send to members **(Action 4 – Mr Graham)**.

109/22.8 Professor Rooney sought clarity about NICE representation on an

oversight group, but Ms Boulter explained that this refers to SPPG commissioning staff who are leads for NICE guidance.

109/22.9 The Chief Executive reported that at the NICON Conference yesterday, PHA was a joint winner of an HSCQI Quality Award relating to a project undertaken with care homes around falls. He said that he wished to bring this to attention of the Board and offer his congratulations to Ms Ceara Gallagher who lead on this work.

109/22.10 Mr Blaney sought clarity on the COVID vaccination data as he thought that Dose 3 was the booster, but Ms Boulter explained that the third dose was administered to those with specific health conditions. Mr Morton suggested that this should be explained in the Report. Mr Blaney asked if there has been any up to date research and if the groups listed for vaccination are still correct. Dr McClean advised that the Joint Committee on Vaccination and Immunisation (JCVI) would review these all the time.

109/22.11 Professor Rooney asked if there is a better way of telling people about the work contained in this Report. She noted that at the NICON Conference there were presentations which she knew were about pieces of work that PHA is involved in, but these partner organisations did not make any reference to PHA. Mr Wilson advised that PHA has made a commitment this year to develop a new Communications Strategy to help increase awareness of the organisation. He noted that part of the difficulty is the breadth of work that PHA is involved in and trying to get keep people informed about all of this is a challenge. The Chief Executive said that this will be incorporated into PHA's new strategy. He advised that some Trusts are promoting their "unsung heroes", and a lot of information is shared on social media. He said that PHA needs to share more about the projects that it funds. He commented that the Permanent Secretary wishes to see more of what PHA does. The Chair said that PHA should insist that it gets recognition if it contributes to an initiative to let people know that PHA is funding particular work.

109/22.12 Ms Henderson commented that the role of PHA vis-à-vis the role of SPPG is very nebulous at times and difficult for a Board member to fully understand in what PHA is involved. Mr Morton said that PHA is very active in areas such as mental health and emotional wellbeing, and that within his team there is a dedicated team for mental health and learning disability. He added that PHA is also involved in prevention and early recovery, and each day it is sorting out issues such as mental health inpatient beds, schemes for trauma and Adverse Childhood Experiences. He said that this work should be made better known.

109/22.13 The Chair thanked all of those who were involved in the compilation of this Report.

109/22.14 The Board **APPROVED** the Annual Quality Report.

**110/22** **Item 13 – ALB Self-Assessment 2021/22**

110/22.1 The Chair thanked members for their contributions to the compilation of the draft self-assessment. He said that he has asked the Board Secretary of UKHSA if they use a self-assessment tool and if this could be shared.

110/22.2 Ms McCaig advised that she has sent some comments to Mr Graham, and she wished to ensure that this cross referenced with the recommendations in the Internal Audit report on Board Effectiveness.

110/22.3 Mr Graham outlined to members his proposal that members should consider the draft and feed back any comments and then the final completed assessment will come back to the Board in November for approval.

**111/22** **Item 14 – Any Other Business**

111/22.1 There was no other business.

**112/22** **Item 15 – Details of Next Meeting**

*Thursday 17 November 2022 at 1:30pm*

*Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast*

Signed by Chair:

Date:

# Finance Report September 2022

Tracey McCaig
Director of Finance

October 2022

**Section A: Introduction/Background**

1. The PHA Financial Plan for 2022/23 set out the funds notified as available, the risks and uncertainties for 2022/23 and summarised the opening budgets against the high level reporting areas. It also outlined how the PHA will manage the overall funding available and enable it to support key programmes of work that will help achieve its corporate priorities. It received formal approval by the PHA Board in the June 2022 meeting.

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. On the basis of this approved Plan, this summary report reflects the latest position as at the end of September 2022 (month 6).

**Section B: Update – Revenue position**

4. The PHA has reported a year to date surplus at September 2022 of £1.1m (£1.0m, August 2022), against the annual budget position outlined in the Financial Plan for 2022/23.

5. In respect of the year to date surplus of £1.1m:
   - The annual budget for programme expenditure to Trusts of £41.1 m has been profiled evenly for allocation, with £20.6m expenditure reflected as at month 6 and a nil variance to budget shown.
   - The remaining annual programme budget is £59.2m. Programme expenditure of £21.3m has been recorded for the first six months of the financial year with an underspend to date of £0.4m. The main area of underspend to date is within Health Improvement, which is primarily in respect of the Smoking Cessation budget. This budget has been separately reviewed and is currently anticipated to achieve full spend by the end of the financial year. Budget holders are required to continually keep all programme budgets under close review and report any expected slippage or pressures at an early stage.
   - A year-to-date underspend of £0.8m is reported in the area of Management & Administration, primarily in the areas of Public Health and Operations, which

reflects a high level of vacant posts in each area. Whilst efforts have continued to fill posts, there has been a temporary pause to the scrutiny process to allow time to develop a new process which considers priorities in the context of the PHA's Programme to Reshape and Refresh.

- There is annual budget of c£3.0m in ringfenced budgets, most of which relates to COVID funding for the Contact Tracing Centre for quarter 1 (£2.2m). A small variance is reported on these areas to date, however they are largely expected to breakeven against funded budgets.

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

**PHA Summary financial position - September 2022**

| | 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 | 12,722 | 6,361 | 6,361 | 0 | |
| Health Protection | 8,086 | 4,043 | 4,043 | 0 | |
| Service Development & Screening | 14,322 | 7,161 | 7,161 | 0 | |
| Nursing & AHP | 4,515 | 2,257 | 2,257 | 0 | |
| Centre for Connected Health | 1,476 | 738 | 738 | 0 | |
| HSC Quality Improvement | 23 | 11 | 11 | 0 | |
| Other | 0 | 0 | 0 | 0 | |
| **Programme expenditure - Trusts** | **41,145** | **20,573** | **20,573** | **0** | **0** |
| Health Improvement | 29,591 | 10,774 | 10,356 | 419 | |
| Health Protection | 17,172 | 9,792 | 9,836 | (45) | |
| Service Development & Screening | 4,367 | 878 | 841 | 37 | |
| Research & Development | 3,418 | 0 | 0 | 0 | |
| Campaigns | 1,943 | 95 | 67 | 28 | |
| Nursing & AHP | 3,876 | 106 | 95 | 11 | |
| Centre for Connected Health | 429 | 123 | 123 | 0 | |
| HSC Quality Improvement | 142 | 38 | 39 | (1) | |
| Other | (1,722) | 0 | 0 | 0 | |
| **Programme expenditure - PHA** | **59,215** | **21,806** | **21,357** | **449** | **(1,673)** |
| **Subtotal Programme expenditure** | **100,360** | **42,379** | **41,930** | **449** | **(1,673)** |
| Public Health | 16,621 | 8,267 | 7,703 | 564 | |
| Nursing & AHP | 5,049 | 2,523 | 2,525 | (2) | |
| Operations | 4,493 | 2,158 | 1,960 | 198 | |
| Quality Improvement | 635 | 297 | 279 | 18 | |
| PHA Board | 388 | 189 | 215 | (26) | |
| Centre for Connected Health | 421 | 210 | 268 | (58) | |
| SBNI | 850 | 425 | 369 | 56 | |
| **Subtotal Management & Admin** | **28,455** | **14,069** | **13,319** | **750** | **2,303** |
| Trusts | 0 | 0 | 0 | 0 | |
| PHA Direct | 2,224 | 2,124 | 2,170 | (46) | |
| **Subtotal Covid-19** | **2,224** | **2,124** | **2,170** | **(46)** | **(50)** |
| Trusts | 65 | 32 | 32 | (0) | |
| PHA Direct | 207 | 0 | (0) | 0 | |
| **Subtotal Transformation** | **272** | **32** | **32** | **0** | **0** |
| Trusts | 0 | 0 | 0 | 0 | |
| PHA Direct | 491 | 160 | 206 | (46) | |
| **Other ringfenced** | **491** | **160** | **206** | **(46)** | **0** |
| **TOTAL** | **131,803** | **58,763** | **57,656** | **1,107** | **580** |

*Table subject to roundings*

7. In September 2022, the Permanent Secretary advised that given the projected financial position for the HSC in year all ALB's, including PHA, were asked to consider how they could contain costs or reducing expenditure in-year. An assessment of slippage and pressures was previously undertaken for the purposes of finalising the 2022/23 Financial Plan, however a further formal review has been recently undertaken to revisit assumptions and forecasts and provide an update on the in-year financial position. This has indicated that there is a projected additional slippage of circa £0.5m in-year, the source of this primarily being windfall gains on additional vacant senior posts, return of funding from a provider due to non-delivery, Connected Health and other general slippage on demand led budgets. This has been notified to the DoH in a response to the request. The PHA is also awaiting confirmation of in-year funding support for the Programme to Reshape and Refresh the PHA's implementation costs.

8. A range of known service pressures and strategically aligned developments were detailed in the Financial Plan and subsequently a number of these were approved, subject to the necessary business case approval. A review was also performed on these areas of planned expenditure and confirmation secured that these have been progressed and expenditure committed.

9. Following this review of in-year slippage and pressures an updated forecast year-end surplus of £0.58m is currently shown (£0.1m, August 2022). The movement in the forecast is summarised as follows:
    - £0.4m increase in underspend against Management and Administration budgets. Recent movements in staffing have been factored into forecast expenditure and further assessments have been made against the timing of filling vacancies in the latter half of the financial year and the level of release of the annual leave provision at year end.
    - A small decrease in the forecast level of programme expenditure.

**Section C: Risks**

10. Any significant assumptions, risks or uncertainties facing the organisation, and the management of these elements, are set out below.

11. **Impact of COVID-19 on Financial Planning:** The global pandemic and its impact on the HSC brings with it obvious challenges for predicting and managing budgetary resources as the service continues to respond during 2022/23. Whilst the cost of the Contact Tracing Service has been included for quarter 1 of the financial year, at this stage no significant assumptions have been made for any further requirements later in the financial year - should the service be required to restart to respond to any future changes in the COVID-19 landscape. The longer term requirements for the Vaccination Programme transfer to PHA are being worked through for this service and will be kept under close review.

12. **Demand led services:** Whilst an initial estimate of funding has been identified within the 2022/23 Financial Plan, to enable pressures or strategic developments to pass through an approval process, clarity on the financial impact of this can only be secured on conclusion of the process. Additionally, business as usual Programme expenditure will need to be monitored closely to ensure that planned expenditure is met. As in previous years, the PHA operational management will continue to review expenditure plans to identify any potential easements or inescapable pressures which may need to be addressed in-year.

13. **Annual Leave:** PHA staff are carrying a significant amount of annual leave, due to the demands of responding to the COVID-19 pandemic over the last two years. As at each financial year end, this is converted into a financial balance. This balance of leave will need to be managed to a more normal level during the year, and this may present some risk to the delivery of organisational objectives. Based on current position of leave taken an estimate of the partial release of the financial balance during 2022/23 is contributing toward the forecast available for deployment in-year.

14. **Funding not yet allocated:** there are a number of areas where funding is anticipated but has not yet been released to the PHA. These include AfC and Non-AfC Pay uplift for 2022/23, however no expenditure is currently being assumed for these areas.

15. **Budget 2023-25**: The financial challenge facing HSC is significant in-year and will continue to present an ongoing challenge to manage. PHA will be required to work

closely with DoH in the coming months, where required, to inform any assessment of options to address the wider HSC financial position.

16. 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

17. The PHA has a current capital allocation (CRL) of £13.6m. The majority of this (£12.0m) relates to Research & Development (R&D).

18. The overall summary position, as at September 2022, 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 | 6,551 | 721 | 6,551 | 0 |
| R&D - Trusts | 8,208 | 4,123 | 8,208 | 0 |
| R&D Capital Receipts | (2,759) | (79) | (2,759) | 0 |
| **Subtotal HSC R&D** | **12,000** | **4,765** | **12,000** | **0** |
| **CHITIN Project:** | | | | |
| CHITIN - Other Bodies | 0 | 0 | 0 | 0 |
| CHITIN - Trusts | 0 | 0 | 0 | 0 |
| CHITIN - Capital Receipts | 0 | 0 | 0 | 0 |
| **Subtotal CHITIN** | **0** | **0** | **0** | **0** |
| **Other:** | | | | |
| Congenital Heart Disease Network | 436 | 29 | 436 | 0 |
| i-REACH Project | 405 | 0 | 405 | 0 |
| Online Safety Project | 15 | 0 | 15 | 0 |
| Covid Wastewater | 697 | 0 | 600 | 97 |
| **Subtotal Other** | **1,553** | **29** | **1,456** | **97** |
| **Total HSCB Capital position** | **13,553** | **4,794** | **13,456** | **97** |

19. 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.

20. 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. It should be noted that the values for CHITIN have not yet been fully confirmed by way of an CRL allocation letter. PHA R&D team are working with the DoH Capital Investment Team to finalise and any update will be noted in future finance reports.

21. PHA has also received a number of smaller capital allocations including the Congenital Heart Disease (CHD) Network (£0.4m), which is managed through the PHA R&D team, the i-REACH project (£0.4m), and a COVID-19 Wastewater project (£0.7m) which is a QUB project analysing wastewater to help with the tracking of outbreaks of COVID-19. There is an anticipated underspend on this project and it is anticipated that the CRL allocation will be reduced to reflect this position. A small CRL allocation has been received for an online safety project, which relates to SBNI, and is anticipated to be spent in quarter 4 of the financial year.

22. The capital position will continue to be kept under close review throughout the financial year.

**Recommendation**

23. The PHA Board are asked to note the PHA financial update as at September 2022.

# Public Health Agency

## Annex 1 - Finance Report

## 2022-23

### Month 6 - September 2022

# PHA Financial Report - Executive Summary

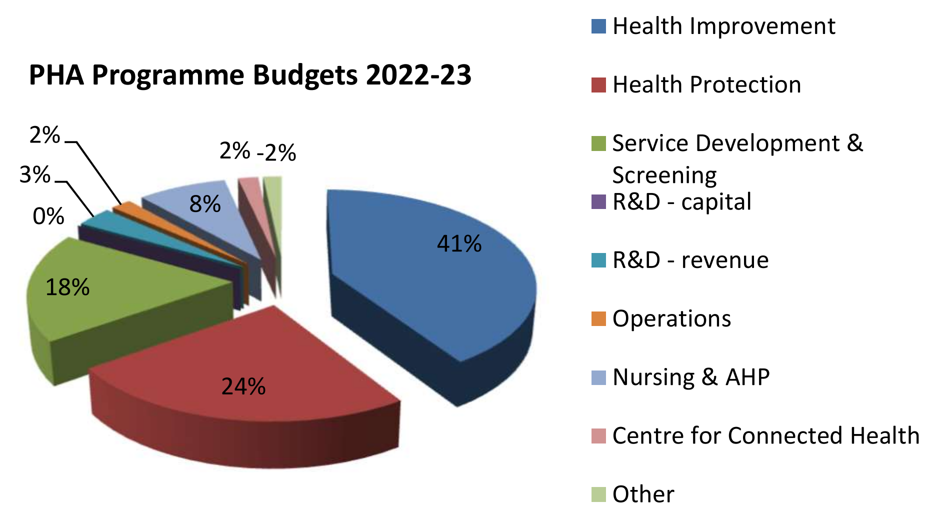
**Year to Date Financial Position (page 2)**

At the end of month 6 PHA is reporting an underspend of £1.1m against its profiled budget. This underspend is primarily the result of underspends on Administration budgets (page 6) and PHA Direct programme budgets, with expenditure running behind profiled budget in a number of areas.

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.

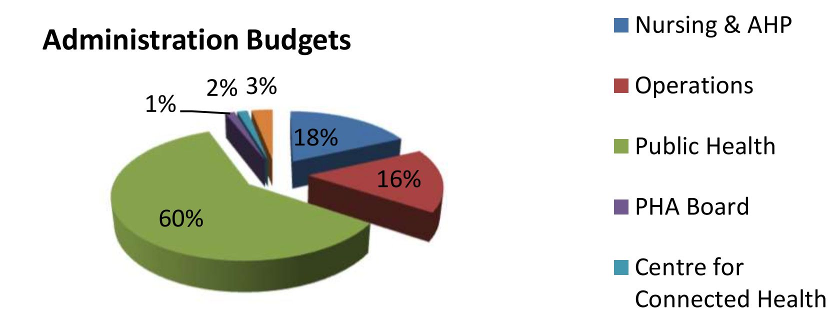



**Administration Budgets (page 5)**

The breakdown of the Administration budget by Directorate is shown in the chart below. Over half of the budget relates to the Directorate of Public Health.

A 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 small surplus of £0.6m for the full year.

The Administration and Programme budgets are being continually reviewed in order to update the full year forecast.

# Public Health Agency

## 2022-23 Summary Position - September 2022

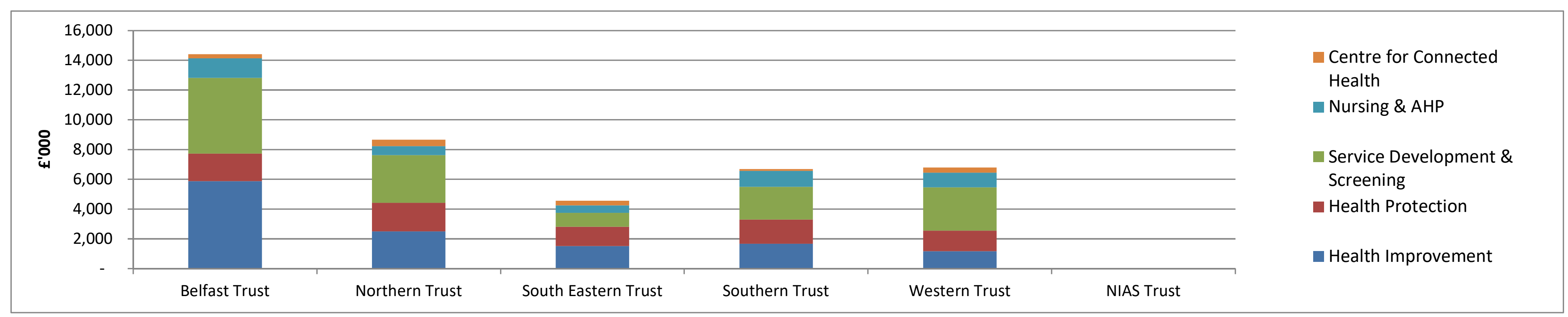
| | Annual Budget | | | | | Year to Date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Programme | | Ringfenced | Mgt & | Total | Programme | | Ringfenced | Mgt & | Total |
| | Trust | PHA Direct | Trust & Direct | Admin | | Trust | PHA Direct | Trust & Direct | Admin | |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Available Resources** | | | | | | | | | | |
| Departmental Revenue Allocation | 41,145 | 59,192 | 2,987 | 27,631 | **130,955** | 20,573 | 21,783 | 2,315 | 13,669 | **58,340** |
| Revenue Income from Other Sources | - | 23 | - | 825 | **848** | - | 23 | - | 400 | **423** |
| **Total Available Resources** | 41,145 | 59,215 | 2,987 | 28,456 | **131,803** | 20,573 | 21,806 | 2,315 | 14,069 | **58,763** |
| **Expenditure** | | | | | | | | | | |
| Trusts | 41,146 | - | 65 | - | **41,210** | 20,573 | - | 32 | - | **20,605** |
| PHA Direct Programme * | - | 60,888 | 2,972 | - | **63,861** | - | 21,357 | 2,375 | - | **23,732** |
| PHA Administration | - | - | - | 26,152 | **26,152** | - | - | | 13,319 | **13,319** |
| **Total Proposed Budgets** | 41,146 | 60,888 | 3,037 | 26,152 | **131,223** | 20,573 | 21,357 | 2,408 | 13,319 | **57,656** |
| **Surplus/(Deficit) - Revenue** | (0) | (1,673) | (50) | 2,303 | **580** | - | 449 | (93) | 750 | **1,107** |
| ***Cumulative variance (%)*** | | | | | | ***0.00%*** | ***2.06%*** | ***-4.01%*** | ***5.33%*** | ***1.88%*** |

The year to date financial position for the PHA shows an underspend of £1.1m, which is a result of PHA Direct Programme expenditure being behind profiled budgets and a year-to-date underspend within Administration budgets.

A surplus of £0.6m is currently forecast for the year.

*Please note that a number of minor rounding's may appear throughout this report.*
** PHA Direct Programme may include amounts which transfer to Trusts later in the year*

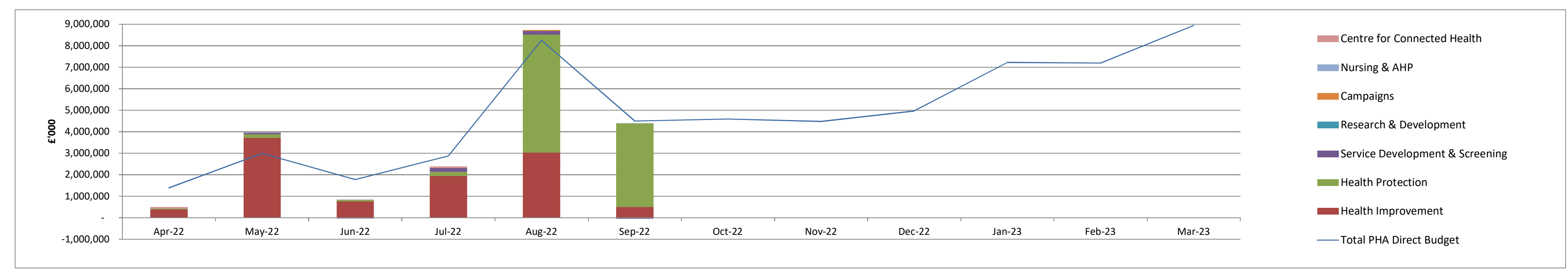
# Programme Expenditure with Trusts




| Current Trust RRLs | Belfast Trust £'000 | Northern Trust £'000 | South Eastern Trust £'000 | Southern Trust £'000 | Western Trust £'000 | NIAS Trust £'000 | Total Planned Expenditure £'000 | YTD Budget £'000 | YTD Expenditure £'000 | YTD Surplus / (Deficit) £'000 |
|---|---|---|---|---|---|---|---|---|---|---|
| Health Improvement | 5,865 | 2,508 | 1,515 | 1,664 | 1,170 | - | **12,722** | 6,361 | 6,361 | - |
| Health Protection | 1,870 | 1,914 | 1,290 | 1,637 | 1,376 | - | **8,086** | 4,043 | 4,043 | - |
| Service Development & Screening | 5,078 | 3,207 | 941 | 2,188 | 2,909 | - | **14,322** | 7,161 | 7,161 | - |
| Nursing & AHP | 1,316 | 603 | 498 | 1,074 | 996 | 27 | **4,515** | 2,257 | 2,257 | - |
| Centre for Connected Health | 279 | 431 | 315 | 115 | 336 | - | **1,476** | 738 | 738 | - |
| Quality Improvement | 23 | - | - | - | - | - | **23** | 11 | 11 | - |
| Other | - | - | - | - | - | - | **0** | - | - | - |
| **Total current RRLs** | **14,431** | **8,662** | **4,560** | **6,678** | **6,787** | **27** | **41,146** | **20,573** | **20,573** | - |
| ***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-22 £'000 | May-22 £'000 | Jun-22 £'000 | Jul-22 £'000 | Aug-22 £'000 | Sep-22 £'000 | Oct-22 £'000 | Nov-22 £'000 | Dec-22 £'000 | Jan-23 £'000 | Feb-23 £'000 | Mar-23 £'000 | Total £'000 | YTD Budget £'000 | YTD Spend £'000 | Variance £'000 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Profiled Budget** | | | | | | | | | | | | | | | | | |
| Health Improvement | 1,268 | 2,538 | 1,454 | 2,248 | 2,621 | 646 | 3,445 | 2,699 | 1,083 | 3,651 | 3,585 | 4,355 | **29,591** | 10,774 | 10,356 | 419 | *3.9%* |
| Health Protection | 42 | 254 | 144 | 128 | 5,448 | 3,775 | 864 | 1,141 | 1,727 | 1,241 | 1,120 | 1,288 | **17,172** | 9,792 | 9,836 | (45) | *-0.5%* |
| Service Development & Screen | 79 | 144 | 102 | 489 | 53 | 11 | 192 | 430 | 201 | 303 | 493 | 1,869 | **4,367** | 878 | 840.82 | 37 | *4.2%* |
| Research & Development | - | - | - | - | - | - | - | - | 1,000 | 1,000 | 1,000 | 418 | **3,418** | - | - | - | *0.0%* |
| Campaigns | 3 | 2 | 18 | 5 | 15 | 52 | 40 | 130 | 227 | 342 | 332 | 777 | **1,943** | 95 | 67 | 28 | *29.3%* |
| Nursing & AHP | 2 | 3 | 50 | 14 | 19 | 19 | 43 | 53 | 645 | 668 | 662 | 1,699 | **3,876** | 106 | 95 | 11 | *10.7%* |
| Centre for Connected Health | - | 61 | 5 | - | 57 | - | 7 | 27 | 83 | 19 | 6 | 164 | **429** | 123 | 123 | 0 | *0.1%* |
| Quality Improvement | - | - | - | - | 38 | - | - | - | - | - | - | 104 | **142** | 38 | 39 | (1) | *-3.7%* |
| Other | - | - | - | - | - | - | - | - | - | - | - | (1,722) | **(1,722)** | - | 0 | 0 | *100.0%* |
| **Total PHA Direct Budget** | **1,393** | **3,001** | **1,772** | **2,884** | **8,252** | **4,503** | **4,591** | **4,480** | **4,965** | **7,225** | **7,198** | **8,950** | **59,215** | **21,806** | **21,357** | **449** | |
| ***Cumulative variance (%)*** | | | | | | | | | | | | | | | | ***2.06%*** | |
| **Actual Expenditure** | **521** | **3,970** | **1,106** | **2,336** | **8,954** | **4,470** | **-** | **-** | **-** | **-** | **-** | **-** | **21,357** | | | | |
| **Variance** | **873** | **(969)** | **666** | **548** | **(702)** | **33** | | | | | | | **449** | | | | |

The year-to-date position shows an underspend of approximately £0.4m against profile, primarily due to expenditure running behind profiled budgets. A year-end overspend position is anticipated, reflecting the use of forecast underspend within Administration budgets.

September 2022

# Public Health Agency
## 2022-23 Ringfenced Position

| | Annual Budget | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| | Covid £'000 | NDNA £'000 | Other ringfenced £'000 | Total £'000 | Covid £'000 | NDNA £'000 | Other ringfenced £'000 | Total £'000 |
| **Available Resources** | | | | | | | | |
| DoH Allocation | 2,224 | 272 | 491 | **2,987** | 2,124 | 32 | 160 | **2,315** |
| Assumed Allocation/(Retraction) | - | | | 0 | - | - | - | **-** |
| Total | 2,224 | 272 | 491 | **2,987** | 2,124 | 32 | 160 | **2,315** |
| **Expenditure** | | | | | | | | |
| Trusts | - | 65 | - | **65** | - | 32 | - | **32** |
| PHA Direct | 2,274 | 207 | 491 | **2,972** | 2,170 | 0 | 206 | **2,376** |
| Total | 2,274 | 272 | 491 | **3,037** | 2,170 | 33 | 206 | **2,408** |
| **Surplus/(Deficit)** | **(50)** | **-** | **-** | **(50)** | **(46)** | **(0)** | **(46)** | **(92)** |

PHA has received a COVID allocation totalling £2.2m to date, £2.1m of which is for Contract Tracing. A small overspend is forecast for the full year, maily relating to Vaccination roll out, which is currently being managed within the PHA's overall financial position.

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 a breakeven position is anticipated for the year.

Other ringfenced areas include Safe Staffing, NI Protocol and funding for SBNI. A small overspend has been shown for the year-to-date. This is a timing issue only, and it is expected that these areas will achieve a breakeven position for the year.

September 2022

## PHA Administration

**2022-23 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 | 4,887 | 623 | 3,489 | 16,298 | 322 | 379 | 619 | **26,617** |
| Goods & Services | 162 | 12 | 1,004 | 323 | 66 | 42 | 230 | **1,839** |
| **Total Budget** | **5,049** | **635** | **4,493** | **16,621** | **388** | **421** | **850** | **28,455** |
| **Budget profiled to date** | | | | | | | | |
| Salaries | 2,441 | 291 | 1,657 | 8,104 | 156 | 189 | 310 | **13,149** |
| Goods & Services | 82 | 6 | 501 | 163 | 33 | 21 | 115 | **920** |
| **Total** | **2,523** | **297** | **2,158** | **8,267** | **189** | **210** | **425** | **14,069** |
| **Actual expenditure to date** | | | | | | | | |
| Salaries | 2,451 | 273 | 1,438 | 7,533 | 198 | 266 | 308 | **12,467** |
| Goods & Services | 74 | 6 | 522 | 169 | 17 | 2 | 61 | **852** |
| **Total** | **2,525** | **279** | **1,960** | **7,703** | **215** | **268** | **369** | **13,319** |
| **Surplus/(Deficit) to date** | | | | | | | | |
| Salaries | (10) | 18 | 219 | 571 | (42) | (76) | 2 | **682** |
| Goods & Services | 8 | (0) | (21) | (7) | 16 | 19 | 54 | **68** |
| **Surplus/(Deficit)** | **(2)** | **18** | **198** | **564** | **(26)** | **(58)** | **56** | **750** |
| ***Cumulative variance (%)*** | *-0.08%* | *6.01%* | *9.16%* | *6.83%* | *-13.74%* | *-27.44%* | *13.20%* | ***5.33%*** |

PHA’s administration budget is showing a year-to-date surplus of £0.8m, which is being generated by a number of vacancies, particularly within Health & Well-being Improvement and SDS. 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 c£2.3m, which includes a release of the annual leave accrual.

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

# PHA Prompt Payment

## Prompt Payment Statistics

| | September 2022<br><br>Value | September 2022<br><br>Volume | Cumulative position as at September 2022<br>Value | Cumulative position as at September 2022<br>Volume |
|---|---|---|---|---|
| Total bills paid (relating to Prompt Payment target) | £4,469,631 | 332 | £28,955,620 | 2,766 |
| Total bills paid on time (within 30 days or under other agreed terms) | £4,451,330 | 317 | £28,392,151 | 2,701 |
| **Percentage of bills paid on time** | **99.6%** | **95.5%** | **98.1%** | **97.7%** |

Prompt Payment performance for September shows that PHA achieved the 95.0% target on both volume and value. The year to date position shows that on both value and volume, PHA is achieving its 30 day target of 95.0%. Prompt payment targets will continue to be monitored closely over the 2022-23 financial year.

The 10 day prompt payment performance remains very strong at 86.1% on volume for the year to date, which significantly exceeds the 10 day DoH target for 2022-23 of 70%.

**item 9**

| | |
|---|---|
| **Title of Meeting** | PHA Board Meeting |
| **Date** | 17 November 2022 |
| **Title of paper** | ALB Self-Assessment 2021/22 |
| **Reference** | PHA/02/11/22 |
| **Prepared by** | Robert Graham |
| **Lead** | Andrew Dougal |
| **Recommendation** | For **Approval** ☒ For **Noting** ☐ |

## 1 Purpose

The purpose of this paper is to approve the draft ALB Self-Assessment for 2021/22.

## 2 Background Information

The Public Health Agency is required to complete an annual self-assessment tool. In previous years it was a requirement to send the completed tool to the Department of Health, but while this is not the case, reference is made to it in PHA's Governance Statement.

## 3 Key Issues

The tool is in the same format as previous years, with the good practice section in the first half of the document and then PHA's responses to that in the second half.

Non-Executive Directors met to agree a plan for the completion of the Assessment on 9 August 2022. Following that workshop groups of Executive and Non-Executive Directors were tasked to complete different sections. A collation of the responses was considered by the Chair and a copy of the full assessment was circulated to all members for comment.

Following receipt of comments, this final version has been prepared and an action plan developed.

## 4 Next Steps

Progress against the Action Plan will be monitored during 2022/23 with work commencing on this year's Assessment in early 2023/24.

# BOARD GOVERNANCE SELF ASSESSMENT TOOL

## For use by Department of Health Sponsored Arms Length Bodies

**Updated 16th June 2016**

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## Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

**Application of the Board Governance Self-Assessment**

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

**Complete the self-assessment**: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

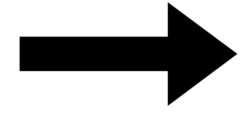
Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

**Approval of the self-assessment by ALB Board and sign off by the Chair**: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

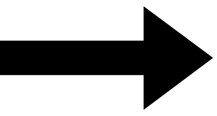
**Independent verification:** The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

## Overview

Self-assessment completed on behalf of the ALB Board



Self-assessment approved by ALB Board and signed-off by the ALB Chair



Case Study completed and report reconsidered by the ALB

The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

## Scoring Criteria

The scoring criteria for each section is as follows:

**Green** if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

**Amber**/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
  - robust Action Plans in place that are on track to achieve good practice; or
  - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

**Amber**/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
  - Action Plans are not in place, not robust or not on track;
  - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
  - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

**Red** if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

# 1. Board composition and commitment

## 1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

# 1. Board composition and commitment

## 1.1 Board positions and size

| Red Flag | Good Practice |
|---|---|
| 1. The Chair and/or CE are currently interim or the position(s) vacant.<br>2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago).<br>3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making. | 1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled.<br>2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities.<br>3. It is clear who on the Board is entitled to vote.<br>4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.<br>5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Standing Orders<br>• Board Minutes<br>• Job Descriptions<br>• Biographical information on each member of the Board. |

# 1. Board composition and commitment

## 1.2 Balance and calibre of Board members

| Red Flag | Good Practice |
| --- | --- |
| 1. There are no NEDs with a recent and relevant financial background.<br>2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.<br>3. The majority of Board members are in their first Board position.<br>4. The majority of Board members are new to the organisation (i.e. within their first 18 months).<br>5. The balance in numbers of Executives and Non Executives is incorrect.<br>6. There are insufficient numbers of Non Executives to be able to operate committees. | 1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan.<br>2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.<br>3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*.<br>4. There is at least one NED with a background specific to the business of the ALB.<br>5. Where appropriate, the Board includes people with relevant technical and professional expertise.<br>6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.<br>7. The majority of the Board are experienced Board members.<br>8. The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.<br>9. The Chair of the Board has previous non-executive experience.<br>10. At least one member of the Audit Committee has recent and relevant financial experience. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Board Skills audit<br>• Biographical information on each member of the Board |

# 1. Board composition and commitment

## 1.3 Role of the Board

| Red Flag | Good Practice |
|---|---|
| 1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues.<br>2. The Board tends to focus on details and not on strategy and performance.<br>3. The Board become involved in operational areas.<br>4. The Board is unable to take a decision without the Chief Executive's recommendation.<br>5. The Board allows the Chief Executive to dictate the Agenda.<br>6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making. | 1. The role and responsibilities of the Board have been clearly defined and communicated to all members.<br>2. There is a clear understanding of the roles of Executive officers and Non Executive Board members.<br>3. The Board takes collective responsibility for the performance of the ALB.<br>4. NEDs are independent of management.<br>5. The Chair has a positive relationship with Sponsor Branch of the Department.<br>6. The Board holds management to account for its performance through purposeful, challenge and scrutiny.<br>7. The Board operates as an effective team.<br>8. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.<br>9. Board members respect confidentiality and sensitive information.<br>10. The Board governs, Executives manage.<br>11. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.<br>12. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.<br>13. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken.<br>14. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them.<br>15. The Board is aware of and annually approves a scheme of delegation to its committees.<br>16. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes. |

| **Examples of evidence that could be submitted to support the Board's RAG rating.** | <ul><li>Terms of Reference</li><li>Board minutes</li><li>Job descriptions</li><li>Scheme of Delegation</li><li>Induction programme</li></ul> |
|---|---|

# 1. Board composition and commitment

## 1.4 Committees of the Board

| Red Flag | Good Practice |
|---|---|
| 1. The Board notes the minutes of Committee meetings and reports, instead of discussing same.<br>2. Committee members do not receive performance management appraisals in relation to their Committee role.<br>3. There are no terms of reference for the Committee.<br>4. Non Executives are unaware of their differing roles between the Board and Committee.<br>5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team. | 1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.<br>2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.<br>3. Schemes of delegation from the Board to the Committees are in place.<br>4. There are clear lines of reporting and accountability in respect of each Committee back to the Board.<br>5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle.<br>6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.<br>7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.<br>8. It is clearly documented who is responsible for reporting back to the Board. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Scheme of delegation<br>• TOR<br>• Board minutes<br>• Annual Evaluation Reports |

# 1. Board composition and commitment

## 1.5 Board member commitment

| Red Flag | Good Practice |
|---|---|
| 1. There is a record of Board and Committee meetings not being quorate.<br>2. There is regular non-attendance by one or more Board members at Board or Committee meetings.<br>3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings).<br>4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.<br>5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months. | 1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events.<br>2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.<br>3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.<br>4. Board meetings and Committee meetings are scheduled at least 6 months in advance. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Board attendance record<br>• Induction programme<br>• Board member annual appraisals<br>• Board Schedule |

# 2. Board evaluation, development and learning

## 2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;
2. Whole Board Development Programme;
3. Board induction, succession and contingency planning;
4. Board member appraisal and personal development.

# 2. Board evaluation, development and learning

## 2.1 Effective Board level evaluation

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months.<br>
2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years.<br>
3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc).<br>
4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).
</td><td>
1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months.<br>
2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken.<br>
3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.<br>
4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.<br>
5. The focus of the self assessment included traditional ‘hard’ (e.g. Board information, governance structure) and ‘soft’ dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum:<br>
• The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board’s membership currently has this;<br>
• How effectively meetings of the Board are chaired;<br>
• The effectiveness of challenge provided by Board members;<br>
• Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees;<br>
• Whether the Board’s agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.<br>
• The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.
</td></tr>
</table>

| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation<br>• The Board Scheme of Delegation/ Reservation of Powers |
|---|---|

# 2. Board evaluation, development and learning

## 2.2 Whole Board development programme

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members.<br><br>2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.</td><td>1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board’s annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements.<br><br>2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department’s expectations in relation to those roles and responsibilities.<br><br>3. Development specific to the ALB’s governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.<br><br>4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve:<br><br>• The focus and balance of Board time;<br>• The quality and value of the Board’s contribution and added value to the delivery of the business of the ALB;<br>• How the Board responded to any service, financial or governance failures;<br>• Whether the Board’s subcommittees are operating effectively and providing sufficient assurances to the Board;<br>• The robustness of the ALB’s risk management processes;<br>• The reliability, validity and comprehensiveness of information received by the Board.<br><br>5. Time is ‘protected’ for undertaking this programme and it is well attended.<br><br>6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>• The Board Development Programme<br>• Attendance record at the Board Development Programme</td></tr>
</table>

## 2. Board evaluation, development and learning

### 2.3 Board induction, succession and contingency planning

| Red Flag | Good Practice |
|---|---|
| 1. Board members have not attended the “On Board” training course within 3 months of appointment.<br>2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable.<br>3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable.<br>4. NED appointment terms are not sufficiently staggered. | 1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.<br>2. Induction for Board members is conducted on a timely basis.<br>3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation’s structure, ALB values and meetings with key leaders.<br>4. Deputising arrangements for the Chair and CE have been formally documented.<br>5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions. |
| **Examples of evidence that could be submitted to support the Board’s RAG rating.** | • Succession plans<br>• Induction programmes<br>• Standing Order |

## 2. Board evaluation, development and learning

### 2.4 Board member appraisal and personal development

| Red Flag | Good Practice |
|---|---|
| 1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.<br>2. Individual Board members have not received any formal training or professional development relating to their Board role.<br>3. Appraisals are perceived to be a 'tick box' exercise.<br>4. The Chair does not consider the differing roles of Board members and Committee members. | 1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair<br>2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.<br>3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).<br>4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.<br>5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.<br>6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.<br>7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Performance appraisal process used by the Board<br>• Personal Development Plans<br>• Board member objectives<br>• Evidence of attendance at training events and conferences<br>• Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors. |

# 3. Board insight and foresight

## 3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

# 3. Board insight and foresight

## 3.1 Board performance reporting

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>1. Significant unplanned variances in performance have occurred.<br><br>2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.<br><br>3. Finance and Quality reports are considered in isolation from one another.<br><br>4. The Board does not have an action log.<br><br>5. Key risks are not reported/escalated up to the Board.</td><td>1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.<br><br>2. The Board receives a performance report which is readily understandable for all members and includes:<br>• performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made;<br>• Variances from plan are clearly highlighted and explained ;<br>• Key trends and findings are outlined and commented on ;<br>• Future performance is projected and associated risks and mitigating measures;<br>• Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible.<br><br>3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made.<br><br>4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.<br><br>5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board's RAG rating.</td><td>• Board Performance Report<br>• Board Action Log<br>• Example Board agendas and minutes highlighting committee discussions by the Board.</td></tr>
</table>

# 3. Board insight and foresight

## 3.2 Efficiency and Productivity

<table>
<tr><th>Red Flag</th><th>Good Practice</th></tr>
<tr><td>
1. The Board does not receive performance information relating to progress against efficiency and productivity plans.<br><br>
2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans.<br><br>
3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need.<br><br>
4. The Board does not have a Board Assurance Framework (BAF).
</td><td>
1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.<br><br>
2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.<br><br>
3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.<br><br>
4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
</td></tr>
<tr><td>Examples of evidence that could be submitted to support the Board’s RAG rating.</td><td>
• Efficiency and Productivity plans<br>
• Reports to the Board on the plans<br>
• Post implementation reviews
</td></tr>
</table>

# 3. Board insight and foresight

## 3.3 Environmental and strategic focus

| Red Flag | Good Practice |
|---|---|
| 1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc.<br><br>2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB.<br><br>3. The Board does not formally review progress towards delivering its strategies. | 1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).<br><br>2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.<br><br>3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan.<br><br>4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.<br><br>5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF). |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • CE report<br>• Evidence of the Board reviewing lessons learnt in relation to enquiries<br>• Outcomes of an external stakeholder mapping exercise<br>• Corporate objectives and associated milestones and how these are monitored<br>• Board Annual programme of work<br>• BAF<br>• Risk register |

## 3. Board insight and foresight

### 3.4 Quality of Board papers and timeliness of information

| Red Flag | Good Practice |
|---|---|
| 1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing.<br><br>2. Board discussions are focused on understanding the Board papers as opposed to making decisions.<br><br>3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting.<br><br>4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision.<br><br>5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information | 1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.<br><br>2. A timetable for sending out papers to members is in place and adhered to.<br><br>3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).<br><br>4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings.<br><br>5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through.<br><br>6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.<br><br>7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality.<br><br>8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured.<br><br>9. Board members can demonstrate that they understand the information presented to them, |

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| | including how that information was collected and quality assured, and any limitations that this may impose.<br>10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Documented information requirements<br>• Data quality assurance process<br>• Evidence of challenge e.g. from Board minutes<br>• Board meeting timetable<br>• Process for submitting and issuing Board papers<br>• In-month reports<br>• Board papers<br>• Data Quality updates |

# 3. Board insight and foresight

## 3.5 Assurance and risk management

| Red Flag | Good Practice |
|---|---|
| 1. The Board does not receive assurance on the management of risks facing the ALB.<br>2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources.<br>3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic.<br>4. The Board has not reviewed the ALB's governance arrangements regularly. | 1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.<br>2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured.<br>3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc<br>4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.<br>5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.<br>6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Risk management policy and procedures<br>• Risk register<br>• Evidence of review of risks, e.g. Board minutes<br>• Evidence of review of governance structures, e.g. Board minutes<br>• Board Assurance Framework (BAF)<br>• Clinical and Social care governance policy |

# 4. Board engagement and involvement

## 4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

# 4. Board engagement and involvement

## 4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

| Red Flag | Good Practice |
|---|---|
| 1. The development of the Business Plan has only involved the Board and a limited number of ALB staff.<br><br>2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc.<br><br>3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports.<br><br>4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months.<br><br>5. The Board has not overseen a system for receiving, acting on and reporting | 1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services.<br><br>2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including ‘hard to reach’ groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.<br><br>3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan.<br><br>4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan. |

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| outcomes of complaints. | 5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide<br><br>6. The ALB has constructive and effective relationships with its key stakeholders. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • PPI Consultation Scheme<br>• Complaints<br>• Customer Survey<br>• Regulatory and Review reports |

# 4. Board engagement and involvement

## 4.2 Internal stakeholders

| Red Flag | Good Practice |
|---|---|
| 1. The ALBs latest staff survey results are poor.<br><br>2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.).<br><br>3. There are significant unresolved quality issues.<br><br>4. There is a high turn over of staff.<br><br>5. Best practise is not shared within the ALB. | 1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.<br><br>2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included.<br><br>3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.<br><br>4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB.<br><br>5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours.<br><br>6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Staff Survey<br>• Grievance and disciplinary procedures<br>• Whistle blowing procedures<br>• Code of conduct for staff<br>• Internal engagement or communications strategy/ plan. |

# 4. Board engagement and involvement

## 4.3 Board profile and visibility

| Red Flag | Good Practice |
|---|---|
| 1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.<br><br>2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions). | 1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.<br><br>2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.<br><br>3. Board members attend and/or present at high profile events.<br><br>4. NEDs routinely meet stakeholders and service users.<br><br>5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.<br><br>6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. |
| **Examples of evidence that could be submitted to support the Board's RAG rating.** | • Board programme of events/ quality walkabouts with evidence of improvements made<br>• Active participation at high-profile events<br>• Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings |

# 5. Board Governance Self- Assessment Submission

## Name of ALB – Public Health Agency

Date of Board Meeting at which Submission was discussed – 20 October 2022

Approved by Andrew Dougal (ALB Chair)

# 1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2022

## 1.1 Board positions and size

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br><br>Green | During the year 3 new Non Executive Directors were appointed bringing the Board back to its full complement and ensuring that it has an appropriate range of skills and expertise to discharge its functions.<br><br>In addition the previous interim Director of Finance Non Executive post holder was appointed into the role permanently following a full Recruitment and Selection process. | | | |
| GP2<br>Green | The Board receives full information from senior officers in order to inform it in its deliberations, decisions and evaluatons | | | |
| GP3<br>Green | The process for voting, and who the voting members are is as outlined in Standing Order 5.2.17. Members are aware of their responsibilities in this area | | | |

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| | from induction and through guidance from the chair. | | | |
| GP4 Green | There are only two Committees of the Board and these are stipulated in standing orders:<br>• The Governance and Audit Committee<br>• The Remuneration and Terms and Conditions of Service Committee.<br><br>The Chair has initiated discussions on the scope for a further committee to examine performance and resourcing . | Terms of reference for a new Committee will be finalised by October 2022. | | |
| GP5 Green | The appointment time of NEDs is appropriately managed to ensure continuity of corporate memory is retained across the Board. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |

## 1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2022

### 1.2 Balance and calibre of Board members

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or<br>Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br>Green | The appointment of NED's is the responsibility of the Department of Health and the Public Appointments Unit overwhich the PHA has no control.<br><br>With the appointment of 3 new Non Executive Directors in year the Board has now been returned to its full complement. Board members bring a wide and varied set of skill sets and experience which accord with both the business of the PHA and the need to ensure effective controls and governance are in place.<br><br>As a result of the appointments process, on 31st March 2022 there were three females and five male non- executive directors.<br><br>Of the Executive Directors one of the four is female and three are male. However from December 2021 onwards Dr. | | | |

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| | Brid Farrell acted into the positon of DPH due to the long term absence of Dr. Stephen Bergin thereby increasing the female complement to 2 of the 4 positions.<br><br>Two of the four Executive Directors are in interim positions.<br><br>There is a broad range of experience across all three sectors. | | | |
| GP2<br>Green | The Board now has an appropriate representation of experienced members across all 3 sectors. | | | |
| GP3<br>Green | The Board is extremely conscientious in its concern to ensure equality of opportunity in accordance with Section 75 of the Northern Ireland Act 1998 and oversees the submission of the annual Equality report to the Equality Commission | | | |
| GP4<br>Green | There are three Non-Executive Directors with a background spedific to the business of the PHA. | | | |
| GP5<br>Green | As per legislation, the Board is constituted from local government and lay members. | | | |

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| | The Board includes people with relevant technical and professional expertise. | | | |
| GP6 Green | As at 31 March 2022 the composition of the Board reflects the need for a balance btween those that are new and those that have served for longer than 3 years. | | | |
| GP7 Green | All Board members are experienced board members. | | | |
| GP8 Green | The Chair of the board has 32 years experience of leading a large and complex organisation up to 2015.<br><br>This organisation would have been regulated by the Northern Ireland Charity Commission. | | | |
| GP9 Green | The Chair of the Board has served on boards in the private, voluntary and public sector since 1985. | | | |
| GP10 Green | The Chair of the Governance and Audit Committee has highly competent financial skills as does the Chair of the Board. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |
| RF5 | | |
| RF6 | | |

## 1. Board composition and commitment  ALB Name - Public Health Agency  Date – 31 March 2022

### 1.3 Role of the Board

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | The role and responsibility of the board is outlined within Standing Orders. Members will have a copy of Standing Orders as part of their induction. Standing Orders are reviewed annually with the last update approved at the Board meeting of March 2021. | | | |
| GP2 Green | There a clear understanding of the distinct roles of the executive officers and the non-executive board members as outlined in job descriptions and the scheme of delegation within Standing Orders.<br><br>During 2021/22 a Buddy system was introduced to help improve understanding of roles. | | | |
| GP3 Green | The Board takes collective responsibility for the performance of the ALB. It is important that if there are any shortcomings that these are | | | |

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| | acknowledged and addressed with vigour. In year a new performance monitoring system was introduced by the Board to address previous shortcomings in process. The Board is satisfied that it takes responsibility for the performance of the ALB. | | | |
| GP4 Green | Non-Executive Directors regularly make a point of emphasising the role of challenge and support for the Board. | | | |
| GP5 Green | The Chair has a positive relationship with sponsor branch of the Department and is in regular contact.<br><br>The Chair and Chief Executive are members of the Programme Board overseeing the reform and refreshing of the PHA and liaise directly with the CMO in this regard through a Review Programme Board.<br><br>The Chair is also a member of the Health ALB's Chairs' Forum which provides a good opportunity to discuss issues directly with the Minister and Senior DoH colleagues. | The Chair should discuss with the Chief Executive how this can be improved. | | |
| GP6 Green | All NEDs hold the CEO and Executive Directors to account | | | |

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| | at regular Board meetings and Committee meetings. | | | |
| GP7 Green | The Board effectiveness is considered to be of a high standard.<br><br>During the year additional Board workshops and meetings have facilitated effective team building. | | | |
| GP8 Green | The Board makes decisions based on data and evidence presented.<br><br>The board as a whole shares corporate responsibility for all decisions. | | | |
| GP9 Green | Board members do respect confidentiality and sensitive information. | The Board Secretariat will work with Non-Executive Board members to ensure their HSC laptops are fully operational. | | |
| GP10 Green | The Board is clear on the relative responsiblilities to be discharged by Board and at Executive level. The Board governs and Executives manage. | | | |
| GP11 Green | Board members contribute fully to board decisions and deliberations and exercise a challenge function which is both healthy and supportive. | | | |

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| GP12<br>Green | The Chair is always available for guidance and advice for board members. | | | |
| GP13<br>Green | The Chair maintains a clear focus on the important issues facing the Board and facilitates the Board discussions so that all members are heard, engaged and actively involved in debate and constructive challenge prior to making a Board decision. | | | |
| GP14<br>Green | The Board is provided with the appropriate information and considers the concerns and needs of identified stakeholders.<br>As the Regional lead for PPI across the HSC the Board takes seriously its responsibility to drive forward its role in regard to Patient and Public Involvement across its programmes of work. | | | |
| GP15<br>Green | Currently the Board does not approve annually the scheme of delegation to its committees. While Committees do not have delegated powers of decision making, their terms of reference are included within Standing Orders which are approved by the Board. | | | |
| GP16 | The Board receives evaluation | | | |

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| Green | reviews on some programmes and projects. However, the Board has agreed that more work is required to ensure consistent and in depth evaluation is provided in a timely fashion on a Outcomes based plaform. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |
| RF5 | | |
| RF6 | | |

## 1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2022

### 1.4 Committees of the Board

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | Clear terms of reference have been given for the two statutory committees of the Board. | | | |
| GP2 Green | The Board is aware that it has full responsibility for all decisions taken by committees of the board. | | | |
| GP3 Green | The scheme of delegation is outlined in Standing Orders. | | | |
| GP4 Green | There are clear lines of responsibility in terms of reporting and accountability regarding each committee back to the Board. | | | |
| GP5 Green | There is an Assurance Framework in place that covers the Board, and its Committees, and this is reviewed and approved by the Governance and Audit Committee and also the Board. It outlines the frequency of when certain reports and papers should come to the Board and the | | | |

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| | assurance provided. | | | |
| GP6 Green | The Board receives regular reports from its committees. These summarise the key issues as well as any decisions or recommendations made. | | | |
| GP7 Amber | The GAC undertakes a formal evaluation each year of the performance of its committee. (Self assessment). However, a formal evaluation of the Remuneration Committee has not been undertaken. The Chairs of committees report back to the chair of the Board regarding the annual appraisal of each member of such committees. | There is a need to carry out an audit of the effectiveness of the Remuneration Committee. | | |
| GP8 Green | The Chair of the committee is responsible for reporting back to the board on all issues dealt with by that committee. This is understood by all Board members. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |

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|---|---|---|
| RF5 | | |

## 1. Board composition and commitment ALB Name - Public Health Agency Date – 31 March 2022

### 1.5 Board member commitment

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | An attendance record is maintained by the Secretariat. Attendance is generally very good for board and committee meetings.<br><br>The Chair discusses attendance with members as part of their appraisal. | | | |
| GP2 Green | Members' commitment is 5 days per month which is broken down as 1 day for board meeting, 1 day for committee meetings and general background reading, 2 days for reading papers and 1 day available for any other ad hoc events and launches | | | |
| GP3 Green | Board members have all received a copy of the DHSSPS Code of Conduct and Code of Accountability. Compliance is included in the Chair's annual appraisal of NEDs. | | | |

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| GP4<br>Green | An annual schedule of meetings is prepared and agreed with members in relation to Board meetings, workshops and strategic days.<br><br>Schedules are also in place for Governance and Audit and Remuneration Committees and other specific meetings. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |

## 2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2022

### 2.1 Effective Board level evaluation

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | The PHA Board completed its annual self-assessment in 2020/21. | By 15 January 2023, the Board will stipulate how it plans to complete the self-assessment for 2022/23. | | |
| GP2 Green | The PHA Board continues to review itself to ensure improvement and development. | | | |
| GP3 Green | The PHA Board continues to carry out regular engagement sessions based on the On Board review recommendations. | | | |
| GP4 Red | The Board has not obtained the perspective of staff or external stakeholders in the completion of this questionnaire. | Linked to GP1 above, the Board will also stipulate how it intends to engage with staff and stakeholders as part of the process for completing the questionnaire. | | |
| GP5 Green | The current self-assessment has covered those questions/areas included in the DHSSPS checklist, both ‘hard’ and ‘soft’ dimensions of effectiveness. | | | |

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| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
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| RF1 | | |
| RF2 | The Board will aim to have an independent evaluation of its Self-Assessment for 2022/23 (by June 2023) | |
| RF3 | The Board will undertake a survey of those outside the Board as part of its self-assessment in 2022/23 (by June 2023) | |
| RF4 | | |

## 2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2022

## 2.2 Whole Board development programme

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | Following the review of Board effectiveness, a paper was prepared during 2018/19 outlining a suggested series of workshops on a range of public health topics. A series of workshops, facilitated by Anne McMurray took place during 2019/20 giving members an overview of different work programmes within the PHA. This work also led to a much greater appreciation by Non-Executive Directors and Executive Directors of their respective roles. All Board Directors now are aware of the pressures and constraints experienced by Directors. | | | |
| GP2 Green | The relationship between the Minister, Department and ALB board members is included in the Management Statement.<br><br>Management Statements and due to be replaced by Partnership Agreements but the | | | |

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| | work on this has not yet finished.<br><br>The Chair and Chief Executive raised the need for this work to be progressed at an Accountability Review meeting with the Chief Medical Officer on 22 March 2022. A workshop was arranged by the Permanent Secretary for July 2022. | | | |
| GP3 Green | The Governance & Audit Committee has oversight on all matters of the control and challenge function of the PHA Board. Its meetings are reported directly to the Board both for noting and action. The GAC Chair also provides an update alongside the minutes whist compiling an Annual Report. | | | |
| GP4 Green | This will be covered as part of the Board Development Programme referenced at GP1 above. | | | |
| GP5 Green | This will be covered as part of the Board Development Programme referenced at GP1 above. | | | |
| GP6 Green | This will be covered as part of the Board Development Programme referenced at GP1 | | | |

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| | above. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |

## 2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2022

### 2.3 Board induction, succession and contingency planning

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or<br>Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br>Green | All Board members have had induction which includes attendance at the On Board training course.<br><br>Specific induction is also provided for new members of the Governance and Audit Committee.<br><br>There is not a highly prescriptive process for the induction. The induction is tailored to each individual depending on the extent of their experience and knowledge of the subject matter.<br><br>New members will meet with in the first instance the Chair followed by a meeting with the Chief Executive, the Director of Finance, Director of Public Health, the Director of Nursing and AHP and the Director of HSCQI. | | | |

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| GP2 Green | Induction is undertaken as soon as possible after appointment. | | | |
| GP3 Green | At the induction, new members will receive a pack of relevant corporate and strategic documentation.<br><br>As part of the Board effectiveness review, the induction process was reviewed. | | | |
| GP4 Amber | Deputising arrangements are specified within Standing Orders.<br>An Interim Deputy Chief Executive was appointed, but retired in 2020/21. The role of Deputy Chair is currently vacant as the previous Deputy has resigned from the Board. | The appointment of a Deputy Chair will be reviewed by December 2022. | | |
| GP5 Green | Appropriate action has been taken by the PHA. The Chair will liaise with PAU to ensure that any future vacancies do not impact on the governance of the PHA. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |

| RF3 | | |
|---|---|---|
| RF4 | | |

## 2. Board evaluation, development and learning ALB Name - Public Health Agency Date – 31 March 2022

### 2.4 Board member appraisal and personal development

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or<br>Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br>Green | Annual appraisals are carried out by the Chair in line with the requirements of the PAU.<br><br>The Chair has initiated a series of more regular 1:1 meetings with members. | | | |
| GP2<br>Green | The Chief Executive carries out appraisals with Executive Directors. The performance of the Chief Executive and Executive Directors is discussed at the Remuneration Committee. | | | |
| GP3<br>Green | The Chair receives an appraisal from the Chief Medical Officer. | | | |
| GP4<br>Green | As part of the appraisal system, this is clearly discussed and specified to ensure continuous development.<br><br>Not all will have been given specific responsibilities, this will be reviewed by the Chair. | | | |

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| GP5<br>Amber | Board members appraisals allow members to highlight development needs.<br><br>At each appraisal the chair explicitly asks each Non-Executive Director what additional training they feel would be useful. | It is proposed by the Chair that in addition to the annual appraisal the chair will have one-to-one meetings with all Non-Executive Directors. | | |
| GP6<br>Green | This is covered through the appraisal system and PDPs, as well as through Director/Chief Executive away days. Relevant training/awareness is also built in where particular needs arise during the year. | | | |
| GP7<br>Green | Where appropriate, this is the case. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |

## 3. Board insight and foresight

**ALB Name - Public Health Agency Date – 31 March 2022**

### 3.1 Board performance reporting

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | PHA prepared an Annual Business Plan for 2021/22. During the course of the year, an approach was initiated by AMT of providing quarterly reports against the actions set out in the Business Plan to the Board. The Board received and discussed regular reports on financial performance at its meetings. The Board agreed an Annual Report and accounts for the year ending 31st March 2022, reflecting progress on delivering on corporate priorities and highlighting examples of the work undertaken during the period.<br><br>The PHA Corporate Strategy and Annual Business Plan (including commissioning direction targets) set the parameters for performance reporting. Work is ongoing to | | | Moving into 2022/23, the Board will focus further attention on PHA performance in relation to discharging responsibilities around SAIs and in dealing with complaints. |

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| | develop a new PHA Corporate Strategy. In light of pressures on HSC organisations in 2021/22, DoH agreed that existing Corporate Strategies for all ALBs could be extended to cover 2021/22. | | | |
| GP2 Amber | During the year, an approach was initiated by AMT of providing quarterly reports against the actions set out in the 2021/22 Business Plan to the Board. This began following fieldwork for a report by Internal Audit on Board Effectiveness which highlighted the lack of a robust performance management framework being in place. | In developing the 22/23 Annual Business Plan, a focus should be placed on identifying a number of measurable KPIs linked to actions and that quarterly reporting against the Business Plan should continue. | | |
| GP3 Green | The Committee Chairs provide updates to the Board following each Committee meetings as specified in Standing Orders. The approved minutes of each Committee are brought to the Board for noting. | | | |
| GP4 Green | The Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the | | | |

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| | Governance and Audit Committee.<br><br>The Board is briefed in both public and confidential sessions of new and emerging risks where necessary.<br><br>BSO Internal Audit carried out an audit of risk management in early 2022/23, the outcome of which will be reported to GAC in July 2022. | | | |
| GP5<br>Green | BSO Internal Audit in its report on Board Effectiveness identified that while an action log is maintained of actions arising at Board meetings, this document is not formally considered at the next Board meeting as a means to formally confirm the status of actions arising.<br><br>From January 2022 an action log began to be kept for Board meetings. This identifies the owner of the action, the due date and status. This is presented in advance of the subsequent meeting and is discussed under matters arising. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | Finance and Quality reports are considered in isolation from one another. However, should the Board perceive that quality is less than optimal, it may look to see if one of the reasons is a lack of supporting resources. | |
| RF4 | | |
| RF5 | | |

## 3. Board insight and foresight

**ALB Name - Public Health Agency Date – 31 March 2022**

### 3.2 Efficiency and Productivity

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or<br>Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br>Green | The Board is assured that there are robust processes for assessing risks and the potential knock on or impact these could have on the health and social care system.<br><br>During 2021/22, the Board regularly discussed the impact of the Covid-19 pandemic on the health and social care system and the delivery of important programmes. | | | |
| GP2 | Not applicable. | | | |
| GP3<br>Green | While the Board has not received information on efficiency and productivity plans, any risks to non-achievement in performance are highlighted in the Performance Management Report. | | | |
| GP4<br>Green | Ongoing risks to service delivery across various PHA | | | |

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| | programmes are monitored. Key performance is reported via the PHA Performance Report. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |

## 3. Board insight and foresight

**ALB Name - Public Health Agency Date – 31 March 2022**

### 3.3 Environmental and strategic focus

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | The Chief Executive provides a verbal report at every Board meeting. This, if required, will cover areas such as the external environment, policy changes and any other areas as required.<br><br>The Chair also provides a written report for each meeting of the Board. | | | |
| GP2 Amber | BSO Internal Audit carried out an audit of Serious Adverse Incidents (SAIs) within PHA and HSCB during 21/22, the report of which was discussed at the Governance and Audit Committee in April '22. The audit considered the robustness of the arrangements in place within both HSCB and PHA for the governance, oversight and performance management/accountability | The implementation of the recommendations made by BSO Internal Audit by AMT will be monitored by the Governance and Audit Committee and reported to the whole Board. An action plan was shared with Governance and Audit Committee in April '22 outlining the steps being taken to address the recommendations made by Internal Audit. | | |

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| | arrangements in place in respect of SAIs. A limited assurance was provided, on the basis that HSCB and PHA does not have a joint accountability mechanism in place to ensure each partner delivers their respective responsibilities. Management indicated that HSCB (SPPG) and PHA, as part of their improvement plan, are developing a partnership agreement which will set out the escalation arrangement between SPPG and PHA. It was recommended that Performance information to the Agency Board needs to be significantly developed. This recommendation was accepted by management.<br><br>The Board considers findings and recommendations from reports that relate directly or indirectly to the PHA, and consider the impact of such reports on the PHA. The Board develops actions in conjunction with the Agency Management Team to respond to any such findings and recommendations, as well as considering the learning outcomes in an effort to sustain continuous | | | |

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| | organisational improvement. | | | |
| GP3<br>Green | PHA prepared an Annual Business Plan for 2021/22 which was brought to the Board for approval. The Business Plan highlighted the need to continue to focus a significant element of resource on dealing with the Covid-19 pandemic, whilst also attempting to return to 'business as usual'. The plan reflected the key actions from all functions and directorates across the five strategic outcomes and three delivery areas. | In developing the 22/23 Annual Business Plan, the PHA Board agreed to focus on achieving a smaller number of high priority corporate outcomes, with KPIs attached. An enhanced focus was placed on identifying a number of measurable KPIs linked to actions. Quarterly reporting against the Business Plan is continuing.<br>(Same as GP1 above) | | |
| GP4<br>Green | As GP3 above, and reports are brought to the board on a quarterly basis as outlined in section 3.1 (GP2). There is also an Assurance Framework which outlines what reports are required to be brought to the board and a corporate calendar outlining when these will be brought to the board.<br><br>Work is ongoing to develop a new PHA Corporate Strategy. In light of pressures on HSC organisations in 2021/22, DoH agreed that existing Corporate Strategies for all ALBs could be extended to cover 2021/22. | | | |

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| GP5<br>Green | The Board's annual programme of work allows for time for the board to consider environmental and strategic risks (including confidential board meetings, board workshops and board away day). Where relevant the Assurance Framework will be amended to include additional reporting, and/or amendments brought back through Executive Directors for the Risk Register.<br><br>As per section 3.1 (GP4) the Corporate Risk Register is openly discussed and challenges on same are made at the Governance and Audit Committee. The Corporate Risk Register is brought to the Board annually, or more frequently at the request of the Governance and Audit Committee.<br><br>The Chair and Chief Executive of the Agency sit on the Departmental Programme Board undertaking a programme to reshape and refresh the Agency. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
| --- | --- | --- |
| RF1 | | |
| RF2 | | |
| RF3 | | |

## 3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2022

### 3.4 Quality of Board papers and timeliness of information

| | Evidence of compliance with good practice (Please reference supporting documentation below) | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Amber | Efforts have been made to improve the interval between meetings of the GAC and Board. The Board does not currently receive the minutes of the most recent GAC meeting, but a verbal update on that meeting is provided by the Chair of GAC to the Board, with the approved minutes following at subsequent Board meetings. | Timetable of Board and GAC meetings for 2022/23 will be reviewed. | | |
| GP2 Green | A timetable is drawn up each year for board meetings and governance and audit committee meetings. Papers are dispatched one week before the meeting giving members 5/6 days to absorb what is sometimes a very large volume of documents. | Reports should be provided to Directors three weeks in advance of the Board meeting in order to allow time for revision and change. Report authors should know that if reports are not received in the appropriate format they will not be placed before the board. | | |
| GP3 Green | The Committee Manager has instituted a system whereby those submitting reports to the | In August 22, the Board held a workshop to review the Assurance Framework. This included further | | |

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| | board must indicate clearly on the front page the role of the board i.e. noting, approving, decision, discussion. The chair of GAC has raised the issue of the need for clarity in terms of the rationale behind whether it should be noting, approving, decision-making or discussion. | discussion on the need for clarity in terms of the rationale behind whether items should be for noting, approving etc. AMT will review and make further proposals to the Board in relation to the matters brought before the Board under the Assurance Framework. | | |
| GP4 Amber | Many programmes which are delivered by Health and Social Trusts or by voluntary organisations are not subject to performance against key objectives as far as the Board is concerned. There is a need for Board to stipulate which programmes should be presented to the board in order to satisfy Board members that the outcomes of these programmes are as agreed and to a sufficiently high level.<br><br>During 2022/23 it is proposed that a Performance Committee is established and as part of its role, it will ask to see annual evaluation reports on a selected number of projects during the course of each year. | If an urgent issue arises in between board meetings the chair of the Chief Executive will write by email to Board members alerting them to any urgent developments. If necessary the Chair or Chief Executive may discuss issues by telephone with Board members particularly in the case of a highly sensitive issue. | | |
| GP5 Amber | Board papers include the relevant information in respect of proposals or decisions that | Reports should follow the guidance in the ICSA publication,"Effective Board Reporting"(2018) (for | | |

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| | have been proposed or made. They also state if they have been considered by the Executive Team, or other board committee before they are brought to the board. | implementation by March 2023).<br>The Chair will seek to identify potential training in terms of how Board papers should be prepared. | | |
| GP6<br>Amber | The Board is presented with quality updates. The PHA has a robust mechanism for ensuring the collection and analysing of data.<br>Board members regularly question and challenge data to ensure quality and understanding of same when both verbal and formal papers are brought to Board meetings.<br><br>Also, the Governance and Audit Committee have the opportunity to challenge and question data provided.<br><br>Internal and External Audit consider data quality in relevant audits. | There is scope to improve the presentation of data in order that trends over time can be identified (for implementation by March 2023)<br><br>The Chief Executive has initiated a review of data collection and to ensure that there is complete robustness in such data. | | |
| GP7<br>Green | The Board cannot recollect a discussion about the underlying data quality of performance measures.<br><br>A review of PHA by Dr Ruth Hussey made recommendations with regard | | | |

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| | to the PHA developing its science and intelligence capability. PHA is hoping to secure funding to implement fully the recommendations of that Review. | | | |
| GP8 Green | The Assurance Framework outlines clearly the information being brought to the Board for approval/noting etc. Board members discuss the information status at various workshops. | See action under GP3 above. | | |
| GP9 Amber | Board members will not always be able to demonstrate that they understand fully the information presented to them particularly how that information was collected and quality assured.<br><br>Board members will be encouraged by the Chief Executive to contact him in an instance where they do not understand information or complex data. The Chair himself will attempt to answer this. if not this is not possible he will refer the matter to a senior member of staff with the appropriate expertise. That member of staff will report back either to the chair or to the Board member concerned. | Board members should seek to ensure that the collection of data is properly quality assured (for implementation by March 2022)<br><br>As noted under GP5 above, the Chair is aiming to identify a suitable training in the preparation and content of Board reports are near to completion. It is hoped that such training will take place no later than the 15th of February 2023 | | |

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| GP10<br>Amber | The PHA takes all steps to ensure that documentation presented to the Board complies with DoH guidance where appropriate. However, the design of reports needs to be reviewed. | When reports are being designed and written, authors and editors must keep in mind and be explicit about the purpose of presenting each report to the board (for implementation by March 2022)<br><br>See comment under GP5 above re training. | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |
| RF5 | | |

## 3. Board insight and foresight

ALB Name - Public Health Agency Date – 31 March 2022

### 3.5 Assurance and risk management

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | The PHA has a clear strategy and policy and procedures in relation to risk management and emerging risks which have been approved by the GAC. These are regularly reviewed and are also supported by operational procedures. This clearly includes the level of risk, risk appetite and how risks escalate from directorate risk register to Corporate Risk Register, as well as reporting arrangements to GAC and PHA Board.<br><br>During 2021/22, the Governance and Audit Committee continued to review directorate risk registers from across the organisation.<br><br>BSO Internal Audit carried out an audit of risk management in early 2022/23, the outcome of which will be reported to GAC in July 2022. | | | |

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| GP2<br>Green | There is an Assurance Framework in place which outlines the key sources of assurances and how these will be reported to the board.<br>The risk register is brought to the GAC each quarter, where it is scrutinised. It is also brought to the Board annually. | | | |
| GP3<br>Green | The Assurance Framework identifies a range of sources of assurance for the board, including internal and external audit. | | | |
| GP4<br>Green | The Board regularly reviews/updates governance arrangements and practices against DoH standards, good practice and good governance standards for public service. | | | |
| GP5<br>Green | Given the nature of the PHA functions it does not have a separate clinical and social care risk assessment and management. All types of risk are included in the Directorate and Corporate risk registers and are subject to systematic review. | | | |
| GP6<br>Green | The Director of Public Health is responsible for professional issues in respect of medical | | | |

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| | staff, and the Director of Nursing and AHP for nursing and AHP staff. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |

## 4. Board engagement and involvement

ALB Name - Public Health Agency Date – 31 March 2022

### 4.1 External stakeholders

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or<br>Areas were additional assurance is required |
|---|---|---|---|---|
| GP1<br>Green | The PHA has an approved PPI consultation scheme and has had service users present to the Board.<br><br>The Agency Management Team has commissioned a survey of members of the public. The Chair of the Board has been pressing for this for some years. | | | |
| GP2<br>Green | A variety of methods is used across the PHA to engage with service users and the wider public. Board members can attend a range of activities/events/conferences of voluntary, community organisations as well as other HSC events.<br><br>The Chair and Chief Executive report at monthly board meetings in respect of events etc they have attended. | | | |

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| | Executive Directors will also have direct contact with a range of external stakeholders.<br><br>It is the plan to consult with those users who are in “hard to reach” groups. | | | |
| GP3 Amber | When the PHA developed its Corporate Plan for the period 2017/21, this involved a public consultation exercise, part of which saw two stakeholder events which offered an opportunity for stakeholders to attend and give their views on PHA’s future strategic direction. | During 2022/23 the PHA will develop its approach for how it will consult on its new Corporate Strategy. | | |
| GP4 Green | The PHA Business Plan is available in a number of formats to ensure access to a wide range of stakeholders. The Business Plan is in a format that has been tried and tested to ensure a wide range of stakeholders understand the work of the PHA. | | | |
| GP5 Green | The PHA ensures that the learning from SAIs is disseminated through learning letters and where appropriate influences the commissioning of services | | | |
| GP6 Green | PHA Board / Agency has very constructive and effective relationships with a range of key stakeholders. | | | |

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| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |
| RF4 | | |
| RF5 | | |

## 4. Board engagement and involvement ALB Name - Public Health Agency Date – 31 March 2022

### 4.2 Internal stakeholders

| | Evidence of compliance with good practice (Please reference supporting documentation below) | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Green | For some 18 months and more the chair in the Chief Executive have undertaken staff engagement sessions every two months with staff in order to discuss issues of concern throughout the organisation. This has proved to be very constructive and fruitful.Both the Chair and the Chief Executive are completely committed to continuing these staff engagement sessions notwithstanding the Chair and Chief Executive are keen to have face-to-face contact with individuals. The Chief Executive has embarked on a programme of visits to the various offices of the PHA both in Belfast and then other locations. During his first year in post he has made a point of visiting on at least one occasion each of the locations for staff of the PHA. | | | |
| GP2 | Staff are involved in the | | | |

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| Green | development of corporate and directorate business plans at directorate/function level. This information is then fed through to the corporate business plan. | | | |
| GP3<br><br>Green | This is communicated through Directors to their teams, and is the basis for appraisals. | | | |
| GP4<br><br>Green | The Board regularly thanks individuals and departments at Board meetings or other group functions, it acknowledges contributions and achievements as and when appropriate.<br>A new weekly staff newsletter, inPHA, was launched in June 2016 and this highlights and acknowledges achievements of PHA staff. | | | |
| GP5<br><br>Green | The PHA Board and Agency have clear values and behaviours that have been communicated to staff not only in internal meetings by management, but clearly in policies and procedures. | | | |
| GP6<br><br>Green | Staff are informed about major risks etc through a range of channels, including emails from the Chief Executive, and through Chief Executive and Directorate briefings. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |
| RF3 | | |

## 4. Board engagement and involvement

ALB Name - Public Health Agency Date – 31 March 2022

### 4.3 Board profile and visibility

| Evidence of compliance with good practice (Please reference supporting documentation below) | | Action plans to achieve good practice (Please reference action plans below) | Explanation if not complying with good practice | Areas were training or guidance is required and/or Areas were additional assurance is required |
|---|---|---|---|---|
| GP1 Amber | Due to lingering impact of COVID-19 there have not been as many events or opportunities for NEDs to engage with staff apart from the online staff engagement sessions which are organised by the Chair and Chief Executive approximately every 2 months.<br><br>Board workshops have provided the opportunity for staff to present to board members and discuss programme areas in more depth. | Board members should continue to be kept informed of opportunities to attend high profile events. | | |
| GP2 Amber | As above there has not been the same opportunity in 2021/22 for Board members, and in particular the Chair and Chief Executive to attend a range of meetings and events with external stakeholders.<br><br>The Chair is a very active member of the Health Chairs’ | Board members should continue to be kept informed of opportunities to attend high profile events. | | |

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| | Forum. There is much cross fertilisation in the discussions with Chairs of other health bodies. He is also an active member of the Public Sector Chairs Forum for Northern Ireland where there is an opportunity to meet and discuss issues with tears of ALBs across government departments.<br><br>The Chair is an active member of the Institute of Directors and uses that as an opportunity to promulgate the work of the PHA In an informal manner. | | | |
| GP3 Amber | Largely due to COVID-19 this has not been the case during 2021/22. However, towards the end of the year and into the beginning of 2022/23 the situation began to change with NEDs being invited to events e.g. Balmoral Show. | Board members should continue to be kept informed of opportunities to attend high profile events. | | |
| GP4 Amber | As GP3 above. | Board members should continue to be kept informed of opportunities to meet with stakeholders and service users. | | |
| GP5 Green | The Board holds its meetings in public, and only has a small number of confidential sessions, with very specific, sensitive and/or urgent agendas. Board agendas and | | | |

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| | minutes are published on the PHA website.<br><br>The schedule of meetings later into 2022 includes meetings in other PHA offices, e.g. Tower Hill and Gransha Park. | | | |
| GP6 Green | As part of the Board member appraisal process, the Chair gives feedback to NEDs on their contributions at meetings and values informed and challenging contributions at Board meetings. | | | |

| Red Flags | Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag | Notes/Comments |
|---|---|---|
| RF1 | | |
| RF2 | | |

**Summary Results** **ALB Name - Public Health Agency** **Date – 31 March 2022**

| 1.Board composition and commitment | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| 1.1 Board positions and size | **Green** | |
| 1.2 Balance and calibre of Board members | **Green** | |
| 1.3 Role of the Board | **Green** | |
| 1.4 Committees of the Board | **Green** | |
| 1.5 Board member commitment | **Green** | |

| 2.Board evaluation, development and learning | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| 2.1 Effective Board level evaluation | **Amber** | |
| 2.2 Whole Board development programme | **Amber** | |
| 2.3 Board induction, succession and contingency planning | **Green** | |
| 2.4 Board member appraisal and personal development | **Green** | |

| 3.Board insight and foresight | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| 3.1 Board performance reporting | **Amber** | |
| 3.2 Efficiency and Productivity | **Green** | |
| 3.3 Environmental and strategic focus | **Green** | |
| 3.4 Quality of Board papers and timeliness of information | **Amber** | |

| | | |
|---|---|---|
| 3.5 Assurance and risk management | Green | |

| 4. Board engagement and involvement | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| 4.1 External stakeholders | Green | |
| 4.2 Internal stakeholders | Green | |
| 4.3 Board profile and visibility | Amber | |

| 5. Board impact case studies | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| 5.1 | | |
| 5.2 | Green | |
| 5.3 | | |

| Areas where additional training/guidance is required | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
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| | | |

| Areas where additional assurance is required | | |
|---|---|---|
| Area | Self Assessment Rating | Additional Notes |
| | | |
| | | |

# 6. Board impact case studies

# 6. Board impact case studies

## Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

# 6. Board impact case studies

## 6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

*Note: Recent refers to any appropriate case study that has occurred within the past 18 months.*

## 6. Board impact case studies     ALB Name -     Date –

### 6.1 Case Study 1

| | |
|---|---|
| Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery | |
| Brief description of issue | |
| Outline Board's understanding of the issue and how it arrived at this | |
| Outline the challenge/scrutiny process involved | |
| Outline how the issue was resolved | |
| Summarise the key learning points | |
| Summarise the key improvements made to the governance arrangements directly as a result of above | |

## 6. Board impact case studies ALB Name - Public Health Agency Date – 31 March 2022

### 6.2 Case Study 2

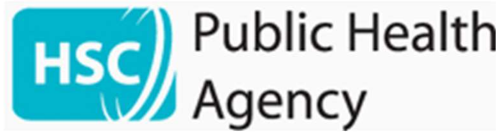
| Organisational Culture Change | |
|---|---|
| Brief description of area of focus | Financial management and Stewardship of PHA Finances; specifically focusing on strengthening relationships and improving communications between the Board, the Executive team and a new Interim Director of Finance, following on from reported challenges in previous relationships. |
| Outline reasons/ rationale for why the Board wanted to focus on this area | Improvement process to strengthen decision-making within the organisation, based on supportive, challenging, open and transparent communication between the new Interim Director of Finance and the Board, linked to outputs-based performance reporting. |
| Outline how the Board was assured that the plan/ (s) in place were robust and realistic | A number of key areas was developed throughout 2021/22 and into 2022/23.<br>• Revised executive summary monthly finance report developed by the new Interim Finance Director, setting out risks and opportunities for management of PHA allocated resources.<br>• Slippage and priorities identified and share with full board for prioritisation during 2021/22. Previously this would have been at Executive level only.<br>• Quarterly Financial accountability meetings with Directors established by the Chief Executive with support from the Director of Finance covering all business areas.<br>• Refreshed financial planning process for 2022/23 to support early identification of risks and opportunities for Board level decision making.<br>• Establishment of a new process and a Funding Panel for consideration of funding priorities populated by Non-Executive and Executives, resulting in collective decision making to support financial planning.<br>• Financial briefs on wider HSC financial position introduced at confidential sessions of the Board.<br>• New NEDs briefed by way of presentations on the PHA's budget, where it is spent, how to interpret the Finance report, key financial governance fundamentals eg scheme of delegated authority, statutory duty to breakeven, ringfencing of funds etc.<br>• Buddy system set up at wider board level and Director of Finance and NED with Financial expertise meet on a regular basis. This has been very positive and allows for wider constructive conversations surrounding PHA financial strategy and position. This relationship has further supported an improved culture of trust within the wider Board. |
| Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture | While this has been one strand of improvement in the overall culture at Board level there is clear evidence of a more positive atmosphere and strengthened relationships resulting from more open, positive, transparent communications between the new Director of Finance and the Board.<br><br>This is evidenced by the increased visibility, by way of reports and briefings for the Board, regarding the financial |

| | |
|---|---|
| | projections and financial risks.<br><br>There have been improvements in constructive challenge and collective decision making on financial matters as evidenced by in-year slippage reviews and enhanced accountability processes at Executive and Board wide level, such as the new Financial Accountability reviews and the whole Board’s increased input into the financial planning process for 2022/23. |

## 6. Board impact case studies ALB Name…………………………………………………Date……………

### 6.3 Case Study 3

| **Organisational strategy** | Title: |
|---|---|
| Brief description of area of focus | |
| Outline reasons / rationale for why the Board wanted to focus on this area | |
| Outline how the Board was assured that the plan/ (s) in place were robust and realistic | |
| Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture | |
| Specifically explain how the NEDs were involved | |



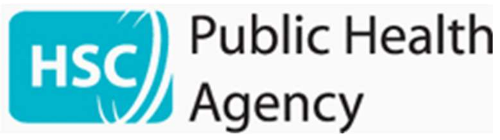
**ALB Self-Assessment Action Plan 2022/23**

| Section | Good Practice / Red Flag Reference | Action | Target Date | Progress (Red / Amber / Green rating) |
|---|---|---|---|---|
| 1.1<br>Board positions and size | GP4 | Terms of Reference for new Board Committee to be agreed by the end of October 2022 | 31 October 2022 | |
| 1.3<br>Role of the Board | GP5 | The Chair should discuss with the Chief Executive how the relationship between PHA and the Department can be improved. | 31 December 2022 | |
| 1.3<br>Role of the Board | GP9 | The Board Secretariat will work with Non-Executive Board members to ensure their HSC laptops are fully operational. | 31 October 2022 | |
| 1.4<br>Committees of the Board | GP7 | An audit of the effectiveness of the Remuneration Committee should be carried out. | 31 December 2022 | |
| 2.1<br>Effective Board Level Evaluation | GP1 | By 15 January 2023, the Board will stipulate how it plans to complete the self- | 15 January 2023 | |

| | | | | |
|---|---|---|---|---|
| | | assessment for 2022/23. | | |
| 2.1<br>Effective Board Level Evaluation | GP4 | Linked to 2.1 GP1 above, the Board will also stipulate how it intends to engage with staff and stakeholders as part of the process for completing the questionnaire. | 15 January 2023 | |
| 2.1<br>Effective Board Level Evaluation | RF2 | The Board will aim to have an independent evaluation of its Self-Assessment for 2022/23. | 30 June 2023 | |
| 2.1<br>Effective Board Level Evaluation | RF3 | The Board will undertake a survey of those outside the Board as part of its self-assessment in 2022/23. | 30 June 2023 | |
| 2.3<br>Board induction, succession and contingency planning | GP4 | The appointment of a Deputy Chair will be reviewed by December 2021. | 31 December 2022 | |
| 2.4 Board member appraisal and personal development | GP5 | It is proposed by the Chair that in addition to the annual appraisal the chair will have one-to-one meetings with all Non-Executive Directors. | 31 March 2023 | |
| 3.1 Board performance reporting | GP2 | In developing the 22/23 Annual Business Plan, a focus | 30 June 2022 | |

| | | | | |
|---|---|---|---|---|
| | | should be placed on identifying a number of measurable KPIs linked to actions and that quarterly reporting against the Business Plan should continue. | | |
| 3.3 Environmental and Strategic Focus | GP2 | GAC to monitor the implementation of the recommendations of the Internal Audit review of SAIs and report to PHA Board. | Ongoing during 2022/23 | |
| 3.4 Quality of Board papers and timeliness of information | GP1 | Timetable of Board and GAC meetings for 2023 to be reviewed in late 2022. | 30 November 2022 | |
| 3.4 Quality of Board papers and timeliness of information | GP2 | Reports should be provided to Directors three weeks in advance of the Board meeting in order to allow time for revision and change. Report authors should know that if reports are not received in the appropriate format they will not be placed before the Board. | 31 March 2023 | |
| 3.4 Quality of Board papers and timeliness of information | GP3 | AMT to review the Assurance Framework | 31 October 2022 | |
| 3.4 Quality of Board | GP5 | Reports should follow the | 31 March 2023 | |

| | | | | |
|---|---|---|---|---|
| papers and timeliness of information | | guidance in the ICSA publication, "Effective Board Reporting" (2018). | | |
| 3.4 Quality of Board papers and timeliness of information | GP6 | There is scope to improve the presentation of data in order that trends over time can be identified. | 31 March 2023 | |
| 3.4 Quality of Board papers and timeliness of information | GP9 | Board members should seek to ensure that the collection of data is properly quality assured. | 31 March 2023 | |
| 3.4 Quality of Board papers and timeliness of information | GP10 | When reports are being designed and written, authors and editors must keep in mind and be explicit about the purpose of presenting each report to the Board. | 31 March 2023 | |
| 4.1 External Stakeholders | GP3 | During 2022/23 the PHA will develop its approach for how it will consult on its new Corporate Strategy. | 31 December 2022 | |
| 4.3 Board Profile and Visibility | GP1-4 | Board members should continue to be kept informed of opportunities to attend high profile events. | Ongoing through 2022/23 | |



**item 10**

| | |
|---|---|
| **Title of Meeting** | PHA Board Meeting |
| **Date** | 17 November 2022 |
| **Title of paper** | Performance Management Report |
| **Reference** | PHA/03/11/22 |
| **Prepared by** | Stephen Murray / Rossa Keegan |
| **Lead Director** | Stephen Wilson |
| **Recommendation** | For **Approval** ☐ For **Noting** ☒ |

## 1 Purpose

The purpose of this paper is to provide the PHA Board with a report on progress against the objectives set out in the PHA Annual Business Plan 2022/23.

## 2 Background Information

PHA's Annual Business Plan was approved by the PHA Board in May 2022. Against this plan 31 actions were developed against 9 priorities for 2022/23.

## 3 Key Issues

The attached paper provides the progress report, including RAG status, on the actions set out in the PHA Annual Business Plan 2022/23 Part A as at 30 September 2022.

Of the 31 actions across 9 Key Priorities

- No action has been categorised as red (significantly behind target/will not be completed)
- 7 actions have been categorised as amber (will be completed, but with slight delay)
- 24 actions have been categorised as green (on target to be achieved/already completed).

For the Business Plan Part B, it was agreed that any actions rated Amber or Red would be reported on by exception to the Board.  As at 30 September 2022, 4 actions have been categorised as amber as an exception report is included.

## 4 Next Steps

The next quarterly Performance Management Report update will be brought to the Board in February 2023.

# PERFORMANCE MANAGEMENT REPORT

## Monitoring of Targets Identified in

## The Annual Business Plan 2022 – 2023 Part A

As at 30 September 2022

This report provides an update on achievement of the actions identified in the PHA Annual Business Plan 2022-23 Part A.

The updates on progress toward achievement of the actions were provided by the Lead Officers responsible for each action.

There are a total of 31actions across 9 Key Priorities in the Annual Business Plan. Each action has been given a RAG status as follows:

Part A - 31 Actions, 24 Green, 7 Amber

| | | | |
|---|---|---|---|
| (Green) | On target to be achieved or already completed | (Amber) | Will be completed, but with slight delay |
| (Red) | Significantly behind target/will not be completed | | |

Of the 31 actions 7 are current rated with an Amber RAG status.

The progress summary for each of the actions is provided in the following pages.

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 1a | Protecting the population of NI by leading work to effectively manage the COVID 19 pandemic and ensure we save lives, protect our health and social care services and rebuild services to ensure the health and | Vaccination<br><br>Deliver the Spring booster programme by end of May 2022 and Autumn booster programme, as advised by DoH | Autumn booster and flu programme commenced officially 19th September.<br><br>Training, public information materials and operational data dashboards developed. Targeted interventions to improve uptake are being taken forward by the Low Uptake Group. | Green | Green | Director of Public Health |
| 1b | | Testing and Contact Tracing<br><br>Complete the transition of testing (pillar 1 and 2) and contact tracing by the end of June 2022. | Contact Tracing Service stood down from 30 June 2022 | Green | Green | Director of Public Health |
| | | | Test, Trace and Protect Transition Plan implemented; now Test and Trace as part of the steady state. | Green | Green | |

| | **Key Priorities** | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)**<br>June | <br>Sept | **Mitigating actions where performance is Amber / Red** |
| 1c | wellbeing needs of society are effectively addressed. | Infection Prevention and Control<br><br>Review and plan for a refresh of the IPC guidance for Health care setting by February 2023 | The IPC team have updated the Regional NI IPC Manual. This is being kept under constant review. The IPC Manual Editorial Board is now working on further developing and reformatting the manual. Work is also underway to update the IPC Regional Resource Framework. Once the framework is in a final draft position is will go out to Trusts and RQIA along with the IPC Cell for consultation. It is anticipated this work will be presented to AMT prior to being submitted to DoH for review and consideration. | | | Director of NAHP<br><br>The Regional IPC Framework is currently being reviewed and updated by the Senior IPC Nurse within Health Protection and will be issued for consultation once in a final draft position. We have just appointed an Assistant Director for IPC and this work will be progressed once in post |
| 2a | Implement the agreed action plan for 2022/23 that sets out the | Quarterly update reports on PHA Business Plan to be provided to PHA Board | First Quarterly update report for Annual Business Plan provided to PHA Board in August 2022, second update to be provided November 2022. | | | Director of Operations |
| 2b | key programmes of work that will be progressed by PHA officers in | 90% of actions in the 22/23 Action Plan to be RAG rated as Green and exception reports to be provided to PHA board to address those rated Red/Amber. | Of the 53 items identified in the 22/23 Action Plan 49 are rated Green as at September 2022. (92%) | | | All Directors |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| | meeting Ministerial, DOH and PHA Corporate priorities. | | Amber items to PHA Board in October 2022 | | | |
| 3a | Re-build and further develop services where access and performance have been adversely impacted during the pandemic, | Return bowel cancer screening programme to a 2-year screening interval by September 2022 | In bowel cancer screening, a managed catch-up was successfully undertaken with the result that by the end of August there were no ongoing queued lists within the programme (return to 2-year screening interval). | | | Director of Public Health |
| 3b | | Reinstate formal quality assurance visits in the breast screening programme by June 2022 | These have been reinstated. A QA visit was made to the Northern HSC Trust on 23 June 22. The next visit will be to the Belfast (which also provides the breast screening service for the South Eastern HSC Trusts) in June 2023. The Western HSC Trust will be visited in June 2024 and the Southern in June 2025. Each trust will have a QA visit once every four years. | | | Director of Public Health |

| | | Key Priorities | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Achievability (RAG) Sept | Mitigating actions where performance is Amber / Red |
| 3c | | Establish a project structure for the implementation of primary HPV testing in cervical screening by June 2022. | Project structure has been established and the first project implementation team meeting took place in Sept 22. | | | Director of Public Health |
| 3d | | Identification by June 2022 of potential additional support measures to enable full return of screening programmes. | • Non-recurrent corporate slippage identified for AAA screening recovery work. Work ongoing to progress IPT to allocate this to programme. Recovery activity to include additional hours and weekend clinics.<br>• The Diabetic Eye Screening Team within BHSCT, with assistance from PHA screening, has developed a recovery plan, setting out what will be needed in terms of additional capacity to screen the backlog of patients. Recurrent funding was requested for 2022-2025 period to continue the non-recurrent funding made available for 2020/21 and 2021/22. | | | Director of Public Health |

| | Key Priorities | | | | |
|---|---|---|---|---|---|
| | Action from Business Plan: | Progress | Achievability (RAG) June | Sept | Mitigating actions where performance is Amber / Red |
| | | The recovery plan was submitted by the Trust. Non-recurrent funding has been secured to meet in post roles for Quarters 1-3 of 22/23.<br><br>• The Infectious Diseases in Pregnancy Screening Programme, the Newborn Blood Spot Screening Programme and the Newborn Hearing Screening Programme continued to operate during the COVID-19 pandemic and are operating normally.<br><br>• The Breast Screening programme continues to be delivered across all Trust areas. There has been an extended round length due to the pause in services in 2020, staff absence, social distancing and infection control measures. The provision of additional screening clinics has resulted in stabilisation and improvement in the round length figure. However, the | | | |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Sept | Mitigating actions where performance is Amber / Red |
| | | | improvement is unlikely to be linear, and will probably fluctuate, as the number of additional screening sessions that can be provided is dependent upon the ability of staff to continue to provide them. | | | |
| 3e | | Increase uptake rates across all vaccination programme areas in 2022/23 | The covid Autumn Booster programme is underway:<br>• Over 352,000 vaccinations have been administered (as of 08/11/2022)<br>• Over 50s uptake 47.8%<br>• Care home uptake 67%<br>• Trust employed frontline HSCW 29%<br><br>Work is underway to target specific risk groups as part of the low uptake group for covid vaccination<br><br>The flu vaccination programme is underway:<br>• Over 65s uptake: 68%<br>• 50-64: 31%<br>• Over 8600 vaccinations to at risk under 50s | | | Director of Public Health |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG)<br>June | Sept | Mitigating actions where performance is Amber / Red |
| | | | • Care home uptake 66.7%<br>• Trust employed frontline HSCW 30%<br><br>A task and finish group for pre-school immunisations has been establish to address falling uptake rates – an action plan has been drafted.<br><br>School based immunisation programmes are running business as usual. | | | |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 4a | Shape and influence the design and implementation of the proposed new Integrated Care system and ensure the role of the Public Health Agency is embedded appropriately into the new planning and commissioning | PHA to be represented on all project Team implementation structures [KPIs to be reviewed in September when more clarity on ICS model] | DoH has revised the operational structures for developing the Integrated Care system and New Planning Model and PHA has now nominated staff to represent the organisation at all levels of the structure and subgroups.<br><br>PHA has also established an internal ICS Hub which meets monthly to provide a central process and coordinating mechanism for PHA that enables joined up planning and corporate oversight for the organisation relating to the development of the ICS in Northern Ireland. | | | Director of Operations |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 4b | model being established | 5 key public health areas to be identified for incorporation into ICS plans by end of September 2022 [KPIs to be reviewed in September when more clarity on ICS model] | The establishment of the ICS and new planning model has still to be finalised by DoH. New structures to develop the ICS are now established and PHA is represented on these. The start date for the ICS has been pushed back to April 2024. | | | Director of Public Health<br><br>PHA will continue to work to identify 5 key Public Health areas to be included in ICS planning. However, ICS development is currently delayed and so PHA will work within these timescales to incorporate their key areas once agreed through PHA ICS Planning Group |

| 5a | HSCQI will continue to support the rebuild of Health & Social Care by increasing QI knowledge and capability across the HSC System. | HSCQI has agreed a workplan to support the ‘timeliness’ theme with the Alliance by end of June 2022 | In April 2022, it was agreed at the HSCQI Alliance meeting that a workshop would be held to showcase existing areas of best practice in relation to Timely Access to safe care, and identify and prioritise opportunities for regional scale and spread.<br><br>HSCQI hosted a regional Timely Access to safe care “sharing learning with purpose” event on 17th June 2022, chaired by the HSCQI Director. This event showcased local improvement work underway within Trusts that is focused on improving timely access. This event highlighted existing and potential opportunities for regional collaboration leading to scale and spread.<br><br>A regional workshop took place with HSC QI Leads in July 2022. Project charter developed and tabled at the HSCQI Alliance meeting in August 2022. The charter was approved by Alliance members at the August meeting and the Timely Access to Safe Care Programme of work will commence in November 2022. | | | Director of HSCQI |
|---|---|---|---|---|---|---|

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Achievability (RAG) Sept | Mitigating actions where performance is Amber / Red |
| | | | "Timely Access" to safe care is the programme theme for the 2022/23 Regional ScIL programme. The programme has progressed throughout the summer/autumn months as planned, with all projects developed focused on Timely Access to Safe Care. | Amber | Green | |
| 6a | Work with DoH to reshape and refresh the PHA and agree a new operating model that will deliver a re-focused professional, high quality public health service for the population of NI | Phase 1 of Review completed by end of June 2022 | Phase 1 of the Review has been completed and the Report has been finalised. | Amber | Green | Chief Executive |
| 6b | | Quarterly newsletter to update staff on progress to be published (first issue September 2022) | The first newsletter has not yet been published due to the delay in completing the Phase 1 Report. | Green | Amber | Chief Executive<br><br>First newsletter to be published by the end of November |
| 6c | | Implementation of phase 2 of the review to commence by end of September 2022 | The commencement of the implementation of Phase 2 is subject to confirmation of funding | Green | Amber | Chief Executive<br><br>Chief Executive to follow up with Department regarding funding |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 7a | PHA will place additional focus on staff welfare and wellbeing and agree and implement a range of appropriate actions to help staff recover from the impact that the Covid 19 pandemic has had in both a professional and personal capacity | Organisational Workforce Development Plan drafted by end of October 2022 | An OD plan for 22/23 has been developed by OWD. | Green | Green | Director of HR |
| 7b | | New appropriate policies and procedures to facilitate new working arrangements developed in partnership with staff side and BSO HR by Sept 2022 | The Pilot Hybrid Working Scheme was launched in September 2022. | Green | Green | Director of HR |
| 7c | | 80% of Individual appraisals and personal development plans agreed by 29th July 2022 which clearly demonstrate the staff member's role in helping to contribute to the Agency's ABP key priorities. 100% by 30 September 2022 (subject to sickness absence, maternity and those seconded out of the PHA) | Appraisal documentation was approved by AMT in early June 2022 and a supporting training programme for managers delivered by BSO by end of June 2022. Remaining appraisals are currently being undertaken by managers but the target of 100% achieved by 30th September has not been possible due to a combination of wider work pressures having to be prioritised and annual leave commitments. Revised target of 100% to be met by 31st November 2022. | Amber | Amber | All Directors<br><br>Reminder communication sent to all Directors for cascading to line managers. |

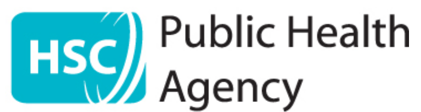
| | | Key Priorities | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Achievability (RAG) Sept | Mitigating actions where performance is Amber / Red |
| 7d | | All temporary appointments to be reviewed by end of September 2022 and plan agreed for permanency of position. | The new Senior HR Business Partner was appointed in September 2022, this was delayed from July due to the postholder not being released from previous post. Each Director has met with the Senior HR Business Partner and Directorates now have plans to ensure temporary posts are appointed permanently where possible in light of funding and impact of the EY review of the PHA | | | Chief Executive /All Directors |
| 7e | | Staff absence will be effectively managed and will perform in line with 2021/22 at 3.10% or better | Absence is currently 3.09% which is slightly above the 2021/22 level. Action is on target. | | | Director of HR |

| | | Key Priorities | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Achievability (RAG) Sept | Mitigating actions where performance is Amber / Red |
| 7f | | Staff will have completed all mandatory training as required by the organisation. 90% compliance by end of March 2023 | A list of mandatory training is being finalised and will be included as part of the on-going development and roll out of the Individual Appraisal system. Managers will be required to confirm staff completion rates by end of February 2023 and any areas of underperformance addressed by March 2023. | Green | Green | Director of Operations |
| 8a | Ensure good financial governance and stewardship of PHA budgets and expenditure decisions and develop a new performance management framework for the organisation to establish clear processes of accountability | 90% of Internal Audit recommendations from 2021/22 addressed and progress reported to GAC by October 2022 | Mid-year result of 77% implemented, reported to GAC in October 2022 meeting. Action plan drawn up to address the balance outstanding. Discussions held at Governance and Finance monitoring meetings between Chief Executive and Directors. | Green | Amber | Director of Operations / Director of Finance<br><br>PHA follow up of Internal Audit recommendations in progress with requests to relevant Managers/Directorates issued. |
| 8b | | 100% of Internal Audit recommendations from 2021/22 addressed and progress reported to GAC by March 2023 | Not yet due. | Green | Green | Director of Operations / Director of Finance |

| | Key Priorities | | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 8c | and performance reporting across all levels of the organisation. | All Directorate Business Plans approved by 30 May 2022 | Operations: Approved<br>HSCQI: Approved<br>NAHP: Approved<br>Public Health: Pending | | | Director of Operations |
| 8d | | Delivery of a balanced Financial Plan by end of May 2022, taking into account budgetary uncertainties and agreed investment plan – approval by Board in June 2022 | Complete | | | Director of Finance |
| 8e | | Budget holders to manage their agreed budgets to support the statutory breakeven target of +0.25% or circa 0.3m within 2022/23 | Ongoing –<br>Forecast position at month 6 is c£0.5m surplus, which is above the breakeven threshold, however this has been communicated to DoH and the year end-financial position will continue to be managed by PHA, supported by DoF and with engagement with DoH. | | | Director of Finance |

| | | Key Priorities | | | | |
|---|---|---|---|---|---|---|
| | **Action from Business Plan:** | | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| 9a | Further improve the level of public and professional awareness, recognition and confidence in the PHA as the leading Public Health organisation in order to encourage wider engagement with and support for public health priorities. | Baseline public awareness levels of PHA (including role and functions) established through quantitative/qualitative research programme by end of August 2022 and 3% increase achieved by March 2023. | Remains on track – baseline established through NI Omnibus survery – key results include: high prompted awareness of PHA (73%), low unprompted awareness (4%). | Green | Green | Director of Operations |
| 9b | | PHA media training development programme implemented, by end of Sept 2022 | Commissioned media training sessions have resumed. Two sessions have taken place to date, for registrars and senior management. A further session is being planned for Health Improvement, and options for internal refresher training being explored. | Amber | Green | Director of Operations |
| 9c | | Marketing strategy developed to maximise PHA Brand awareness including promotion of funded programmes and projects, by end of Dec 2022. | Remains on track | Green | Green | Director of Operations |

| | | Key Priorities | | | | |
|---|---|---|---|---|---|---|
| | Action from Business Plan: | | Progress | Achievability (RAG) June | Sept | Mitigating actions where performance is Amber / Red |
| 9d | | New digital communications strategy launched, targeting increased engagement with target audiences, by Feb 2023 | Recruitment underway to appoint digital communications manager – on course | | | Director of Operations |

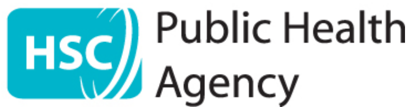


# PERFORMANCE MANAGEMENT REPORT

## Monitoring of Targets Identified in

## The Annual Business Plan 2022 – 2023 Part B

As at 30 September 2022



This report provides an update on achievement of the actions identified in the PHA Annual Business Plan 2022-23 Part B.

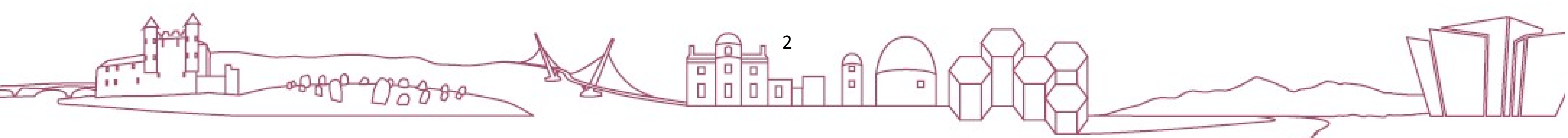
The updates on progress toward achievement of the actions were provided by the Lead Officers responsible for each action.

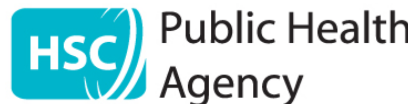
There are a total of 53 actions in the Annual Business Plan. Each action has been given a RAG status as follows:

| | | | |
|---|---|---|---|
| (Green) | On target to be achieved or already completed | (Amber) | Will be completed, but with slight delay |
| (Red) | Significantly behind target/will not be completed | | |

Of these 53 actions 46 have been rated green, 4 as amber and 0 as red

| Outcome | Red | Amber | Green | Total |
|---|---|---|---|---|
| **1) Managing Covid 19 Response** | - | 1 | 9 | **10** |
| **2) Health Protection** | - | - | 7 | **7** |
| **3) Improving Health and Social Wellbeing and addressing health inequalities** | - | 2 | 13 | **15** |
| **4) Shaping future health** | - | - | 13 | **13** |
| **5) Our organisation works effectively** | - | 1 | 7 | **8** |
| **Total** | **-** | **4** | **49** | **53** |





| | **Priority 1 :Managing Covid 19 Response** – Protecting the population of NI by leading work to effectively manage the COVID 19 pandemic and ensure we save lives, protect our health and social care services and rebuild services to ensure the health and wellbeing needs of society are effectively addressed. | | | | |
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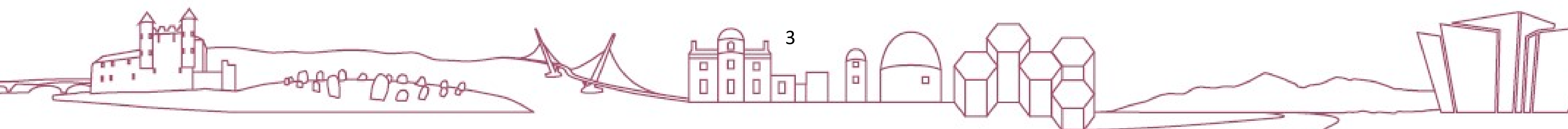
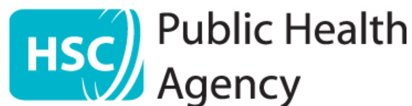
| | **Action** | **Progress** | **Achievability (RAG)**<br>**June** | <br>**Sept** | **Mitigating actions where performance is Amber / Red** |
| **5** | Lead the Regional Infection Prevention Control Response, including supporting Trusts and independent sector, nursing and residential facilities.<br><br>Review and develop the regional Infection Protection and Control (IPC) infrastructure | **1.**The Regional IPC Cell leads on the IPC response across HSCNI through influencing, informing, translating and dissemination of National policy guidance into local practice. For example, the previous IPC GOV.UK guidance which was implemented throughout the pandemic until it was stood down in April 2022.<br><br>The IPC Cell and the PHA has also developed local guidance and protocols such as the Regional Fit Testing Protocol and the Car Sharing protocol to promote consistency and safe practices across Northern Ireland. The IPC Cell also provides input to various guidance documents led by the Department of Health including Care Homes Guidance, Support Living Guidance and Children's Home Guidance.<br><br>The IPC Product Review Group remains in place and meet on an ad hoc basis to discuss product CAGs and to also review new products. This enables the Trust IPC Leads and Fit testers to assess products and ensure they are fit for purpose before they are implemented across HSCNI.<br><br>Support is provided to Trusts via this cell and through regular communication with Trust IPC Teams. The cell has provided a forum to address issues and concerns as a region which has helped promote | Green | Amber | Director of Nursing, Midwifery and AHPs<br><br>We have just appointed an Assistant Director for IPC and this work will be progressed once in post |





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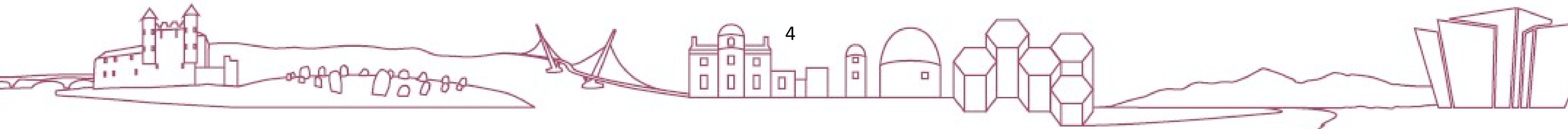
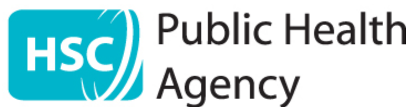
| | **Action** | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| | | consistency in approach and practices.<br>The PHA has also provided funding to Trusts over the last two years to strengthen IPC Teams and provide additional capacity to support the independent sector. We are currently seeking funding through the PHA in excess of £800,000 to help ease pressures and increase IPC capacity.<br><br>Making Risk Management Work in Health & Social Care Training was carried out on 25th October by CLS Education. This training was procured in response to a need identified by the Regional IPC Cell to ensure all risk assessments are standardised across the Trusts and also to enable staff to make more informed decisions. The training is also available to Trusts if they would like to avail of it for any other staff.<br><br>We are currently developing a Regional IPC Framework which aims to strengthen IPC across Northern Ireland and develop the IPC infrastructure. The framework will be submitted to the Department of Health for review and consideration when we are in the final draft position. Trust Finance Teams provided estimates of their COVID-19 requirements for 2022/23 and it is currently with PHA / SPPG finance teams.<br><br>**2** Following the submission of the Regional IPC Framework a Regional Managed Care IPC Network will be developed and will replace the current Regional IPC Cell. The Managed Care Network will be | Green | Amber | |







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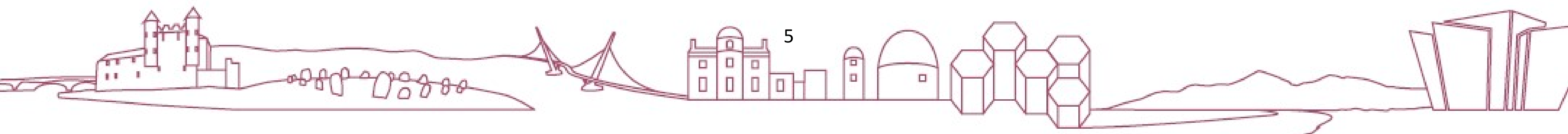
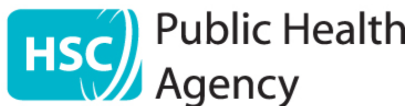
| | **Action** | **Progress** | **Achievability (RAG)**<br>**June** | **Sept** | **Mitigating actions where performance is Amber / Red** |
| | | multidisciplinary and will provide an opportunity to promote consistency, standardisation and shared learning.<br><br>There have been a number of delays due to the consultation and engagement process and we are still working through comments and suggestions. The Senior IPC Nurse is currently reviewing the framework which will be shared with RQIA, Trusts and the IPC Cell for further consultation once in final draft. | | | |





| | Priority 2 : **Health Protection -** *Protecting the community (or any part of the community) against communicable disease and other transmissible dangers to health and social well-being including dangers arising on environmental or public health grounds or arising out of emergencies.* | | | | |
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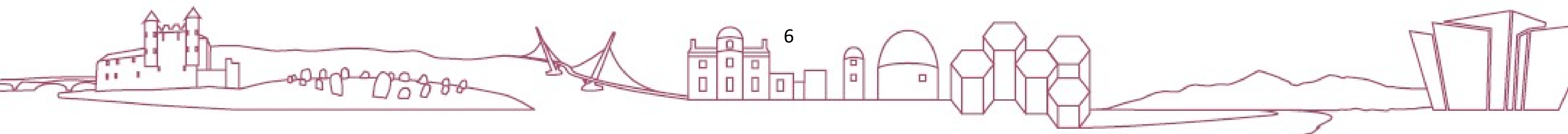
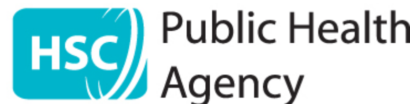
| | **Action** | **Progress** | **Achievability (RAG)**<br>**June** | <br>**Sept** | **Mitigating actions where performance is Amber / Red** |





| | Priority 3: **Improving Health and Social Wellbeing and addressing health inequalities** - *Increasing health and well-being at individual, community and regional levels by developing and securing the provision of programmes and initiatives designed to secure the improvement of the health and social well-being of and reduce health inequalities between people in Northern Ireland.* | | | | |
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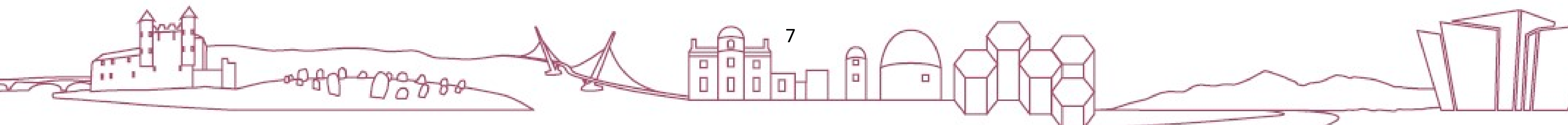
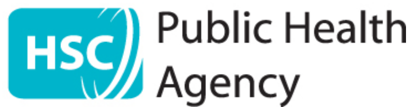
| | **Action** | **Progress** | **Achievability (RAG)** **June** | **Sept** | **Mitigating actions where performance is Amber / Red** |
| **26** | Lead implementation of the current Breastfeeding Strategy 2013-2023 and support IPH with a review of the current Strategy to inform the development of a new Strategy for 2024 onwards. | Work has stalled temporarily due to retirement of previous Breastfeeding thematic lead | Amber | Amber | Director of Public Health<br><br>Discussions are underway to ensure the post is filled ASAP |
| **29** | Lead the regional implementation of the specialist Peri-natal mental health service | The Implementation of Phase 1 of the Trusts Community Specialist Perinatal Mental Health Teams is in progress. Funding for the further development of Phase 1 will be considered in the Funding Allocation by DH for 22/23<br><br>The hosting arrangement of the Regional Perinatal Mental Health Service is to be considered by PHA AMT | Green | Amber | Director of Nursing, Midwifery and AHPs |





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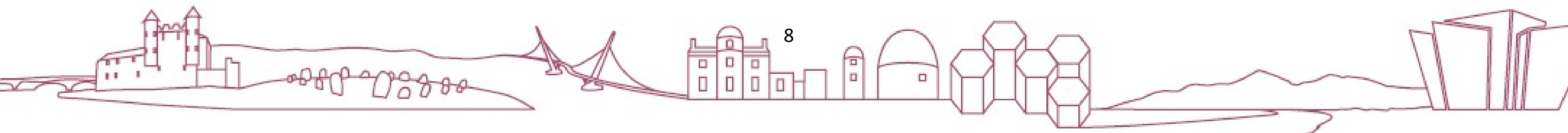
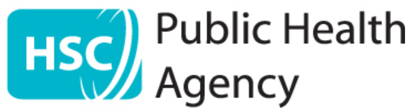
|---|---|---|---|---|---|
| | **Action** | **Progress** | **Achievability (RAG)**<br>**June** | **Sept** | **Mitigating actions where performance is Amber / Red** |
| | | Arrangements will be put in place for one of the Trusts to be selected to develop a capital Business Case for the Mother and Baby Unit<br><br>Funding for "the further development of Phase 1" has been finalised<br><br>A paper has been prepared regarding the hosting arrangements of the Regional Perinatal Mental Health Service for considered by PHA AMT. However, this is to be discussed with Chief Exec before being tabled.<br><br>A regional workshop has taken place to consider the development of a capital Business Case for the Mother and Baby Unit. It has been recommended that a consultancy firm would take this forward to assess state of readiness. | | | Once hosting arrangements have been made these will be submitted early November to AMT |





| | Priority 4: Shaping future health - preparing for future challenges and increasing the ability of individuals, communities and society to withstand threats to health and well-being by providing professional input to the commissioning of health and social care services which meet established quality standards and support innovation. | | | |
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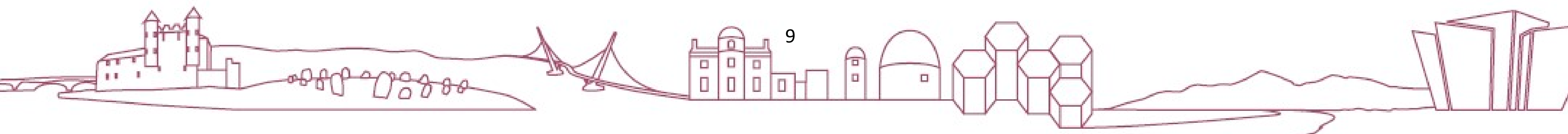
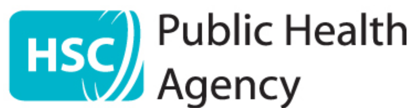
| | **Action** | **Progress** | **Achievability (RAG)**<br>**June Sept** | **Mitigating actions where performance is Amber / Red** |





| | Priority 5: Our organisation works Effectively – Increasing core organisational capability and capacity to become a modern and effective public health organisation | | | | |
|---|---|---|---|---|---|
| | **Action** | **Progress** | **Achievability (RAG)** June | Sept | **Mitigating actions where performance is Amber / Red** |
| **47** | Work with DoH colleagues to oversee the reform and transition of the PHA to a new operating model, taking into account lessons learned from responding to Covid 19 and manage the process of organisational change in line with further clarification from the DoH, ensuring appropriate and timely internal and external communication. | Phase 1 report delayed by DoH with subsequent delay on commencement of Phase 2. Individual Directorates undertaking important reviews to help inform phase 2. Internal and external communications impacted by delay around phase 1 reporting. | | | All Directors<br><br>Engagement with DoH permanent secretary |