# Public Health Agency Draft Corporate Plan 2025-2030 Public Consultation Questionnaire

Welcome to the draft Public Health Agency (PHA) Corporate Plan 2025-2030 Preventing, protecting, improving; Better health for **everyone**. Our new draft plan is open for public consultation.

## Overview

The Public Health Agency (PHA) has developed a draft Corporate Plan for the period 2025-2030, setting out the strategic direction for the PHA for the next five years. This draft plan takes account of engagement and discussion with a range of stakeholders, the vision set out by the Minister of Health in Health and Wellbeing 2026: Delivering Together, Department of Health (DoH) priorities, especially the Making Life Better Public Health Framework and the Draft Programme for Government Framework 2024-2027 within the context of financial constraints and Health and Social Care (HSC) reform and restructuring.

## Priorities and Approach

The PHA's objectives apply to everyone in the population, aiming to address health outcomes across all demographics, including diverse backgrounds and needs. Achieving these outcomes will require determination, innovative thinking, and collaborative efforts across HSC, government and the community and voluntary sectors. We must make partnership, involvement and engagement central to our work, explore new and different ways of doing things and make the best use of our combined resources.

We recognise our work cannot be done in isolation and requires a whole system, cross government approach with robust engagement with the public. Cognisant of this, we have now published our draft corporate plan for public consultation from Thursday 28th November 2024 until Friday 28th February 2025.

## Respondent Information Form

Please use this questionnaire to share your views on the draft PHA Corporate Plan 2025-2030. You can email your response to phacorporateplan@hscni.net or return to us by post to PHA Corporate Plan Consultation, Public Health Agency, 4th Floor South, 12-22 Linenhall Street, Belfast, BT2 8BS.

## Here to Help

Please get in touch via contact details above if you require assistance, an alternative format or have any questions with regards to completing your consultation response. We would be happy to receive any other comments you feel do not fit into the questions set out in this survey.

Details of in-person consultation events taking place in the new year will be announced in due course on the PHA website.

The draft PHA corporate plan 2025-2030 aims to have wide reaching effects. We would welcome views on how delivering this plan may affect any particular groups in society. The draft Corporate Plan 2025-2030, an initial draft equality screening and rural needs impact assessment are available via the PHA Website - Current Consultations section

Have your say now by completing our consultation survey. Please make sure to share your thoughts before the consultation deadline **4pm**, **Friday 28 February 2025.**

Thank you for your contribution to this consultation and joining us in building a healthier Northern Ireland for all.

## Consultation Questionnaire

This questionnaire has been designed to help you respond to the Draft PHA Corporate Plan 2025-2030 ‘Preventing, protecting, improving: Better health for everyone. Written responses are welcome either using this questionnaire template, via online survey or in an alternative format which best suits your response.

Please answer the following questions and note your comments and views in the text boxes provided.

## About You

(*Please tick the relevant box*)

Are you responding as an individual or on behalf of an organisation? (required)

[ ] Individual – Please complete Section 1, 2 and 4

[ X ] On behalf of an organisation – skip to Section 3 ‘Responding as an Organisation’ – please complete section 3 and 4

## Section 1 - Responding as an individual

1.1 Please provide your contact details below:
Your name and email address are required for validation purposes.

Name: (required)

Email address: (required)

1.2 Can we contact you to discuss your response to this consultation? This may be to follow up any specific points we need to clarify. (required)

[ ] Yes
[ ] No

1.3 Can we contact you in future about the draft PHA Corporate Plan 2025-2030? For example, to provide you with a link to the results of this consultation, to inform you of further consultations or provide update information on the plan. (required)

[ ] Yes
[ ] No

1.4 To support transparency in our decision-making process, we will publish a summary of the consultation feedback on the PHA website. This will sometimes include the responses themselves and may mention names of the responding organisation (if applicable). However, names of individuals responding on a personal capacity will only be published where consent has been given. Please note we will not publish contact details. (required)

[ ] **Yes**, I consent to my name being published with my response
[ ] **No**, please remove my name before publishing my response

PHA Privacy Notice

Feedback provided may be subject to publication or disclosure under access to information laws like the Data Protection Act 2018, the General Data Protection Regulation 2018, Freedom of Information Act 2000 and the Environmental Information Regulations 2004. If you believe your input should be treated as confidential, please contact us by email, so that this may be considered should we receive a disclosure request.

Email: phacorporateplan@hscni.net

**Section 2 –** (Monitoring Information for individual responses only)

The Public Health Agency (PHA) is committed to providing equal opportunities for everyone. This makes sure everyone has the chance to participate in our survey groups regardless of gender, marital status, disability, age, religion, political views, ethnic origin, caring responsibilities or sexual orientation.

By answering the following questions, you will help us understand who we are reaching and how we can better serve everyone in our community. Your response to these questions is **optional** and answers will be **anonymised**.

**2.1 What is your sex?** By sex we are referring to your current sex.

[ ] Male
[ ] Female
[ ] Identify in a different way
[ ] Prefer not to say

If you identify in a different way, please specify below:

| |
|---|
| |

**2.2 What is your age?**

[ ] Under 16
[ ] 16 to 24
[ ] 25 to 34
[ ] 35 to 44
[ ] 45 to 54
[ ] 55 to 64
[ ] 65 to 74
[ ] 75 to 84
[ ] 85+
[ ] Prefer not to say

**2.3 What is your marital status?**

[ ] Single, that is, never married and never registered in a civil partnership
[ ] Married
[ ] In a registered civil partnership
[ ] Separated but still legally married
[ ] Divorced
[ ] Widowed
[ ] Separated but still legally in a civil partnership
[ ] Formerly in a civil partnership which is now legally dissolved
[ ] Surviving partner from a civil partnership
[ ] Prefer not to say

**2.4 Which council area do you live in?**

[ ] Antrim and Newtownabbey
[ ] Armagh City, Banbridge and Craigavon
[ ] Belfast
[ ] Causeway Coast and Glens
[ ] Derry City and Strabane
[ ] Fermanagh and Omagh
[ ] Lisburn and Castlereagh
[ ] Mid and East Antrim
[ ] Mid Ulster
[ ] Newry, Mourne and Down
[ ] Ards and North Down
[ ] Prefer not to say

**2.5 Do you have any physical or mental health conditions or illnesses lasting or expecting to last for 12 months or more?**

[ ] Yes
[ ] No
[ ] Prefer not to say

If you answered 'Yes', does your condition(s) or illness(es) reduce your ability to carry-out day-to-day activities?

[ ] Yes, a lot
[ ] Yes, a little
[ ] Not at all
[ ] Prefer not to say

**2.6 What is your religion?**

[ ] No Religion
[ ] Catholic
[ ] Presbyterian
[ ] Church of Ireland
[ ] Methodist
[ ] Baptist
[ ] Free Presbyterian
[ ] Brethren
[ ] Protestant - not specified
[ ] Christian - not specified
[ ] Buddhist
[ ] Hindu
[ ] Jewish
[ ] Muslim
[ ] Sikh
[ ] Other
[ ] Prefer not to say

If you have selected Other, please specify below:

| |
|---|
| |

**2.7 Which of the following options best describes how you think of yourself?**

[ ] Heterosexual or Straight
[ ] Gay or Lesbian
[ ] Bisexual
[ ] Other
[ ] Prefer not to say

If you have selected Other, please specify below:

| |
|---|
| |

**2.8 Do you have responsibility for caring of any of the following groups?**

- Care of a child
  [ ] Yes
  [ ] No
  [ ] Prefer not to say

- Care of a person with a disability
  [ ] Yes
  [ ] No
  [ ] Prefer not to say

- Care of a dependant elderly person
  [ ] Yes
  [ ] No
  [ ] Prefer not to say

**2.9 What is your ethnic group?**

[ ] White
[ ] Irish Traveller
[ ] White and Black Caribbean
[ ] White and Black African
[ ] White and Asian
[ ] Any other mixed/multiple ethnic background
[ ] Indian
[ ] Pakistani
[ ] Bangladeshi
[ ] Chinese
[ ] Other Asian background
[ ] African
[ ] Caribbean
[ ] Other Black/African/Caribbean background
[ ] Arab
[ ] Other
[ ] Prefer not to say

If you have selected Other, please specify below:

**2.10 Do you think of yourself as a unionist, a nationalist or neither?**

[ ] Unionist
[ ] Nationalist
[ ] Neither
[ ] Other
[ ] Prefer not to say

If you have selected Other, please specify

## Section 3 – Responding as an organisation

3.1 **Please provide your organisation contact details below**
Organisation name and email address are required for validation purposes. (required)

Organisation name: All Ireland Institute of Hospice and Palliative Care

Organisation email address: info@aiihpc.org

3.2 **Which of the following best describes the sector you work in?**
(*Please tick the relevant box*)

This will assist us in monitoring the range of respondents the consultation has reached.

[ ] Statutory or Regulatory Body
[ ] Arm's Length Body (ALB)
[ X] Organised interest Group: e.g. Education, Health, Business, Creative Industries, Environment, Community, Voluntary & Third sectors
[ ] Business operator
[ ] Local Government
[ ] Government Department
[ ] Trade Union
[ ] Church or faith group
[ ] Media
[ ] Academia
[ ] Charity
[ ] Political Party
[ ] Other (please specify):

3.3 **Can we contact you to discuss your response to this consultation?** This may be to follow up any specific points we need to clarify. (required)

[ X ] Yes
[ ] No

3.4 **Can we contact you in future about the draft PHA Corporate Plan 2025-2030?** For example, to provide you with a link to the results of this consultation, to inform you of further consultations or provide updated information on the plan. (required)

[ X ] Yes
[ ] No

3.5 To support transparency in our decision-making process, we will publish a summary of the consultation feedback on the PHA website. This will sometimes include the responses themselves and may mention names of the responding organisation (if applicable). However, names of individuals responding on a personal capacity will only be published where consent has been given. Please note we will not publish contact details. (required)

[ X ] **Yes**, I consent to my organisation name being published with my response

[ ] **No**, please remove my organisation name before publishing my response

## Section 4 - Have your say

The following questions focus on the core elements of the draft PHA corporate plan 2025-2030.

Our purpose, vision, values and strategic outcomes are set out below and in the document.

**Purpose**: Protect and improve the health and social wellbeing of our population and reduce health inequalities through leadership, partnership and evidence-based practice.

**Vision:** A healthier Northern Ireland.

**Values:** The PHA endeavours to translate the Health and Social Care values into its culture by putting individuals and communities at the heart of everything we do, acting with **openness and honesty** and treating people with dignity, respect and **compassion; working together** in partnership to improve the quality of life of those we serve, listening to and involving individuals and communities; valuing, developing and empowering our staff and striving for **excellence** and innovation; being evidence led and outcomes focused.

Over the next five years, as we work to fulfil our purpose and advance towards our vision of a healthier Northern Ireland, we will focus on delivering a number of key public health priorities under the following strategic outcomes:

- **Protecting Health -** protecting the population from serious health threats, such as infectious disease outbreaks or major incidents
- **Starting Well -** laying the foundations for a healthy life from pre-birth, infancy, early years, childhood to adolescent years
- **Living Well -** ensuring that people have the opportunity to live and work in a healthy way

- **Ageing Well -** supporting people to age healthily throughout their lives

Each outcome sets out our ambition and a number of priorities for the years ahead. These are aligned with the draft Programme for Government Framework 2024-2027 and the strategic direction outlined in key departmental strategies.

Using the scale, please indicate using a cross (x) or a tick (√) to what extent you agree or disagree with the content in each of the sections

### 4.1 Do you agree with our purpose? If not, what alternative do you suggest?

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | | X |

Please include any comments in the box below:

| |
|---|
| N/A |

### 4.2 Do you agree with our vision and values? If not, what alternative do you suggest?

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | | X |

Please include any comments in the box below.

| |
|---|
| N/A |

**4.3 Referring to the draft plan, do you agree with Outcome 1: Protecting Health and the priorities listed? If not, what alternative do you suggest?**

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | X | |

Please include any comments in the box below.

| |
|---|
| The priorities listed are important however it is important to consider the whole life journey of people and therefore including palliative care as part of public health initiatives is important in incorporating the whole life span. |

**4.4 Referring to the draft plan, do you agree with Outcome 2: Starting Well and the priorities listed? If not, what alternative do you suggest?**

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | X | |

Please include any comments in the box below.

| |
|---|
| The priorities listed are important however it is important to consider the whole life journey of people and therefore including palliative care as part of public health initiatives is important in incorporating the whole life span. |

**4.5 Referring to the plan, do you agree with Outcome 3: Living Well and the priorities listed? If not, what alternative do you suggest?**

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | X | |

Please include any comments in the box below.

| |
|---|
| The priorities listed are important however it is important to consider the whole life journey of people and therefore including palliative care as part of public health initiatives is important in incorporating the whole life span. |

**4.6 Referring to the plan, do you agree with Outcome 4: Ageing Well and the priorities listed? If not, what alternative do you suggest?**

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree;
4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | X | |

Please include any comments in the box below.

The only brief reference to palliative and end of life care is *'through working with partners to support individuals and families at the end of life through advance care planning'*. Whilst advance care planning is important, and people should be encouraged to plan for the end of their lives this does not just sit within an ageing context. Unfortunately, children are born with complex and life-limiting conditions and advance care planning, and advance decisions are often needed to support care delivery. Just because a person is dying does not mean that they cannot live well until their death.

Northern Ireland Statistics and Research Agency estimate that by 2046 the population of Northern Ireland will be over 2 million and those aged 65+ will practically double (49.2%). Older people living with multimorbidity are projected to become the main recipients of palliative care in the coming decades. More complex illness as well as younger cohort of patients with late diagnosis or advanced cancer, will create significant pressure on services. Northern Ireland faces a very vulnerable position moving forward into the future, as services are not equipped to meet the future needs of all of its population.

The All Ireland Institute of Hospice and Palliative Care has promoted the implementation of Compassionate Communities which can help meet some of the needs people of people with palliative care needs . Compassionate Communities Position Paper 2025 proposes recommendations for supporting the development of a compassionate communities approach to caregiving, dying, death and grieving on the island of Ireland.

## 4.7 Referring to the plan, do you agree with our organisation ambition and priorities listed? If not, what alternative do you suggest?

1 = Strongly Disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly Agree

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| | | | X | |

Please include any comments in the box below.

| |
|---|
| As a totality the ambitions reflect the multifaceted issues that impact health and health outcomes. However, the priorities and indicators remain ones that are significantly impacted by external determinants to health such as socioeconomic factors. The increasing diagnosis and requirements of people with neurodiversity also needs to be included across the plan as it affects all facets of health across the lifespan.<br><br>Using obesity, vaccination, substance misuse and vaccinations as key indicators does not capture the whole 'health' picture, nor does it appear to be improving health outcomes. |

## 4.8 Is there an outcome you feel is missing or is not sufficiently reflected?

Yes [ X ] No [ ]

HSC Public Health Agency

Please include any comments in the box below:

**An additional stream of Dying Well – Palliative and End of Life Care should be included.**

Since AIIHPC's 2017 Briefing Paper: Public Health Approaches to Palliative Care, AIIHPC has been committed to furthering conversations on how public health approaches to palliative care can be developed to support people living with a life-limiting illness to maintain their quality of life. The need for palliative care is growing and there remains a significant unmet need. Our response to the PHA Corporate plan is a desire for equity of access to care for all groups including older population living with multiple illnesses/conditions, those in nursing and care homes, people in remote areas, people with disabilities, those in prison and homeless people.

Although it might appear contradictory to consider health promotion and end-of-life care together, it is now widely acknowledged that health and wellbeing can be improved in the context of a life-limiting illness, both for the individual and for those around them.

NCPC (2014) states that it is imperative for public health to include end-of-life care because:

1. A public health approach to end-of-life care expands the reach and effectiveness of end-of-life care services by engaging communities.
2. It can address a greater range of needs including social, psychological and spiritual needs, and do so more comprehensively.
3. It can raise awareness about death, dying, loss and care.
4. It can enlist communities in caring for their own at the end of life.
5. In a population health sense, a public health approach is incomplete without provision of care for those experiencing serious illness, ageing and frailty, long-term care, and loss and bereavement.
6. Heart disease, cancer, HIV, and ageing - the major concerns of public health policy - also present major end-of-life care challenges that have wider public health impacts beyond our clinical attempts to address them.
7. Because end of life experiences often take place within community contexts these are also logically the best sites where they can be effectively cared for.
8. The needs and wellbeing of dying, caring, and bereaved people are best met within a wider public health/community focussed approach to end-of-life care because many of the social morbidities associated with the end of life are amenable to traditional public health methods - health promotion, public education, or community development.
9. Social supports that result from increase of social capital (trust, empathy, cooperation) benefit experiences of death, dying, loss and caregiving because they counteract serious psychological and social morbidities, such as depression, anxiety, or loneliness, many of which can be traced to experiences of social isolation, neglect, or stigma.

Palliative care is widely recognised as a public-health concern, with both structural and social determinants of health affecting health inequalities for disadvantaged populations across high-income and low-income countries (Mills et al, 2021). Disadvantaged groups are also found in resource-rich countries—Indigenous peoples, LGBTQI+ communities, and those incarcerated or homeless. The reality is that palliative care service provision reaches only a minority of those who need palliative care and inequities of access substantially affect those from diverse communities.

In line with keeping pace with cross-border working, there are opportunities for agencies within Northern Ireland to be more proactive in this health space.

Health Promotion

Health promotion in palliative care describes the idea that end-of-life social and psychological needs are best addressed through health and death education, community development, personal reorientation, and policy and environmental change. Health-promoting palliative care employs public health methods and concepts to change the way in which healthcare services approach end of life experiences. Health-promoting palliative care addresses a greater range of end-of-life experiences and serves a broad range of needs of people suffering from life-threatening and life-limiting illnesses. It also engages caregivers, the bereaved and communities in their own care by working health and wellbeing at the end-of-life. with those communities to identify issues associated with health and wellbeing at the end of life.

Central to this transformative journey is recognizing death literacy – understanding mortality, grief, and end of life care is a foundational pillar of public health education. When we equip healthcare professionals and the public with tools and knowledge to navigate these topics, we create long lasting changes in how we approach health, encourage empathy and support communities from within (Vassiliou, 2024). Death literacy can be defined as acquiring knowledge regarding death systems, this encompasses exploring societal responses to death and navigating end of life and death care options. Research indicates that communities with higher death literacy indices exhibit reduced levels of anxiety around death. The absence of death literacy and death-related discussions significantly impacts how individuals navigate the practical aspects of end of life care. Many people are uninformed about managing their own end of life journey and that of their loved ones and this lack of communication and avoidance often leads to family tensions, increased healthcare costs and patient dissatisfaction regarding treatment and support options (Vassiliou, 2024).

Healthcare professionals deserve comprehensive training and ongoing support to effectively address palliative care including end of life and bereavement care support and navigate their own grief journeys (Vassiliou, 2024). Such resources foster a more compassionate approach to patient care and provide essential support for health care practitioners, a lot who work in areas where there is little to no training on these aspects.

When communities openly discuss these topics, we foster a culture of understanding, empathy, and support, recognising the need for systemic changes in our work culture, social structures and values. Initiating these dialogues addresses the social determinants of health that contribute to disparities in health outcomes, tackling systemic inequities such as limited access to healthcare, socioeconomic factors and cultural barriers (Vassiliou, 2024). Advocating for dialogue and transparency surrounding topics of death, dying and grief yields benefits that extend to the entire community. Embracing death literacy as an essential component to public health education can alleviate the adverse effects of poor health outcomes and cultivate a society better equipped to navigate the complexities of human existences with dignity and compassion, fostering healthier, more cohesive communities. Work is currently being undertaken by Stephanie Crawford – PhD student at Queens University Belfast to explore death literacy using an

Bereavement has been linked to increased mortality, as well as physical, psychological and psychiatric morbidity. Morbidity and mortality associated with bereavement is an important health issues, yet economic and resource investments to effectively implement and sustain integrated bereavement services are lacking at a national and global level (Lichtenthal et al, 2024). Stroebe et al (2007) found that social isolation and dysfunction are among the symptoms of grief. The effect of inadequate bereavement care disproportionately disadvantages vulnerable groups, including those living in resource-constrained settings.

Ideally, bereavement care includes pre-death grief education and support, family focused psychosocial and spiritual care during the dying process, bereavement services after the death to nurture and sustain surviving family and community members, and assistance with transitioning to community-based support and psychosocial services for those who need long-term professional care. It also includes support for the workforce, as professional caregivers are affected by repeated losses.

After a patient's death, bereaved individuals commonly confront the additional losses of the health-care team and institution, often resulting in a sense of abandonment and leaving them in a precarious emotional lurch. Given health-care institutions cultivate this dependency on their systems throughout the care trajectory, it should be incumbent on these very institutions to address grief needs before and after a patient's death. Outside of health-care settings, availability and access to professional bereavement supports are also scarce, even in geographical locations with accessible mental health services (Lichtenthal et al, 2024). The Lancet Commission on the value of death advocated for the development of global compassionate communities to support bereaved individuals (Sallnow et al, 2022).

Transitional bereavement care is necessary to bridge the gap between health-care systems and the community-based bereavement supports. A transitional bereavement care approach would involve establishing institutional supports to prevent poor bereavement outcomes, with dedicated personnel applying evidence-based care tailored to the individual's level of need.

Transitional bereavement care would also involve shoring up the quality and availability of institution-based offerings and triaging resources according to the bereaved family members' needs, while gradually building sustainable professional and lay supports in the community (Lichtenthal et al, 2024). The Irish Hospice Foundation (2021) has developed a four tiered public health model to address the types of support that needs to be implemented, highlighting how support should be tailored to the individual grievers' needs and level of risk for poor bereavement outcomes. Innovative models, like the one above are inherently cost-effective because they depend primarily on community, rather than institutional support, and given that most bereaved individuals will adapt to their loss without formal or professional intervention. These tiered models cannot exist in a vacuum and must be contextualised by setting to promote culturally tailored grief literacy among both communities and health professionals so they can optimally support bereaved family members. We must bring bereavement care to the forefront in the health and social care discourse and transform the urgent needs surrounding grief and grieving from an afterthought to a public health priority.

Amidst longstanding inequalities in access to hospice and palliative care, if equity in access to palliative care is to be achieved it must be understood that equality of service provision for diverse populations will not necessarily equate to equity in health outcomes, as health inequities are context-bound and socially determined.

Westernised health and death systems have medicalised death and dying processes which has resulted in both the implicit and explicit disenfranchisement of family and community involvement throughout illness and the time surrounding end of life (Lichtenthal et al, 2024). Being proactive in dying, death and bereavement literacy, advocacy, policy and strategy will have positive outcomes on wide ranging public health initiatives at will encourage more open, transparent conversations and activity around planning not just for life but also death. As noted throughout this response the long term financial, resource and human impact on this approach would be long reaching and at the forefront of the public health approach.

**References**


Graham-Wisener, L; Crawford, S & Crowe, A (2025) 'Compassionate Communities Position Paper – Fostering Compassionate Communities: A call to transform caregiving, dying, death an grieving on the island of Ireland' Compassionate-Communities-Position-Paper-2025.pdf

Hospice UK (2015) 'Rehabilitative Palliative Care – Enabling people to live fully until they die, A challenge for the 21st Century' https://www.hospiceuk.org/innovation-hub/clinical-care-support/rehabilitative-palliative-care

Kellehear, A (1999) 'Health promoting palliative care: Developing a social model of practice' *Mortality,* vol. 4, no. 1, p75-82, 10.1080/713685967

Lichtenthal, W; Roberts, K.E; Donovan, L.E; Breen, L.J; Aoun, S.A, Connor, S.R & Rosa, W.E (2024) 'Investing in bereavement care as a public health priority' *Lancet Public Health,* vol. 9, pe270-e274.

Mills, J; Abel, J; Kellehear, A. & Patel, M. (2021) 'Access to palliative care: the primacy of public health partnership and community participation' *The Lancet,* vol.6, p.e791-e792, https://doi.org/10.1016/ S2468-2667(21)00213-9

National Institute of Aging (2019) 'Social isolation, loneliness in older people pose health risks' NIA - Social isolation, loneliness in older people pose health risks, accessed 8.01.25

NCPC (2014) 'Public Health Approaches to End of Life Care' https://www.ncpc.org.uk/communitycharter/ accessed 28.01.25

Northern Ireland Statistics and Research Agency (2019) '2019-based Population Projections for Northern Ireland' https://www.nisra.gov.uk/publications/2018-based-population-projections-northern-ireland, accessed 28.01.25

Sallnow L, Smith R, Ahmedzai SH, et al. (2022) 'Report of the Lancet Commission on the value of death: bringing death back into life' *The Lancet*; vol.399, p. 837–84.

Stroebe, M; Schut, H & Storebe, W (2007) 'Health outcomes of bereavement' *The Lancet*, vol. 370, no. 9603, p1960-1973, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61816-9/abstract accessed 29.01.25

The Irish Hospice Foundation (2021) Adult bereavement care pyramid: a national framework. https://hospicefoundation.ie/our-supports-services/bereavement-loss-hub/i-work-in-bereavement/adult-bereavement-care-pyramid/ accessed 29.01.25

Vassiliou, M (2024) 'Death Literacy as a vital component of Public Health education' *United Nations New Special Magazine, no.828, p36-38*

WHO (2002). Community participation in local health and sustainable development: approaches and techniques. *World Health Organization Regional Office for Europe.* https://apps.who.int/iris/handle/10665/107341.

## 4.9 Have you any other comments or suggestions to improve the document as a whole? If so, please outline these in the box below.

The term 'families' also needs to be explicit, as society has evolved and changed so has the traditional family structure. Some people may not have their families available to them either through choice or necessity (e.g. refugees) therefore language that is inclusive of these diverse support networks should be acknowledged throughout the documentation.

## Consultation process and PHA privacy notice

The PHA will publish a summary of responses following completion of the consultation process on the PHA corporate website. The responses will be used to amend and further develop the draft Corporate Plan 2025-2030. Your response, and all other responses to the consultation, may be disclosed on request, in line with Freedom of Information legsislation.

**Thank you for taking the time to complete and return this questionnaire. We very much value your input.**