PUBLIC HEALTH AGENCY
ANNUAL REPORT & ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2021

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Laid before the Northern Ireland Assembly
under Schedule 2, para 17(5) of the Reform Act for the Regional Agency, by the Department of Health

On 2nd July 2021

Using this report

This report reflects progress by the Public Health Agency (PHA) in 2020/21 in delivering its corporate priorities and highlights examples of work undertaken during this period. It shows how this work has contributed to meeting our wider objectives and fulfilling our statutory functions.

The full accounts of the PHA are contained within this combined document.

For more detailed information on our work, please visit our corporate website at www.publichealth.hscni.net

Other formats

Copies of this report may be produced in alternative formats upon request. A Portable Document Format (PDF) file of this document is also available to download from www.publichealth.hscni.net

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PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2021

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PUBLIC HEALTH AGENCY

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2021

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OVERVIEW

THE PUBLIC HEALTH AGENCY – OUR ROLE, PURPOSE AND ACTIVITIES

The Public Health Agency (PHA) is the statutory body responsible for improving and protecting the health of our population and an integral part of the Health and Social Care (HSC) system, working closely with the Health and Social Care Board (HSCB), local Health Trusts (HSC Trusts), the Business Services Organisation (BSO) and the Patient Client Council (PCC).

Central to our main responsibilities is working in close partnership with individuals, groups and organisations from all sectors – community, voluntary and statutory.

The PHA was set up with the explicit agenda to:

- protect public health;
- improve the health and social wellbeing of people in Northern Ireland and work to reduce health inequalities between people in Northern Ireland; and
- work with the HSCB, providing professional input to the commissioning of health and social care services.

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

During 2020/21, the PHA continued to work and be guided by our purpose, vision and values, as set out in our Corporate Plan 2017 – 2021; however our focus was on responding to the challenges of COVID-19.

Our purpose

- to protect and improve the health and social wellbeing of our population and reduce health inequalities through strong partnerships with individuals, communities and other key public, private and voluntary organisations.

Our vision

- all people and communities are enabled and supported in achieving their full health and wellbeing potential, and inequalities in health are reduced.

Our values

- we put individuals and communities at the heart of everything we do in improving their health and social wellbeing and reducing health inequalities;
- we act with openness and honesty and treat all with dignity, respect and compassion as we conduct our business;
- we work in partnership with individuals, communities and other public, private, community and voluntary organisations to improve the quality of life of those we serve;
- we listen to and involve individuals and communities;

- we value, develop and empower our staff and strive for excellence and innovation; and
- we are evidence-led and outcomes-focused.

CHAIR'S FOREWORD

This report marks the 12th annual report of the Public Health Agency in working to protect and improve the health and wellbeing of the people of Northern Ireland and tackle health inequalities.

This has been a momentous year for the Agency. The health and wellbeing of the people of Northern Ireland have been imperilled by a previously unknown and lethal virus.

On behalf of the board of the Agency I want to convey to the Interim Chief Executive, the Agency Management Team and staff throughout the organisation how much their endeavours to safeguard the health of the people of Northern Ireland are appreciated.

The enduring commitment of the staff has played no small role in containing this virus and mitigating its effects.

Many of the staff have taken on new roles, often at short notice, to ensure an unflinching response to the pandemic. This year's report focuses on the 12 months which saw the Agency playing such a critical role in protecting the population of Northern Ireland from a global pandemic.

Obviously in such a situation health protection is to the forefront. However, staff of the Agency with great alacrity and ingenuity established at breakneck speed a contact tracing service. Staff set up an education support cell in order to give guidance to schools and colleges so that they could operate in a manner which was safe.

Communication staff of the Agency ensured that they dynamically conveyed critical information to the public using a broad range of media.

Staff adapted with unswerving commitment and professionalism to the immense challenges of COVID-19.

The cohesion of the health and social care family played a critical role in achieving successful outcomes.

With great ingenuity and with much urgency staff were able to re-focus the work and resources in order to begin to contain the virus.

Immense credit must go to the Department of Health for its sterling leadership. The rollout of vaccines in Northern Ireland has been an unparalleled success.

Mrs Olive Macleod extremely courageously agreed to become interim chief executive of the PHA at a most difficult juncture – end of March 2020. The work of the Agency has benefitted extensively from her resoluteness and enduring focus.

I wish to thank my fellow directors on the Board for the steadfast zeal and energy which they bring to their work. They willingly participated in many more meetings and workshops in order, at this critical time, to provide guidance and advice to the Interim

Chief Executive, Executive Directors and other senior managers. Their broad experience and mature reflection have been tremendous assets to the organisation and its work.

I want to pay tribute to Mr Leslie Drew, who has been Non-Executive Director (Finance) since 2015. He was also chair of the Governance and Audit Committee. Leslie was appointed as the new Chair of the Health and Social Care Board in early 2020/21 and we wish him every success in his new post.

We are steadfastly rebuilding our services particularly in regard to screening which had to be ceased for a period at the height of the pandemic. Our commitment to health improvement and particularly to tackle the suffering among the people of Northern Ireland caused by inequalities in health will continue to be an unrelenting driver to ensure success in this noble aim.

It is our burning ambition that in the years ahead we will see greatly improved health and wellbeing among all the people of Northern Ireland.

Andrew Dougal OBE

Chair of the Board

Public Health Agency for Northern Ireland

CHIEF EXECUTIVE'S REPORT

The events of this past year have tested us at PHA, in our communities and across Northern Ireland. Given these challenges, I am very proud of the myriad of ways in which everyone in the PHA stepped up and adjusted, particularly in our efforts to ensure the health, safety and wellbeing of the population of Northern Ireland.

In a year like no other, the core mission of the PHA remains the same, we are here to protect and improve the health and social wellbeing of our population. During 2020/21, the Agency's work was carried out against a backdrop of a global pandemic.

The Corporate Plan 2017–2021 sets out the strategic direction for the Agency. The PHA Annual Business Plan normally sets out in more detail what the PHA will do to help achieve the outcomes identified in the PHA Corporate Plan. Due to our response to COVID-19, it was not possible to progress with an annual business plan for 2020/21 as our resources were focused on a sustained public health response to the virus.

This report spotlights the diversity of our response to the virus and highlights some of the key actions taken by the PHA.

It also includes information on the advice and support provided by the Agency to a wide range of stakeholders, including the public, other healthcare professionals, agencies and government.

All of this work was carried out against a rapidly changing and challenging landscape.

During 2020/21, given the need to refocus our priorities as well as having regard to lockdown and social distancing measures, the PHA invoked its Business Continuity arrangements and quickly adapted its management arrangements to suit. As well as the monthly PHA Board meetings, a number of informal briefings were also organised for Board members, to keep them informed between meetings when appropriate (read more in Non-Executive Directors' report).

During the year, we said farewell to two members of our Agency Management Team, Edmond McClean, Deputy Chief Executive and Director of Operations and Professor Hugo van Woerden, Director of Public Health. We send them our very best wishes for the future. We welcomed two interim directors Dr Stephen Bergin as Interim Director of Public Health and Stephen Wilson as Interim Director of Operations.

Professor van Woerden's report 'Coronavirus: the 2020 Director of Public Health Report for Northern Ireland' provides a guide to health's response to the virus and includes more detail on many of the topics that are reflected in this report (www.publichealth.hscni.net/sites/default/files/2020-12/DPH_Report_Final%2031%20Dec%202020.pdf).

The impact of the past year on all our staff and the wider healthcare community will be felt for many years to come. I would like to offer my thanks and gratitude to all PHA staff who have worked so hard over this past year to ensure the provision of

vital services, surveillance data for decision making and guidance and advice for both the public and many other sectors, as we have worked with colleagues locally and nationally in the fight to control and reduce the transmission of COVID-19.

Looking ahead to 2021/22, so much has changed because of a virus. It has brought heartache to many families who have lost loved ones and my condolences to everyone who has suffered loss during these unimaginable times.

As we move forward through whatever the next phases of COVID-19 may be, I am thankful how the PHA staff came together, through partnership, to fight back against an invisible enemy. This work was made more difficult through the challenges of lockdowns, home working and social distancing.

Over the past year there was an incredible strength demonstrated by the healthcare family and I am encouraged that we will move forward together to help ensure the best health for everyone in Northern Ireland.

Olive Macleod

Chief Executive (Interim)

PERFORMANCE ANALYSIS

The performance analysis is normally based on the PHA Annual Business Plan, setting out how we met the planned actions and targets set out at the beginning of the year, in line with the longer term corporate objectives. However, given the unprecedented impact of COVID-19 from the end of 2019/20 and throughout 2020/21, it was not possible to complete the work on the production of an Annual Business Plan for 2020/21.

Further given the PHA role and responsibility to protect health, as set out in our establishing legislation[1], our resources were prioritised and focused on work to control and reduce the transmission of COVID-19, working closely with the Department of Health (DoH), the Health and Social Care Board (HSCB), Business Services Organisation (BSO), HSC Trusts (HSCTs) and other statutory and non-statutory partners.

Combining the necessity of diverting our resources to work on COVID-19 issues, co-leading the HSC emergency preparedness response with the HSCB and finding new ways to work in line with social distancing and maximising working from home provision, meant that business continuity was invoked for much of the year.

The performance report will therefore primarily focus on the work of the PHA in responding to COVID-19 during 2020/21.

[1] The Health and Social Care (Reform) Act (Northern Ireland) 2009, sets out that the PHA Health Protection function, including that "The health protection functions are the protection of the community (or any part of the community) against communicable disease in particular by the prevention or control of such disease"

COVID-19 TIMELINE

A brief timeline for some of the key events that have marked the pandemic to the end of March 2021 is shown in Figure 1 below.

Figure 1: COVID-19 timeline

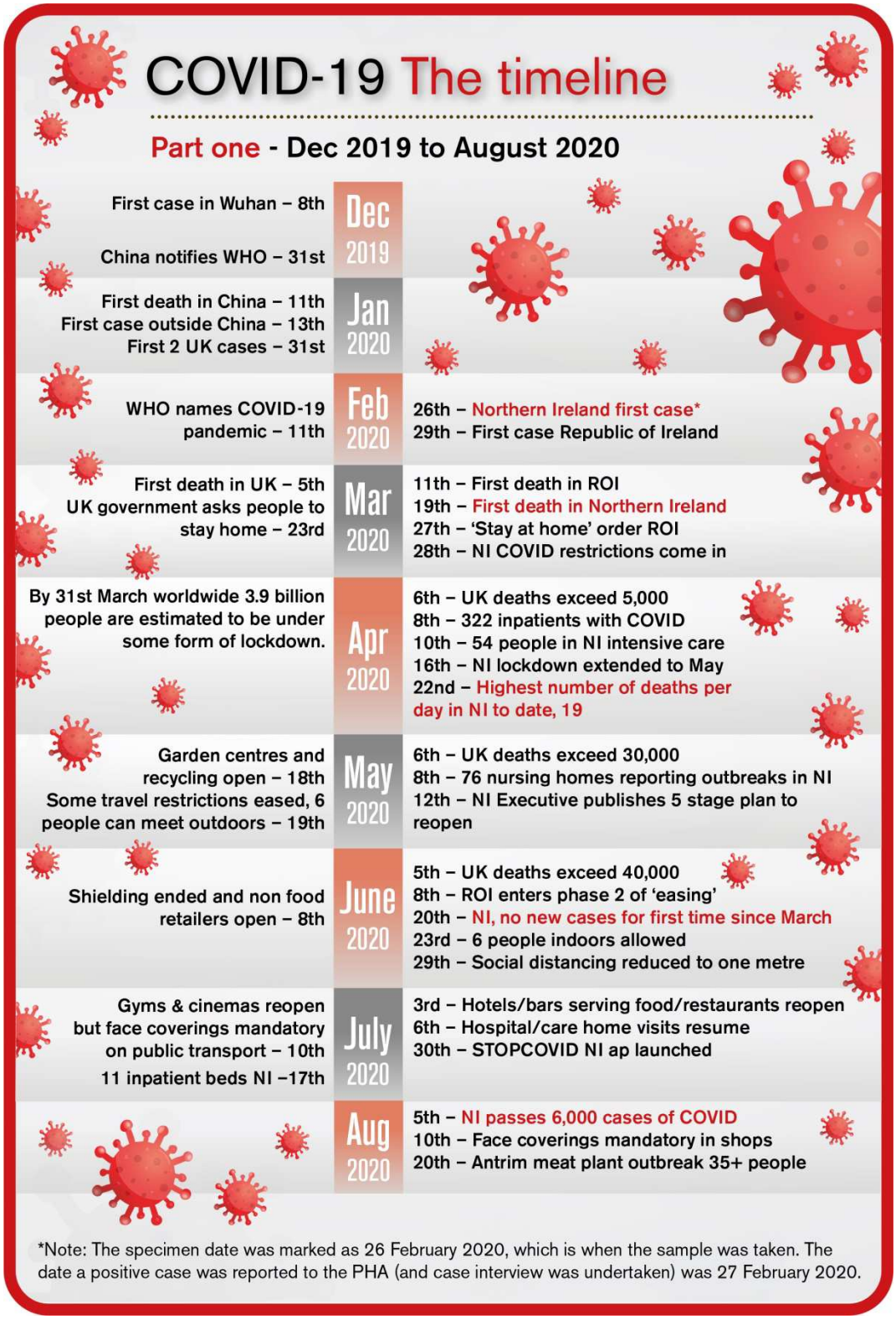
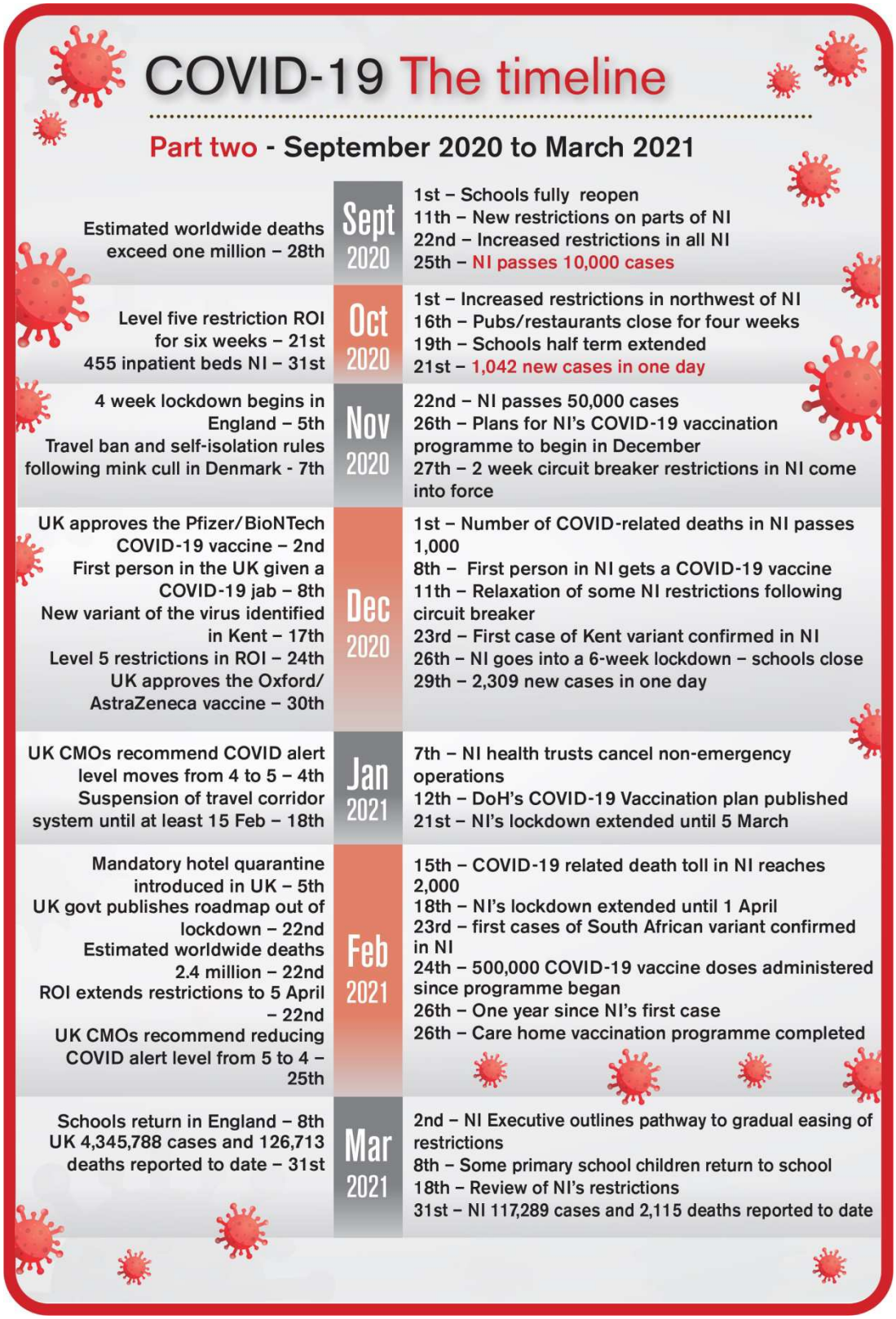


Figure 1: COVID-19 timeline



RESPONSE TO COVID-19

It was an extremely challenging and arguably an unprecedented year in the history of the Agency. Whilst the recognition, identification and management of incidents and outbreaks have been a function of the PHA's business since its inception, the scale and impact of COVID-19 across all aspects of society in Northern Ireland has ensured that the role, support and work of the Agency was kept consistently at the forefront of public attention throughout 2020/21.

Responding to the many challenges of COVID-19 has required a full organisational approach from the Agency. The scale and pace of the pandemic led to the Agency invoking business continuity measures as outlined in the PHA Business Continuity Plan and developing a PHA Covid Management Response Framework (the Framework).

The Framework is based on recognised best practice within the international health protection community and set out the operational plan for the Agency's response including relationships with various stakeholders and the information and intelligence flows required. The Framework aligns with the Department of Health's COVID-19 Emergency Response Strategy 2020 and reflects the principles identified by the Association of Directors of Public Health for the design and implementation of local COVID-19 Management Plans.

The following pages describe some of the work undertaken by the PHA during 2020/21, providing an insight into the breadth of the PHA response across directorates and functions.

These areas include:

- The role of health protection in the response to COVID-19;
- Development of the Northern Ireland Contact Tracing Service;
- Support for the education sector;
- Supporting the care home sector;
- Infection prevention and control during the pandemic;
- Collaborative approach to surge management;
- The Research and Development response to COVID-19;
- Vaccination programmes;
- The impact of COVID-19 on screening services;
- Health and wellbeing improvement initiatives;
- Supporting mental health and emotional wellbeing during COVID-19;
- The key role of communication during a pandemic;
- Planning and operational response; and
- Health & Social Care Quality Improvement (HSCQI) response to the pandemic.

The role of health protection in the response to COVID-19

The Public Health Agency's Health Protection Service has a lead role in protecting the population of Northern Ireland from infectious and environmental hazards through a range of core functions including:

- response to acute health protection incidents;
- surveillance and monitoring;
- operational support and advice; and
- education, training and research.

The first confirmed case of COVID-19 in Northern Ireland was tested on 26 February 2020.[2] In the first months of 2020 the work of the PHA, and indeed the wider HSC, focused on preparing for, and responding to, the challenges of COVID-19.

The Health Protection Service has provided sustained and intensive leadership, intelligence and health protection expertise during the COVID-19 pandemic, in addition to delivering essential ongoing acute response and proactive health protection programmes.

The commitment to pre COVID-19 objectives has also continued. This included the delivery of the seasonal flu vaccination programme for 2020/21, catch up with school and other vaccination programmes, as well as dealing with any emerging outbreaks or hazards, and resetting existing programmes of work (read more about vaccination programmes in section below).

Following confirmation of the first case in Northern Ireland, a programme of COVID-19 contact tracing was initiated as part of the disease containment phase. This was led by the Agency's Health Protection Team (HPT) and operated by staff redeployed from across the organisation (read more about contact tracing in section below).

The PHA Health Protection and Health Intelligence teams developed monthly and then weekly reports on the impact of COVID-19. These epidemiological bulletins present high level data on key areas currently being used to monitor COVID-19 activity (Coronavirus bulletin | HSC Public Health Agency (hscni.net)).

They highlighted current issues and public health messages, along with the analysis of the demographic characteristics (for example, age, sex, geographical location, deprivation) of people affected by the virus. The reports also look at some of the wider impact of the virus on the healthcare system, comparing recent trends in activity with historic norms.

From November 2020, the focus of the Health Protection Service was on planning for and coordination of the third wave of the COVID-19 pandemic response. During this period, the PHA continued to provide health protection guidance and advice for professionals and the public through a comprehensive communication and engagement programme.

PHA staff also worked closely with HSCB and HSC Trust colleagues to prepare for a possible surge, including ensuring HSC readiness, and making critical care escalation plans.

[2] The specimen date was 26 February. Lab confirmation reported to PHA (and case interview) on 27 February.

Working with key partners, including the DoH, Public Health England (PHE), Department of Health and Social Care (England), NHS Digital (England), HSC Trusts, Northern Ireland Pathology Network and universities, the PHA also expanded its COVID-19 testing programme, and oversaw and coordinated its implementation. This included working with the national testing provider to deploy mobile testing units in areas of concern as the pattern of infection continued to move and change.

Cognisant of the potential impact of both the pandemic and the action taken to manage the outbreak on the health and wellbeing of individuals and communities, the PHA then began to plan for the anticipated post-surge and recovery phases. This includes consideration and review of existing resources and contracts to ensure stability and continuity as well as appropriate response to need.

Development of the Northern Ireland Contact Tracing Service

The Northern Ireland Contact Tracing Service was initially set up as a pilot by the PHA on 27 April 2020, and has been fully operational since May 2020. The aim of the service is to enable the rapid identification of close contacts and reduce chains of transmission of COVID-19 in the community.

A team of contact tracers from a range of backgrounds was recruited, alongside a team of medical doctors to advice on contact tracing activities with support from health protection colleagues. The service was initially located in Belfast; however, it relocated to County Hall, Ballymena to facilitate social distancing as the service grew.

There were relatively small numbers of cases observed during the first three months of the service being operational. As per Scientific Advisory Group for Emergencies (SAGE) recommendations, the service aims to contact more than 80% of cases within 24 hours of notification of a positive test result and of close contacts to be informed within 48 hours of notification.

During the subsequent waves of the pandemic rapid increases in case numbers occurred. As a result of increasing case numbers and close contacts, the service needed to adapt. This included the introduction of SMS text notification to notify close contacts of their status and need to self-isolate, and the use of digital self-tracing to allow cases to complete online entry of close contact information.

This has enabled resources to be focused on contacting harder to reach cases and contacts, and identifying settings in which COVID-19 transmission may have occurred. The service was able to upscale its staff numbers as part of the response to these waves. It operates a surge model with a large number of tracing staff employed on bank contracts to allow flexibility to increase or decrease staff numbers according to need.

The service also was able to efficiently train PHA and HSCB staff in the role and re-deploy them as necessary. At the peak of the wave in January 2021, we provided over 6,000 hours of tracing time in one week. At this reporting period, we employ 146 full and part-time contact tracers with a bank of 170 staff also available to us.

There was also investment in equipment to allow staff to work from home – again for responsiveness and also to help reduce the risk of infection from the virus. Even at the peak of over 2,000 cases each day in Winter 2020/21, the service consistently contacted 85-95% of cases within 24 hours and the same for contacts within 48 hours and this remains the case.

Support for the education sector

There are around 350,000 children and young people attending schools and pre-schools in Northern Ireland. In addition there are over 50,000 staff working in schools fulfilling a range of roles. In late August 2020 schools across Northern Ireland re-opened following a five month break as a result of the pandemic.

In recognition of the size of the school population and the important role education plays in promoting children's health and wellbeing, the Agency prioritised support for schools and other educational establishments and established a dedicated PHA COVID-19 education support cell.

The overall aim of the education cell was to reduce the risk of transmission of COVID-19 within schools when a positive case was identified by providing early advice and support on how to effectively manage the individual situation. The cell also risk assesses and manage clusters and outbreaks in the school setting, establishing multiagency incident management teams in response to larger or complex outbreaks when required.

The education cell has worked closely with the Education Authority (EA) to implement a partnership approach to the management of COVID-19 in schools. This effective partnership working has supported related areas of work including the introduction of asymptomatic COVID-19 testing to schools in Northern Ireland.

From schools re-opening on Monday 24 August 2020 until Sunday 4 April 2021, there were 5,542 cases reported in 907 schools to the education cell. A total of 3,542 of these cases were students and the other 2,000 cases were staff (teaching and non-teaching).

The PHA has chaired a Joint Health Education Oversight Group throughout the pandemic with representatives from DoH, DE, HSCB and EA to proactively manage the needs of children and young people.

This helped develop a tiered Contingency Framework to ensure there was a planned and co-ordinated approach to support 'Vulnerable' children and young people. In addition, during the first lock-down, 138 vulnerable children and young people were able to access school placements across the region, which helped manage their and their family's needs.

In the past year the PHA has led work on an initiative to ensure the identification and subsequent support for children and young people with Special Educational Needs (SEN). There is now a standardised approach across Northern Ireland and more timely health advice for children under-going statutory assessment with the Education Authority.

SEN Co-ordinators and Data Analyst posts have been appointed in each Trust area and an improvement programme has been established by the PHA to enhance the input across HSC staff involved in the statutory assessment process. As a result of this work, there has been an improvement in Trust compliance in the provision of health advice with 79% of the reports being provided within the 6 week timeframe where there were no valid medical exceptions.

In addition, the PHA is working with the EA to develop a joint health/education plan that will be used for inspection purposes by the Regulation and Quality Improvement Authority (RQIA) and Education Training Inspectorate (ETI) to evidence how the health and education sectors are meeting requirements of the Children's Co-operation Act (2015).

Supporting the Care Home Sector

The impact of COVID-19 on residents living in care homes in Northern Ireland and the staff who support them has been severe. From the onset of the pandemic in 2020 the PHA has worked collaboratively with partners including local and regional experts to respond quickly, decisively and in supporting the care home sector to minimise infections and ensure the care and wellbeing of all residents and staff.

PHA worked closely with HSCB colleagues to develop a COVID-19 Regional Surge Plan for the Northern Ireland Care Home Sector, which addressed three key areas: Prevention, Mitigation, and Resilience. The Plan's Decision Support Framework and Risk Matrix has been utilised extensively by Care Homes and HSC Trusts to support the early identification of risk, enabling targeted intervention and informing local and regional surge response/planning.

The plan was kept under review during the year as COVID-19 progressed and in September 2020 recommendations from the DoH Rapid Learning Initiative Report on the management of COVID-19 within care homes were incorporated.

As part of this work, the PHA delivered and supported a number of important initiatives to help provide support, guidance, training and protection for care homes residents and their staff during 2020/21. These included:

<u>Enhancing clinical skills</u>
Support for the design and delivery of training sessions, guidance documents and resource material that aimed to enhance the skills of the care homes to respond to COVID-19, in areas such as symptom management; clinical observations; infection prevention and control; environmental cleanliness; verification of death; dynamic risk assessment; managing footfall; visiting; human rights; nutrition; hydration; and communication effectively with PPE.

<u>Engagement and networking</u>
Through the 10,000 More Voices project information was gathered by PHA on the lived experience of care home residents. This work was completed in September 2020 and the feedback from residents was used to inform the recommendations of the DoH Rapid Learning Initiative in relation to care homes.

Feedback from clients highlighted the importance of developing mechanisms to support families and residents to share their experiences and to support a system approach to listening and learning from the feedback.

As a result the PHA collaborated with the Patient and Client Council in the development of a pulse check which offers opportunity to families and residents to reflect on specific change in the system (for example visiting). This survey was co-designed with families of Care Home residents and it is anticipated will launch in 2021 to support an ongoing conversation between the Care Homes, residents and families which will inform change.

Supporting visiting and implementation of the Care Partner concept

The PHA has worked in partnership with the Patient and Client families of care home residents, the HSCB, RQIA, Commissioner for Older People for Northern Ireland (COPNI) and the DoH on a range of initiatives aimed at supporting care homes to increase the number of care partners, in line with the DoH guidance on Care Partners for NI Care Homes. This included developing resources for visitors and care partners, gathering the opinion of families and care home providers and using social media to raise awareness of the guidance; where specific issues were identified targeted intervention was put in place with individual homes. A monitoring process has been put in place to gather intelligence on a daily basis as to progress against implementation.

The PHA has also supported the roll out of the COVID-19 vaccination programme across care home residents and staff to ensure residents were provided with protection against the virus as quickly as possible.

Emerging data comparing the performance of UK countries in the international measure of excess deaths in care homes suggests early positive indicators of the “lowest share of care homes infected” and the “lowest level of excess deaths” in Northern Ireland care homes as compared to England, Scotland and Wales, all of which can be linked to decisive collective actions led by the PHA alongside regional and local organisations.

Infection prevention and control during the pandemic

One of the main roles of the PHA was a focus on infection prevention and control (IPC) as the COVID-19 pandemic began to spread in Northern Ireland. The Agency established the Regional IPC Cell, chaired by the Director of Nursing and Allied Health Professionals, to oversee the co-ordination of IPC across the HSC system including primary care, community, voluntary and independent sector care providers.

This IPC Cell is part of the regional infrastructure that has been key in helping to tackle the COVID-19 pandemic. The Regional IPC Cell also has a link to the National IPC Cell which is made up of representatives from across the four nations and it provides an opportunity to help shape, influence and agree national guidance.

Since the start of the pandemic, the Regional IPC Cell has taken forward a number of strategic tasks and actions which include influencing, informing, translating and disseminating national policy guidance into local practice; for example, through the

development and recent implementation of the 'COVID-19: Guidance for maintaining services within health and care settings' within Northern Ireland. Members of the Regional IPC Cell have also lead on specific pieces of work such as clear masks, ventilation and various other subgroups that have been established to complete regional actions.

The IPC Cell has also worked closely with Trust IPC Teams and Health Protection colleagues to establish and effectively manage regional cluster and outbreak management arrangements. An outreach IPC programme for Care Homes was also established and facilitated through Trusts including the distribution of PPE.

A Product Review Protocol has been developed between IPC Leads (PHA and HSCTs), Business Services Organisation (BSO) and Medicines Optimisation Innovation Centre (MOIC) to assess all new PPE items to ensure they are suitable for use in healthcare settings. Weekly meetings of the IPC Product Review Group take place to review and assess new PPE items.

Work is ongoing to develop a Regional Fit Testing Framework to standardise fit testing across the region to ensure a more consistent approach. Work is also ongoing to develop a fit testing leaflet for staff which will answer frequently asked questions.

The Chair of the IPC Cell has responsibility for overseeing the development of a Personal Protective Equipment (PPE) Modelling Framework. This framework supports the effective procurement of PPE in response to COVID-19 and service rebuilding programme. This work continues to be developed and refined working closely with HSCTs and BSO.

Throughout the pandemic, the IPC Cell has held a number of engagement meetings with Trade Union colleagues to discuss important issues such as the IPC Product Review Group, fit testing, decontamination of PPE and FFP3 (Filtering Face Pieces) masks.

The COVID-19 pandemic has highlighted the need to strengthen IPC across the region and therefore the IPC Cell is leading on the development of an IPC Framework which will promote standardisation.

Work is also ongoing to develop a digital solution to support IPC Teams with outbreak management, contact tracing and patient test results. The need for a digital solution has been highlighted throughout the COVID-19 pandemic. This piece of work has been established by the IPC Cell and will be taken forward during 2021/22.

Collaborative approach to surge management

During 2020/21, the PHA worked collaboratively within the Northern Ireland Health Care system in relation to the management of surges of COVID-19 and the impact of these surges on critical care and respiratory services.

There were a number of risks around the provision of respiratory support for COVID-19 pneumonitis in Northern Ireland. In the event of a larger third wave, risks needed

to be considered around oxygen supply, medical and nursing staff levels, ambulance capacity and regional bed occupancy.

The PHA was involved in a number of initiatives to offset these risks which included working with Trust data, modelling experts, clinical leads and information analysts to determine a strategically led decision making process.

In January 2021, PHA Nursing became part of the newly established command and control hub (the Hub), set up by DoH Gold Command Group to operationally manage critical care admissions and transfers, including respiratory transfers, on a regional basis.

The purpose of the Hub was to maximise critical care and respiratory resources across Northern Ireland at all times. This helped to ensure that demand was spread as evenly as possible and to help manage the risk of any individual hospitals becoming overwhelmed.

PHA Nursing worked with regional critical care and respiratory nurse leads to support the development of a daily nursing report. This report helped inform the decision making within the Hub around a placement sequence of patients requiring critical care and any essential diverts of patients who may require enhanced respiratory support at ward level.

During the de-escalation phase of a surge, the Hub also helped to ensure a systematic and safe approach to the reduction of critical care beds whilst being mindful of the support both critical care and deployed staff require post surge.

PHA Allied Health Profession (AHP) team, worked collaboratively with Trust colleagues and regional professional leads to address workforce preparedness and provide professional consistency in the response to critical care pressures related to COVID-19. This work helped inform Trusts plans to address local critical care escalation needs of Physiotherapy, Dietetics, Speech and Language Therapy and Occupational Therapy staff. It ensured a regionally consistent approach to training and competencies for staff being asked to work into a critical care unit that is not their normal place of work.

Since January 2021, PHA Nursing and AHP have been collaborating with HSCB and Trust colleagues to progress a request from the Department of Health to develop costed proposals for the assessment and treatment of patients experiencing the longer term effects of COVID-19 for consideration by DoH.

A separate proposal is also being developed to address the specific needs of people who continue to experience long term health effects as a result of a COVID-19 infection following discharge from critical care.

Research and Development (R&D) response to COVID-19

HSC R&D Division is a regional function placed within the PHA. It invests significant funding in infrastructure consisting of skilled research professionals to support the delivery of health and social care research in Northern Ireland.

The global community of health and social care has looked to research more than ever to provide a response to the threat posed by the SARS CoV-2 virus (which causes COVID-19).

During 2020/21, the R&D team was requested to undertake a number of significant COVID-19 related projects. These included:

- the establishment of a Scientific and Technical Cell;
- participating in the UK-wide urgent public health prioritisation panels;
- issuing a COVID-19 Rapid Response Funding Call and supporting other COVID-19 studies through our Opportunity Led Scheme;
- leading a laboratory-based community surveillance group and a study of antibody seroprevalence across the Northern Ireland population;
- working with colleagues in the Office of National Statistics and the Northern Ireland Statistics and Research Agency to roll out a UK COVID-19 infection survey in the community;
- setting up and chairing a group looking at behavioural science aspects of COVID-19, with input from colleagues from academia, PHA, DoH and the Strategic Investment Board Innovation lab. This group has produced regular updates on evidence-based approaches to identifying challenges of and managing behaviours towards preventing transmission of the SARS-CoV-2 virus during the pandemic, reporting through to PHA, DoH and other key stakeholders;
- working with UK-wide colleagues to set up a public research registry where people provide their permission to be contacted for participation in the UK-wide vaccine trials;
- taking a leading role in the set-up and roll out of vaccine studies in Northern Ireland; and
- joining a number of UK-wide groups such as the Scientific Pandemic Influenza Group on Behaviours (SPI-B), Public Health England Research & Science Cell and the UK Collaborative on Development Research Epidemics Group.

To avoid duplication of effort during the pandemic, a UK-wide urgent public health funding/decision-making committee was set up involving all the major stakeholders from the research funding community. A series of UK-wide trials was also prioritised, with written recommendation to all Trusts across the UK to participate from the Chief Medical Officers (CMOs).

Northern Ireland researchers have also been able to participate and lead some of these urgent public health studies, delivered across the Northern Ireland Clinical Research Network and other infrastructure such as the Clinical Research Facility and Northern Ireland Clinical Trials Unit. In addition, a series of COVID-19 vaccine trials is being co-ordinated in a similar way across the four nations.

R&D Division senior team members have been a vital part of the vaccine trials delivery group that has built the infrastructure to get the vaccine trials underway in Northern Ireland.

To date, over 20,000 participants have been recruited to COVID-19 studies in Northern Ireland over the past year, including the Novavax vaccine trial, the three priority studies highlighted by the UK CMOs and the Community Infection Survey. Almost half a million people have signed up to the vaccine registry across the UK, with over 8,000 in Northern Ireland.

This has enabled people in Northern Ireland to be among the first to receive therapies which have proven effective in helping the management of severe COVID-19 symptoms.

The entire research infrastructure has played a key role in its response to the COVID-19 crisis. This has been instrumental in highlighting the way forward with both vaccines and treatment. This rapid mobilisation and the benefits of research have also highlighted the important role it plays in the delivery of effective health and social care at all times. It is hoped that this effort and the impact of research will continue during the recovery phase and beyond.

Vaccination programmes

During 2020/21, the PHA continued to prioritise the implementation of all vaccination programmes.

Flu vaccination programme

This year the flu vaccination programme was even more crucial, given the additional threat associated with the COVID-19 pandemic, and the implications of co-infection with both viruses. Given this risk, in the 2020/21 season, access to the influenza vaccination was expanded and has been offered to the following groups:

- pre-school children aged 2 years and over;
- all children in primary school and year 8 in secondary school;
- adults aged 65 years and over;
- adults aged under 65 years ‘at clinical risk’;
- health and social care workers; and
- 50-64 year olds (from January 2021 onwards).

Despite the difficulties presented by COVID-19 and associated social restrictions, vaccination uptake levels for most target groups in the 2020/21 flu season have exceeded those in previous years. The uptake levels can be found in table 1.

Table 1: Influenza vaccine uptake rates (Public Programme), 2020/21 and 2019/20			
	Delivered by	2020/21 (to 31 March)	2019/20 (to 31 March)
All 2 to 4 year olds	GP	55.2%	48.5%
All pregnant women	GP	42.1%	46.3%
All Individuals under 65 years with a chronic medical condition	GP	67.8%	58.9%
All individuals 65 years and over	GP	79.1%	74.8%
% of all primary school children vaccinated to date	Trust School Nurse Service*	72.9%	72.1%
% of all year 8 school children vaccinated to date	Trust School Nurse Service	66.6%	n/a

* This figure includes nasal and injected vaccines delivered by the school, as well as a small number of nasal vaccines delivered by their GP

The increased uptake of seasonal influenza vaccination will form part of the preparations for the next flu season in 2021/22.

Other vaccination programmes

During 2020/21, the PHA also continued to manage all routine and targeted immunisation and vaccination programmes including routine universal childhood vaccines, school vaccine programmes and adult programmes. Uptake rates from some programmes have inevitably been impacted by the COVID-19 pandemic, in particular the schools (non-flu) programme and adults' shingles programme. The PHA is working with Trusts on catch up opportunities for school aged children. Latest uptake for 2019/20 can be found at the following link: www.publichealth.hscni.net/sites/default/files/2021-04/Immunisation%20tables%20and%20charts%202020%20report%20%282019-20%20data%29.pdf

During this year, the PHA has also managed the implementation of changes to the HPV adolescent programme, and the shingles and pneumococcal programmes for adults, in line with Joint Committee on Vaccination and Immunisation (JCVI) recommendations.

The COVID-19 vaccination programme

The COVID-19 vaccination programme began in Northern Ireland on 8 December 2020. The programme, which is led by the Department of Health, is being delivered by HSC Trusts, primary care (from January 2021) and community pharmacists (from March 2021).

The PHA has supported the COVID-19 vaccination programme in a number of ways.

These have included:

- Supporting the roll out of the programme across care home residents and staff. The PHA supported the programme with Northern Ireland being one of the first countries internationally to complete vaccination of care home

residents and staff. Work is currently underway within the Agency to assess the coverage and impact of the vaccination programme;
- Coordinating the recruitment of a bank of clinical staff to be vaccinators in both HSC Trust clinics and GP practices. The PHA has also managed the deployment of bank vaccinators to GP practices;
- Providing bespoke communication solutions, for example, guides to vaccination (including translations), media campaigns, FAQ's, section on PHA website, guidance for healthcare professionals;
- Attending a wide range of UK and Northern Ireland meetings to prepare, plan and deliver the COVID-19 vaccination programme in Northern Ireland;
- Production of essential materials to enable the efficient delivery of COVID-19 vaccinations in Trust, primary care and community pharmacy settings;
- Support to Trusts, primary care and community pharmacy services delivering vaccinations.

The programme is based on the recommendations of the JCVI, an independent expert group. The JCVI has recommended which groups should be prioritised to receive the vaccine Northern Ireland.

The impact of COVID-19 on screening services

Approximately 400,000 invitations are issued by screening programmes annually in Northern Ireland. However, in the second week of March 2020, a Ministerial decision was taken to temporarily pause invites in some programmes as part of the response to COVID-19. This was to reduce the risk of exposure to the virus for the public and screening staff, and to facilitate staff and laboratory resources to be re-directed towards the pandemic response.

The following programmes were temporarily paused:

- Routine breast screening;
- Bowel cancer screening;
- Cervical screening;
- Abdominal aortic aneurysm (AAA) screening;
- Routine diabetic eye screening (DESP).

Screening continued to be offered for time critical programmes:

- Higher risk breast screening;
- Diabetic eye screening for pregnant women;
- Infectious diseases in pregnancy screening;
- Newborn blood spot and hearing screening.

Steps were taken to ensure that each programme was paused safely and that no patient would be missed when invitations recommenced. In early June 2020, the PHA established a Screening Restoration Group to coordinate the process of restoring the programmes, working in partnership with HSC Trusts and liaising with colleagues in other UK nations to share learning. All programmes had restarted by mid-August 2020 and continued to be delivered during further waves of the pandemic.

COVID-19 continues to present challenges across the screening programmes: there is a significant backlog of people awaiting screening invitation; social distancing and enhanced infection control measures mean fewer people can be seen at each clinic; and former screening venues are no longer available for use.

Recovery of screening services and the ongoing innovative work in screening remains vital over the coming months. The programmes are adapting to the new environment and looking at ways they can maximise capacity and participation. For example, the breast screening programme introduced a system called SMART clinics to maximise the number of participants that can be invited to attend a screening clinic based on probability of attendance. This better utilisation of appointment slots enabled the programme to reinstate self-referral for women over the age of 70.

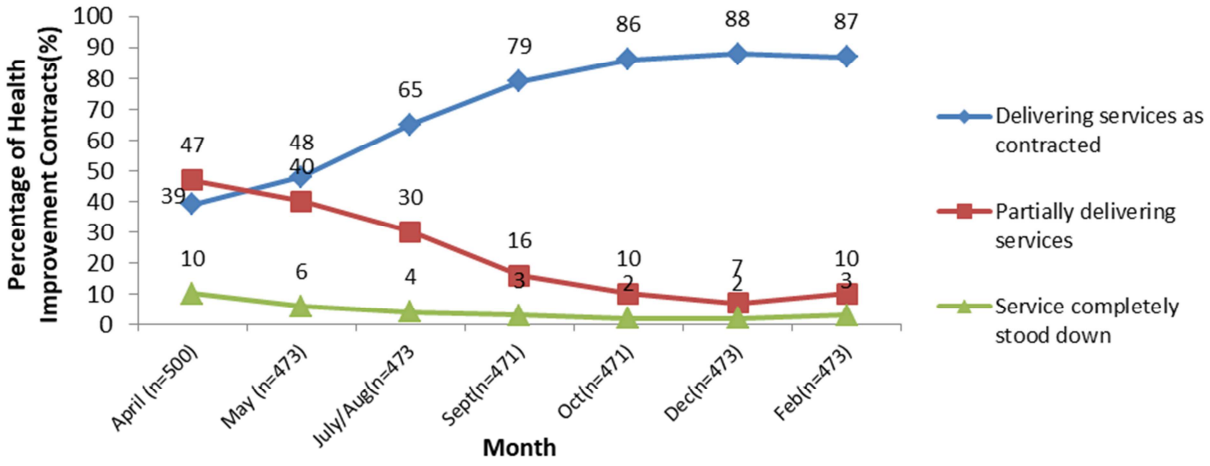
Despite the pandemic, some key successes have also been achieved in the screening programmes during 2020/21. The bowel screening programme successfully launched quantitative Faecal Immunochemical Testing (qFIT) as the new screening test from January 2021. This test is more accurate, is expected to lead to the early diagnosis of more cancers and crucially is an easier-to-use kit for participants. In addition, the newborn hearing screening programme has implemented the SMART4Hearing information system which will help improve the operation and monitoring of the programme going forward.

Health and wellbeing improvement initiatives

During 2020/21, PHA has continued to support approximately 500 services to improve health and wellbeing, across a range of thematic areas including drugs and alcohol, early years, suicide prevention and promoting mental health and addressing social isolation.
Many of these services are delivered face to face, often in our most disadvantaged communities who were already facing high levels of inequality pre-COVID. The PHA's priority was to ensure as many of these services remained operational and accessible to vulnerable clients during the pandemic. During the year, Health Improvement staff have worked closely with providers to adapt and rebuild services as quickly as possible and to facilitate any adjustments necessary to provide a revised or enhanced service where appropriate.

Initial data in April 2020 recorded only 39% of services were able to deliver as contracted, however, ongoing rebuild work throughout the pandemic saw this figure rise steadily to 87% (February 2021). A concomitant fall in those services partially delivering, or stood down, was also observed during this period (47% to 10%) despite subsequent lockdown restrictions (see Figure 1).

Figure 1: Service delivery, April 2020- February 2021.



During 2020/21, Teams identified and implemented a portfolio of support mechanisms / rebuild solutions to address community health needs including:

- 334 grants awarded worth £976,242 to support Emotional Health and Wellbeing;
- £150,000 in grants awarded to support communities address health inequalities;
- Over 100,000 people attended stress awareness sessions;
- 946 Naxolone supplies issued;
- 21,182 needle exchanges reported in Belfast City Centre;
- 600 stop smoking services delivered virtually throughout Northern Ireland;
- Ethnic minorities supported through the dissemination of key public health messages via 61 minority ethnic and migrant partners and 28 plus Traveller Forum members; and
- Move with Mary and *Good vibrations* (the Take 5 for later life campaign) reached 300,000 people.

In responding to the pandemic, Health Improvement teams have also worked closely with local Councils, HSC Trusts and partners in the community and voluntary sectors throughout the year to ensure those shielding or in need due to social isolation or changes in their social and economic circumstances, were provided with immediate emergency assistance and directed to access other support and advice services where required.

Supporting mental health and emotional wellbeing during COVID-19

The pandemic called for a collective response that was able to support local communities in relation to mental health and emotional wellbeing. The PHA played a key role in work that was progressed under the Mental Health and Emotional Wellbeing (MHEWB) Surge Cell, formed in April 2020 as part of the wider Executive Cell response to COVID-19.

The Cell included representatives from DoH, PHA, HSCB, HSC Trusts, primary care and community and voluntary partners.

Outlined below is a summary of key regional Health Improvement programmes/initiatives developed in response to COVID-19 during 2020/21 *(additional local programmes/interventions have also been implemented*):

Communication and support

- Two specific mental health and emotional wellbeing campaigns have been delivered in addition to a Good Vibrations media campaign promoting the Take 5 for Later Life;
- Revamped 'Mindingyourhead.info' website;
- Bereavement support online booklets developed;
- HSC Framework launched to support the workforce;
- Helplines NI website updated to include new COVID-19 related helplines resulting in 7 fold increase in calls;
- Lifeline NI 24 hour crisis counselling helpline responded to over 19,000 calls from April 2020 - January 2021; and
- Self Harm Intervention Programme (SHIP) has continued to operate to provide direct support to vulnerable young people.

Skills and training

- Over 7,500 people have completed free online Psychological First Aid E-learning;
- A bespoke HSCNI Apps Library for Northern Ireland was developed;
- Over 100,000 people have participated in online Stress Control programme (until end of February 2021);
- PHA and WHSCT developed 'Think About These' resource to support young people and parents who access mental health services;
- 2021 Wellbeing Calendar developed;
- Online training programmes delivered (over 2,000 participants) including: looking after your mental health, coping skills, sleeping better, feeling happier, and gaining confidence, support self and others during difficult times; and
- 43 Online Connection Suicide Awareness programmes delivered.

Partnership working

- Supported the work of 11 local councils and 5 HSCTs response hubs;
- Worked with Department for Communities (DfC) on Warm Well, Connected programme supporting the approach to address wellbeing in communities;
- Approximately £1m in a micro grants awarded to support communities mental and emotional wellbeing through COVID-19;
- Worked with universities on a new student wellbeing resource: https://www.publichealth.hscni.net/covid-19-coronavirus/information-schools-colleges-and-universities/covid-19-resources-students;
- Additional engagement/support provided to BAME communities on 'Accessing Mental Health Services during COVID-19;
- Facilitating Life and Resilience Education (FLARE): Throughout COVID-19 FLARE has continued to support vulnerable young people for support and wellbeing purposes**:** https://www.cognitoforms.com/EAYouth/flarereferral;

- Sporting Communities: PHA works in partnership with Sport NI, Ulster GAA and Ulster Rugby to support the delivery of mental health awareness interventions/programmes;
- Rural Communities - Rural Support provides 1:1 support for farmers in financial crisis or ill health and offers a signposting service. Virtual information sessions delivered to young farmers to promote positive mental health;
- Worked with Department of Education to develop the Emotional Health and Wellbeing in Education Framework;
- Supporting the Contact Tracing Service – Team members gained knowledge and skills to signpost individuals to additional support when required, for example:
- Direct referrals to Advice NI and Age NI; and
- Bereavement support and other supports available: https://www.publichealth.hscni.net/sites/default/files/2020-10/Useful%20guide%20to%20mental%20and%20emotional%20wellbeing%20resources%20PDF.pdf.

The key role of communication during a pandemic

Communicating effectively is a key aspect of public health in any context. Within the context of a pandemic it is particularly vital to ensure that information is shared, at the right time, to the right audience and in the most appropriate format so that the population is able to understand, accept and adhere to critical public health guidance.

The PHA's response to COVID-19 was diverse, covering many key areas. Clear communication and engagement from the Agency was required to underpin our response in all of these different areas.
From early 2020, the Agency played a key role in communicating important health messaging to a variety of sectors including the public, those working in healthcare, business and education. We have responded to the need for reliable and trusted information about the virus using a variety of communication channels as set out below.

Public communications
From the outset, the PHA's Communications team has been a lynchpin in public communications around coronavirus, for example, raising awareness among the public about key steps to take to help protect themselves throughout the pandemic, to fronting up in the media throughout. This has ensured there has been clarity and awareness both of the risks of COVID-19, what is being done to tackle it, and what people themselves can do to help in the fight against it.

Campaigns
The need to reach a mass and diverse audience quickly meant campaigns were developed and produced to extremely tight and demanding deadlines. The Agency has worked with Devolved Administrations across the UK including the Northern Ireland Executive, to inform and support the roll out of a range of COVID-19 campaign programmes in Northern Ireland. The Agency has also developed bespoke mass media campaigns introducing the Northern Ireland proximity app, digital self trace contact tracing and COVID-19 vaccine programme and the Northern Ireland FAST campaign which highlights the signs /symptoms of a stroke.

At a local level the Agency has continued to support important health messaging delivered through the PHA/HSCB Community pharmacy based Living Well campaign programme. This has enabled important topics such as mental health promotion and vaccination programmes to be raised with the many individuals who visit a local pharmacy.

Media briefings
The Agency facilitated media interest of an order of magnitude that has been unprecedented, delivering a 24/7 press office service, responding quickly and effectively to media demands across all platforms.

Social media
The number of page likes for the PHA on Facebook has almost quadrupled since the start of the pandemic, and page followers are now in excess of 200,000 people. Twitter followers have also almost doubled since before the pandemic.

Video and design
Video and graphic content have been produced and also translated into a range of languages to expand reach to specific audiences. Video has also integrated subtitles by default and in certain cases also included British Sign Language and Irish Sign Language signing.

PHA website
A dedicated COVID-19 section was created to house this information and a regular blog on relevant topics published. The pandemic has dramatically increased the number of visitors to the Agency's website. In 2019/20, there were over 900,000 visits to the site and in 2020/21, there were over 3,000,000 visits to the PHA website.

Publications
During 2020/21, the team worked with stakeholders to disseminate the most up-to-date messages about COVID-19 to the public and professionals in order to help prevent the spread of the virus. For example information about the vaccination programme was produced in many difficult forms which required frequent updates as the programme rolled out across Northern Ireland.

Planning and operational response

As the PHA moved rapidly to respond to the COVID-19 challenges, the Planning and Operational Services function also moved swiftly to support and enable much of this work in a number of ways.

The establishment of a large scale regional COVID-19 Contact Tracing Service required the PHA to quickly secure appropriate accommodation and IT equipment needed to run the service effectively. Operations staff identified potential accommodation and working with the landlord and BSO ITS ensured that it was fit for purpose with necessary IT infrastructure in place, by the end of June 2020.

A key requirement was flexibility to expand at short notice to deal with significant fluctuations in demand. Planning and Operational services staff ensured the development of detailed business cases for the accommodation, operation of the

Contact Tracing Service and enhanced Health Protection staffing ensuring the rationale for the service model was clearly demonstrated, value for money was considered and the necessary funding secured.

Organisationally, the PHA had to quickly manage the move from office based working to remote working to ensure staff safety. This required significant operational organisation to ensure staff had access to laptops and that remote working systems were operating effectively.

Information governance activities within PHA saw a marked increase with the arrival of COVID-19. The PHA had to deal with a significant increase in personal data in order to provide services such as contact tracing, increased disease surveillance and support to the range of COVID-19 testing services offered. Building on our existing policies and procedures, a number of complex Data Protection Impact Assessments were developed along with associated Privacy Notices and Data Access Agreements, ensuring that data is held and processed in line with UK General Data Protection Regulation (GDPR) and the Data Protection Act.

In doing this, the PHA has worked closely with colleagues in England, Scotland, Wales and Republic of Ireland along with the Northern Ireland Department of Health and other HSC organisations. The PHA also worked closely with the Information Commissioners' Office.

A key issue during the pandemic was to ensure that external service providers, especially those in the community and voluntary sector, continued to receive funding to deliver services and pay staff. PHA Operations staff worked with colleagues in other HSC organisations to develop and agree regional approaches and systems for allocating funding that were reasonable and proportionate but also ensured public funding was managed appropriately.

Health and Social Care Quality Improvement (HSCQI) response to the pandemic

During the COVID-19 emergency response, the HSCQI Hub worked with other PHA colleagues and HSCB staff on a joint response to the pandemic in a number of areas.

These included:

- The HSCQI Hub led on the development and implementation of a joint PHA/HSCB Senior Management Team "Huddle". Using a Quality Improvement (QI) approach the "huddle" occurred on a number of mornings per week from 19 March 2020. QI methodologies used included the Model for

Improvement, Plan-Do-Study-Act cycles, Appreciative Inquiry and elements of Lean; and

- Following discussion at the Agency Management Team (AMT), the HSCQ Hub team led on a QI approach to assess PHA offices on Linenhall Street. The purpose of this initiative was to enhance a safe and pleasant working environment for everyone, removing clutter, standardising workspaces, improving access and flow to enable effective social distancing measures to be put in place. Following the success of this approach it was agreed the learning should be applied across all floors in both PHA and HSCB including regional offices.

In addition, HSCQI responded to a call from the wider HSC system for support.

During the first wave, Trust Chief Executives and the Senior Responsible Officer (SRO) for the HSC Service Delivery Innovation Rebuild workstream asked the HSCQI Director to establish a regional learning system focused on learning from COVID-19. This learning system was established using a 90 day learning cycle QI approach; and resulted in the identification of three key COVID-19 learning themes: Staff Psychological Wellbeing, Virtual Visiting and Virtual Consultations.

Three learning theme subgroups were also established to share ongoing learning in relation to each theme in partnership with the regional Extension for Community Healthcare Outcomes (ECHO) project team. Regular updates are reported to the HSCQI Leadership Alliance and the DOH Rebuild Management Board. In addition learning from this work was shared at an All-Ireland virtual event co-hosted by HSCQI, the National QI team in the Republic of Ireland and the Health Foundation Q Community.

Forward look 2021/22

Coronavirus has shone a light on to public health care across the world and Northern Ireland has been no different. Our core business has always been intervention to prevent ill health alongside promoting good health across the population. The global pandemic has focused attention on these issues like never before. We have been scrutinised like never before and whilst this has sometimes been uncomfortable, we have risen to the challenge.

The population is more aware than ever of the impact of population health issues such as obesity and mental wellbeing on our ability to manage during a real risk to the security of our health. As the regional body charged with improving population health we must maintain this focus and work with government to improve the outcomes for citizens.

Our response to the pandemic has meant we have had to adopt very different ways of working. We find ourselves better placed to be responsive, agile and flexible in our actions. We have begun an exciting journey in a targeted use of data science, information and analytics. Genomic surveillance and behavioural science capacity has been expanded. Our partnerships with colleagues in academia, technology and the wider HSC have been more tightly focused on innovative solutions to the most wicked of problems.

Going forward we must harness these developments. As we move to normalising our services, we must exploit the potential we discovered in the pandemic. We must continue to invest in innovative solutions to difficult issues. We must retain the flexibility of our staff and systems to be able to respond to public health issues – longstanding and emerging.

The quality of all our lives is set on a bedrock of good population health. Many of the factors influencing this – education, employment, housing, environment, air quality and transport – are beyond the remit of health and social care. We must work collaboratively with those agencies charged with these responsibilities in order to meet the challenge of making life better for all. We have the capability to lead from the front – we must ensure we have the capacity and resource to do so as we recover from the impact of COVID-19.

FINANCIAL PERFORMANCE REPORT

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

Financial Planning

At the outset of 2020/21 it was clear that the financial impact of the response to the COVID-19 pandemic would necessitate agility in managing the resources available to the PHA. The normal process for delivering a joint HSCB / PHA commissioning plan was rolled over and Trusts were asked to submit draft financial plans for 2020/21. These plans then became the basis for discussions with DoH regarding the overall system financial position, taking into account the significant budgetary constraints and varied and mounting pressures across the HSC sector, not least the uncertain levels of funding required to respond to the COVID-19 pandemic.

Looking forward into 2021/22, the ongoing response to managing the COVID-19 pandemic, inescapable cost pressures, rebuilding costs, inflation and the 2021/22 budget settlement requires the whole HSC system to continue to work closely together to ensure that resources are prioritised and sound financial management continues. However, the continued response to the COVID-19 pandemic severely limits opportunities for the HSC to invest in growth areas and transformation of services, as resources are directed to the additional unavoidable cost pressures in areas such as personal protective equipment, staffing and other consumable costs.

There continues to be a risk that the financial context will negatively impact on HSC services which the PHA, along with the sector, continues to try to mitigate.

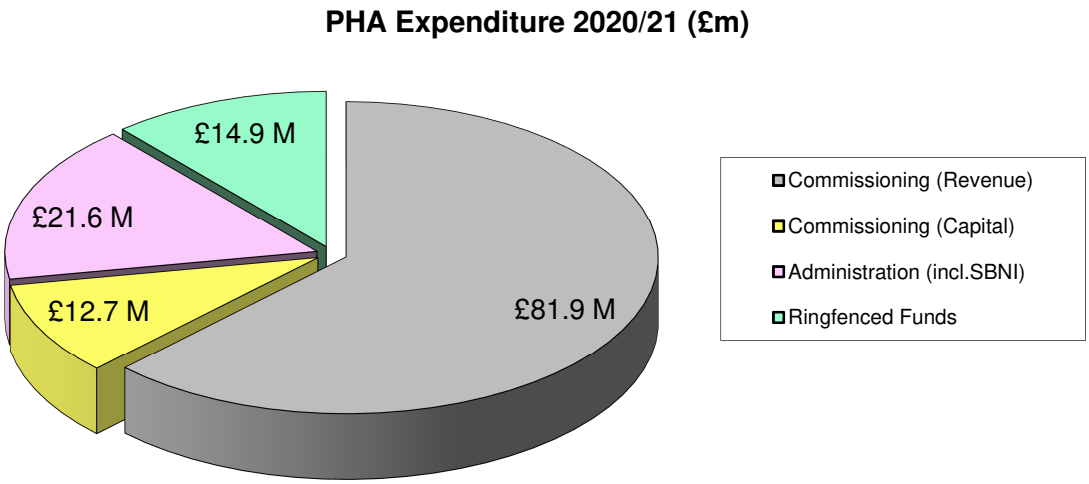
PHA Financial Management and Stability

The PHA received a revenue budget £131m revenue from the DoH in 2020/21, along with income from other sources of £2m, and has a statutory duty to breakeven within 0.25% of these resources. A further £13m capital funding was allocated to PHA in the year, against which there was a small underspend against capital funding of £0.2m.

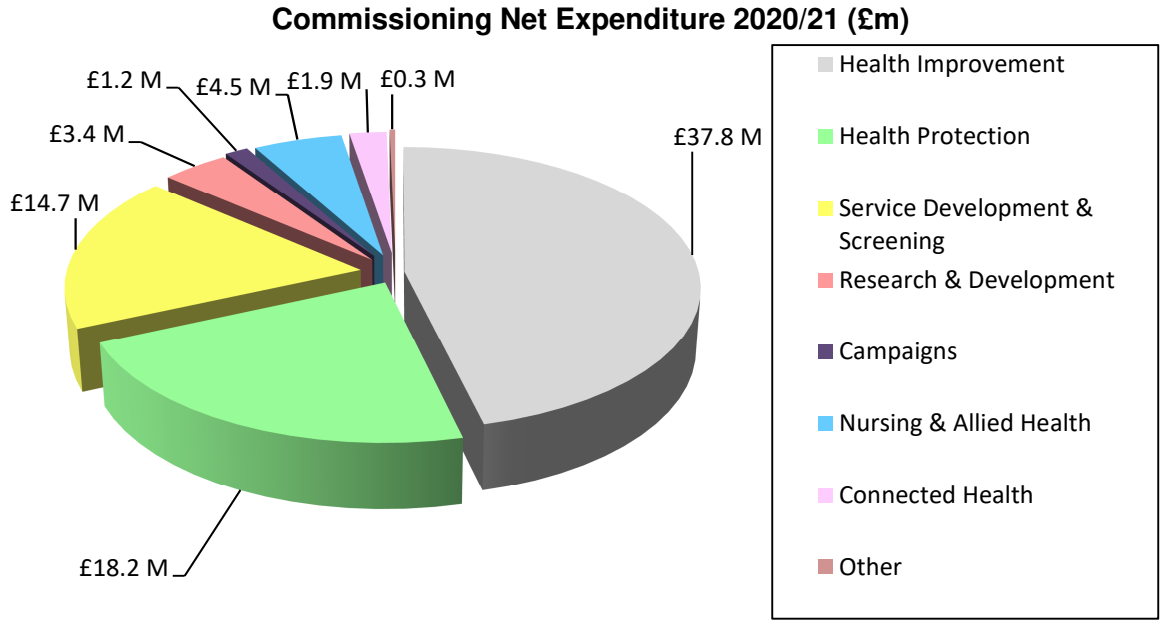
The financial statements presented in this Annual Report and Accounts report a small revenue surplus of £106k, which is within the required breakeven threshold. This was achieved by significant and diligent effort on the part of PHA budget holders, supported by the Finance Directorate (HSCB), in managing the wide range of pressures and demands across both Programme and Management and Administration budgets in the backdrop of the COVID-19 response.

The following charts highlight how the PHA's revenue funds have been utilised during 2020/21.

a. PHA Net Expenditure by Area 2020/21



b. Programme Expenditure by Budget Area 2020/21

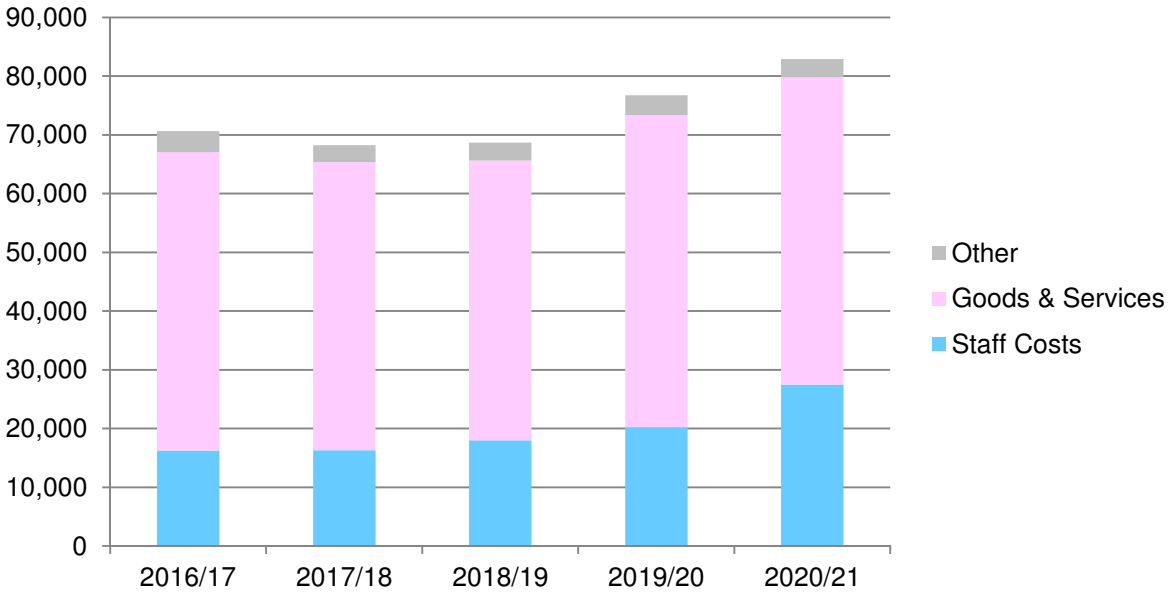


COVID-19 Allocations and Expenditure

During 2020/21, specific ring-fenced allocations earmarked for COVID-19 were allocated to the PHA from DoH. These allocations totalled £10.2m which allowed the PHA to support the region in its response to the pandemic. This included initiatives such as the set up and operation of the regional Contact Tracing Centre, enhancing the level of staffing within Health Protection to provide ongoing support and guidance across the region, roll out public awareness campaigns and to increase the level of flu vaccinations available to the public.

Long Term Expenditure Trends

The following chart highlights how the main categories of expenditure within the Statement of Comprehensive Net Expenditure (SoCNE) have moved over the last 5 years. This relates to the revenue expenditure of the PHA.



Other includes expenditure on general supplies and services, establishment and premises.

The impact of the additional expenditure in respect of the PHA's COVID-19 response is largely illustrated by the increase in expenditure levels from 2019/20 to 2020/21.

Prompt Payment Performance

a) Public Sector Payment Policy - Measure of Compliance

The Department requires that PHA pay their non HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The PHA's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2021 Number	2021 Value £000s	2020 Number	2020 Value £000s
Total bills paid	5,764	£59,103	7,044	£61,517
Total bills paid within 30 day target or under agreed payment terms	5,433	£58,173	6,657	£60,351
% of bills paid within 30 day target or under agreed payment terms	**94.3%**	**98.4%**	**94.5%**	**98.1%**
Total bills paid within 10 day target	4,836	£55,986	5,691	£57,590
% of bills paid within 10 day target	**83.9%**	**94.7%**	**80.8%**	**93.6%**

The PHA performed slightly below the 95% target for payments within 30 days, at 94.3% (2019/20, 94.5%), however has performed well above the 70% target of payments within 10 days, at 83.9% (2019/20, 80.8%).

b) The Late Payment of Commercial Debts Regulations 2002

The PHA paid no late payment fees in 2020/21 (£400 for 2019/20).

SUSTAINABILITY – ENVIRONMENTAL, SOCIAL AND COMMUNITY ISSUES

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

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

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

The PHA is committed to the principles of sustainable development. Our 'Sustainable Development Strategy' sets out the PHA's approach to sustainable development and how we seek to integrate this into our daily activities.

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

EQUALITY AND DIVERSITY

During the year, the PHA commenced work on its Five Year Review of Equality Scheme. Following a briefing of the Agency's Management Team, a number of teams participated in focus group discussions or provided further written information. Input from Tapestry members was likewise sought.

Face-to-face training on equality screenings and Equality Impact Assessments was redesigned during 2020/21 to allow staff to develop their knowledge and skills while working remotely. Accordingly, the training was delivered through a combination of live online sessions and remote learning.

Building on work during the previous year relating to the Recruitment Agencies Contract, the BSO Equality Unit on behalf of the PHA and the regional HSC organisations analysed equality monitoring data provided by agencies for some of the people placed with the organisations under the contract.

This exercise served to ascertain the nature and extent of monitoring undertaken by the agencies. Recognising that staff with a disability may have particular health and wellbeing needs during the pandemic, the BSO Equality Unit on behalf of the PHA and the other regional HSC organisations engaged with members of Tapestry, the disability staff network, in April/May 2020.

The engagement exercise sought to explore their experience of working under COVID-19 during the early stages of the pandemic. It showed that mental health impacts came

out strongest amongst the impacts experienced by members, in particular due to isolation and a loss of routine. Limited information in accessible formats relating to COVID-19 was also identified as an issue by staff with a disability at that point. Staff likewise highlighted benefits that the situation had brought, such as a reduction in stress and anxiety they used to experience when faced with travelling to and from work.

RURAL NEEDS ACT

The purpose of the Act is to ensure that public authorities have 'due regard' to the social and economic needs of people in rural areas and to provide a mechanism for ensuring greater transparency in relation to how public authorities consider rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.

The Act seeks to help deliver fairer and more equitable treatment for people in rural areas which will deliver better outcomes and make rural communities more sustainable.

The Rural Needs Act has been embedded into the PHA's processes; the completion of the Rural Needs Impact Assessments has focused minds on the importance of the needs of rural dwellers, so that these are considered from an early stage in any project. In particular, ensuring consultation with rural dwellers when planning services and consideration given to alternative service delivery methods where appropriate to meet their needs.

The PHA has carried out a number of Rural Needs Impact Assessments for the period 1 April 2020 to 31 March 2021, as part of designing public services. Details are included in the table below.

Description of the activity undertaken by the public authority which is subject to section 1 (1) of the Rural Needs Act (NI) 2016	***The rural policy area(s) which the activity relates to***	***Describe how the public authority has had due regard to rural needs when developing, adopting, implementing or revising the policy, strategy or plan or when designing or delivering the public service***
Relationship and Sexuality Education (RSE) training in the community across Northern Ireland	• Education or Training in Rural Areas • Health and Social Care Services • Deprivation in Rural Areas	The focus of the Public Health Agency in addressing the needs of young people will be to work collaboratively with partners to provide the RSE in the Community Service. This Service will benefit young people in rural areas by reducing social isolation and increase their access to information and peer support around health issues. This Service will contribute to improving the health and wellbeing outcomes in rural areas and reduce health inequalities by enabling participation, empowerment and the growth of self-efficacy. An extensive evaluation was completed on the RSE in the Community Service and further consultation was carried out to gain an insight into the experiences of all young people from both urban and rural settings. PHA staff also looked at data from 'Making Life Better key indicators 2019' on teenage birth rates. Provider organisations will be required to deliver the RSE programmes with young people which are age appropriate, accessible and evidence based with the aim of ensuring that young people in rural areas are supported to access the programme. The evidence is clear that there is a need to continue to offer the RSE in the Community programmes to young people aged 12-19 in both rural and urban communities. The PHA will continue to monitor the geographical spread of service delivery by asking Providers to use an online mapping tool to ensure a balance between rural and urban areas. They will also monitor accessibility of sessions for all young people including those with a disability and how Providers work with

		local organisations to target young people. Providers will need to link with local community organisations and others working in related areas such as drugs and alcohol, mental health etc. In planning the Service, Providers will consider the timing of the Programme as provision in winter months and during inclement weather would be challenging in rural areas with limited public transport options, which may impact on the numbers of young people attending. Other seasonal considerations during the year will also be taken into account.
Addressing Inequalities in Cancer Screening Through Promoting Informed Choice	• Education or Training in Rural Areas • Health and Social Care Services	A variety of social and economic needs have been identified through the evaluation of the service and contract monitoring which may impact the ability of rural inhabitants to avail of this service. Although the awareness sessions are free to attend, the cost of travelling to the sessions may be higher due to further distance to travel to community or women's centres where the session is generally hosted. The current contract holders will reimburse attendees if travel is a barrier; however generally the sessions are delivered in local communities. All fourteen women's centres based in Northern Ireland are in cities or large towns, with the majority based in Belfast; however a range of community centres and other venues will be used to host sessions. Childcare may present a problem for session participants, although where possible, childcare is currently provided to allow participants with child care responsibilities to attend. Not all community groups who have taken part in the programme have a crèche/child-minding facility. Those who rely on public transport may be less likely to access the service if the programme is delivered at a time that has limited transport availability. The service providers will endeavour to offer sessions at a time most suitable to attendees, including morning, afternoon or evening sessions. It is also important

		to note that a target group of the service is people with physical disabilities and in rural areas they may experience greater difficulties in accessing appropriate transport services, although transport costs will be provided. In the evaluation of the current service, adverse weather was noted to have impacted on turn-out at sessions – this may have a greater impact on people in very rural communities where roads may be less accessible and driving conditions poor. The current contract stipulates that a minimum of 10 participants must attend in order to run an awareness session. In rural areas population density is lower; therefore this number may be less achievable and has been identified as a hindrance when recruiting community groups. This may also be an issue for groups with additional support needs, e.g. those with disabilities or from the traveller community, where turn out may well be low. The PHA has agreed not to stipulate a target number of attendees for individual sessions in the next iteration of the contract. The design and delivery of the new contract for the provision of a service to address inequalities in cancer screening through promoting informed choice has been influenced by the rural needs identified above and by those previously identified in the Ipsos MORI evaluation and Health Intelligence Report 2017. Some changes have already been implemented, and others will be stipulated in the service specification for the new contract.
Faecal Immunochemical Test (FIT) As Replacement Test for the Faecal Occult Blood (FOB) Test	• Health and Social Care Services	The UK National Screening Committee (UK NSC) recommended that quantitative faecal immunochemical testing (FIT) should be adopted by the Bowel Cancer Screening Programme as the primary screening test for bowel cancer. Evidence suggests screening using FIT will be a more effective way of detecting cancerous and pre-cancerous lesions in the bowel. The bowel cancer screening test is posted to eligible

		individuals for them to complete at home. The completed test is posted in a prepaid envelope once completed. All tests are processed in a single laboratory, based at Causeway Hospital. It is not considered, at this time, that the proposal to change the type of test being used in the NIBCSP would have any adverse impact on people living in rural areas and the further understanding of social and economic needs in not pertinent at this time. It is hoped that an in depth analysis of the NIBCSP data will be undertaken to provide more granular information to examine uptake in rural areas. This change in test is being undertaken at the same time as work to address inequalities in screening through promoting informed choice is proceeding. Results of the analysis will assist in targeting this work.
Whole Genome Sequencing (WGS) of SARS-CoV-2	• Health and Social Care Services	This service is to determine viral strains and pathogens to assist with public health advice, in particular for SARS-COV-19 and has no direct impact on individuals and is therefore not likely to impact on people in rural areas. Sequencing occurs on test samples to determine viral strains and pathogens and when it occurs is based on a prioritization protocol based on the virus presenting, cluster management, possible vaccine failure and travel history. Sequencing is not determined on the individual who has provided the sample or their place of dwelling. The only potential area for impact on people in rural areas is the availability of testing which is outside of the remit of this impact assessment. However it should be noted that for SARS-COV-19 testing, a range of measures have been put in place to ensure wide availability of testing for all people in Northern Ireland. As well as regional test sites and in-hospital testing, there are also mobile testing units deployed to areas of potential outbreak and a postal testing service.
NI Contact Tracing and Advisory Service	• Health and Social Care Services	There has been no specific rural needs identified. As the service is primarily a

		telephone/SMS based and available across all of Northern Ireland this will ensure that all confirmed cases have equal access to the Service regardless of a person's locality. It is not anticipated that this Service will impact on the needs of rural dwellers any more than people from urban areas.

COMPLAINTS

Three complaints were received by the PHA in 2020/21.

Critically appraising complaints is important and strict procedures are followed. If needed, staff take action to ensure any lessons learned are embedded in practice to prevent recurrences. Learning is also shared to enable others to embed this learning into their area of work.

INFORMATION REQUESTS

Between 1 April 2020 to 31 March 2021 the following requests were made and responded to:

Freedom of Information	144
Environmental Information Regulations	2
Subject Access Requests	2
Open Data Requests	0

One personal data incident occurred during 2020/21 (2019/20: none).

Olive Macleod OBE

Interim Chief Executive

Date 17th June 2021

ACCOUNTABILITY REPORT

NON EXECUTIVE DIRECTORS' REPORT

The primary role of the PHA Board is to establish strategic direction, within the policy and resources set by the Department of Health, monitor performance, ensure effective financial stewardship and ensure high standards of corporate governance are maintained in the conduct of the business of the organisation.

The Board is comprised of a Chair, 7 non-executive Directors, the Chief Executive and 3 executive Directors. One other PHA Director and 2 HSCB Directors are in attendance at Board meetings. The Department of Health appoints the non-executive Directors, with the approval of the Minister of Health. The Non-Executive Directors are:

- Mr Andrew Dougal, OBE (Chair)
- Alderman Billy Ashe, MBE
- Alderman Paul Porter
- Professor Nichola Rooney
- Mr Joseph Stewart, OBE
- Ms Deepa Mann-Kler
- Mr John Patrick Clayton

There is currently one vacant non-executive Director position.

The year 2020/21 has been a year of particular challenges, as the PHA refocused its work, prioritising the response to COVID-19. With the need for social distancing, the majority of staff worked from home for much of the year. Reflecting all of this, business continuity arrangements were instigated. As a result the PHA Board also had to adapt.

The Board and its committees have continued to hold regular meetings during the year, with these mostly being delivered by Zoom. Recognising the quickly changing environment due to COVID-19, and the increased demands and pressures on the PHA, additional Board briefing sessions were held in between the regular monthly Board meetings at the request of the non-executive Directors, to ensure that they were kept informed and up to date between meetings, when appropriate. During 2020/21 the Board instigated work to develop a new Corporate Plan for the next 3 years. A series of meetings, involving non-executive Directors and senior PHA staff have taken place to plan for the future.

The Governance and Audit Committee assists the PHA Board by providing assurance, based on independent and objective review, that effective internal control arrangements are in place within the PHA. The Committee met on five occasions during the year. It is chaired by Mr Joseph Stewart, who provides regular reports to the full Board. The Committee also completes the National Audit Office Audit Committee self-assessment checklist on an annual basis to assess its effectiveness.
The Remuneration Committee is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives subject to the direction of the Department of Health. The Committee is chaired by Mr Andrew Dougal, and met once during the year.

DIRECTORS' REPORT

PHA Board

The Board of the Public Health Agency (PHA) meets frequently throughout the year and members of the public may attend these meetings.

The dates, times and locations of these meetings are advertised in advance in the press and on our main corporate website at www.publichealth.hscni.net.

Andrew Dougal OBE

Andrew Dougal took up the position as Chair of the PHA on 1 June 2015. He was previously Chief Executive of Northern Ireland Chest Heart and Stroke from 1983 and prior to that worked for 10 years in education.

He is an alumnus of the Salzburg seminar on philanthropy and non-profit organisations. He participated in the Duke of Edinburgh work study conference and in the Northern Ireland leadership challenge programme. He was awarded a Paul Dudley White fellowship to the American heart association.

Over the past 35 years he has been a Non-Executive Director of organisations spanning the private, public and voluntary sectors. He is a former Trustee and Chair of the HR Committee of the UK Health Forum, a former Trustee and Treasurer of the World Heart Federation, and a former Chair of the Chartered Institute of Personnel and Development in Northern Ireland. He is also a member of the Ulster Orchestra Foundation Board.

Olive Macleod OBE

Olive Macleod joined PHA as Interim Chief Executive in March 2020. She was previously Chief Executive of RQIA for four years.

Olive qualified as a registered general nurse in St Vincent's Hospital, Dublin and a registered midwife in the Lanarkshire School of Midwifery, Scotland. She spent 14 years in Canada at the Mount Sinai Hospital Toronto and Kingston General Hospital as an obstetric nurse, nurse leader and clinical educator.

In 1997 she joined the Mater Hospital, Belfast, as a staff midwife and worked in a number of roles including Assistant Director of Nursing in the hospital. From 2007, Olive was the Co-Director of Nursing in the Belfast Health and Social Care Trust, with responsibility for governance, performance and standards, before moving to the Northern Health and Social Care Trust as Director of Nursing and User Experience and then the Regulation and Quality Improvement Authority as Chief Executive before her appointment as interim Chief Executive of the PHA on 30 March 2020. Olive was awarded an OBE in 2018, in recognition of her services to nursing.

Edmond McClean

Edmond McClean was appointed Deputy Chief Executive of the PHA at the end of October 2016 and continued as the PHA's Director of Operations heading the PHA's communications, governance, business planning and health intelligence functions until his retirement in September 2020.

Prior to working in PHA Edmond's background included lead Director supporting the initial development of Belfast and East Local Commissioning Groups from 2007 to 2009. From 1997 to 2007 he was Director of Strategic Planning and Commissioning with the Northern Health and Social Services Board.

Stephen Wilson

Stephen Wilson was appointed as Interim Director of Operations in December 2020 having previously worked since 2009 as Assistant Director (Operations) with responsibility for leading Communications and Health Intelligence.

Stephen has extensive experience across a wide range of disciplines including strategic planning, operational management, communications, policy development and project management. His qualifications include a BSc (Hons), MSc (Management) and post-grad in Corporate Governance.

Following graduation Stephen worked in local government in Scotland leading on competitive tendering programmes before returning to Northern Ireland to work with the Sports Council for Northern Ireland and more recently the Health Promotion Agency where he worked as Senior Planning Manager and subsequently as Interim Director of Corporate Services until transferring in 2009 to the PHA under RPA.

Rodney Morton

Rodney Morton took up post as Director of Nursing and Allied Health Professions in January 2020. Previously Rodney held the position of Deputy Chief Nursing Officer with the Department of Health. Rodney was responsible for co-leading the development of a 10-15 year road map for Nursing and Midwifery in Northern Ireland, along with providing professional advice on mental health, learning disability and older people nursing services. In addition, Rodney held policy responsibility for Personal, Public, Involvement, and led the development of a new Co-Production Framework for the Northern Ireland Health and Social Care Sector.

Rodney has over 34 years' experience in a range of practice, managerial and leadership roles in CAMHS, Autism, Adult Mental Health, Addictions, Psychological Therapies, Older People, Public Mental Health and Primary Care Services. Rodney

also led the development of the Regional 'You in Mind' Mental Health Care Pathways Programme, Regional Mental Health and Psychological Therapies Training Programme for Northern Ireland. Rodney is also an improvement science enthusiast and has been promoting and building quality Improvement capability across the Nursing and AHP Services.

Dr Aideen Keaney

Aideen Keaney is the Director of the Northern Ireland Health and Social Care Quality Improvement and Innovation (HSCQI) Network. HSCQI as an entity was launched by the Department of Health in April 2019 and is aligned with the NI HSC strategies Q2020 and Health and Well Being 2026: Delivering Together.

Aideen is a graduate of Queen's University Belfast Medical School and is a Fellow of the College of Anaesthetists (RCSI) Dublin. Aideen also holds a Post Graduate Diploma in Healthcare Risk Management and Quality from University College Dublin.

Aideen completed her anaesthesia training on the Northern Ireland Anaesthesia Training Scheme, also completing Clinical Fellowships in Dublin, Glasgow, London and Melbourne. Aideen is a Scottish Patient Safety Programme Fellow, a Health Foundation Generation Q Fellow and has a Masters in Leadership and Quality Improvement (with Distinction) from Ashridge Executive Education, Hult International Business School.

Aideen has worked as a Consultant in Paediatric Anaesthesia and Paediatric Intensive Care for over 14 years during which time she held a number of Medical Leadership roles namely Clinical Governance Lead, Clinical Lead for Patient Safety and Quality Improvement and Clinical Director.

Since taking up her post Aideen has been leading on the further design, development and growth of HSCQI with a particular focus on supporting the HSC system to share learning and identify and scale up best practice.

Professor Hugo van Woerden

Hugo van Woerden was the Director of Public Health in PHA from March 2020 to December 2020. Hugo is a senior public health doctor, with over seven years as an executive board member on various public sector and charity boards, a decade in senior NHS management roles, and a breadth of experience from over 30 years as an NHS doctor in England, Wales and Scotland.

Dr Stephen Bergin

Dr Stephen Bergin has been the Interim Director of Public Health since December 2020.

Stephen graduated in Medicine from QUB in 1990. After a period of post-graduate general medical training, he trained in Public Health between 1993 and 1998, in the N.E. England public health training scheme. In 1998, he was appointed to the post of consultant in public health medicine with the former Southern Health and Social Board. He continued service in this position, with the Review of Public Administration, from 2009 until 2017. In November 2017, he commenced duties as Assistant Director of Public Health, initially within the Service Development division of the directorate, before taking up responsibility for the Population Screening division in February 2018.

In December 2019, he commenced duties as Deputy Director of Public Health. He assumed the role of interim Director of Public Health in November 2020. He has been on the General Medical Council specialist register (public health) since 1998.

Alderman Billy Ashe MBE

Alderman Billy Ashe MBE has been an Elected member of firstly, Carrickfergus Borough Council since 1997, having served as Mayor twice, and then Mid and East Antrim Borough Council, following its formation after the review of Public Administration in 2015, where he was the first Mayor of the newly formed Borough.

Billy has extensive experience in the community and voluntary sector, having served as Chair of an Urban Farm project for those with learning difficulties and as Coordinator of a Community Umbrella Project. He currently provides advice, coaching and mentoring to community projects and individuals.

John Patrick Clayton

John Patrick Clayton is Policy Officer of the trade union, Unison. He was appointed to the trade union member post on the PHA Board.

He is a qualified barrister who has practised both at the Northern Ireland Bar and at the Bar in the Republic of Ireland.

John Patrick is a member of the Northern Ireland Committee of the Irish Congress of Trade Unions. In 2020 he joined the Executive Committee of the voluntary organisation NIACRO.

Deepa Mann-Kler

Deepa Mann-Kler is an exceptionally experienced public, private and charity sector Chair and Non-Executive Director, having served on 10 Boards across the UK over the past thirteen years. As Chief Executive of Neon and Visiting Professor for Immersive Futures with Ulster University, she specialises in use of immersive technologies for health. As a TEDx speaker and thought leader she regularly keynotes on the intersection of digital transformation, technical innovation, inclusion, ethics, bias, data and AI.

Deepa is author of the first report on race discrimination with policy recommendations for the public sector in Northern Ireland "Out Of The Shadows." As an artist Deepa has a strong focus on public art light installations, notably Light Up Leicester 2020, Lumiere Durham 2019, London 2016 & 2013 in Derry/Londonderry UK City of Culture.

Alderman Paul Porter

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

Over the past 19 years he has worked closely with community and voluntary organisations delivering major projects ranging from early intervention, youth programmes and special needs provision. During this time he has helped secure major capital investment for several community centres in the wider Lisburn area.

Professor Nichola Rooney

Professor Nichola Rooney is a consultant clinical psychologist and former Head of Psychological Services at the Belfast Health and Social Care Trust. She is senior professional adviser in psychology to the RQIA and associate consultant to the HSC Leadership Centre.

Nichola is a former member of the judicial appointments Commission for Northern Ireland and currently chairs the Board of the Children's Heartbeat Trust. The current chair of the BPS Division of Clinical Psychology NI, she holds the position of honorary professor at QUB School of Psychology.

Joseph Stewart OBE

Joseph Stewart has held a number of Board level positions in the public and private sectors in Northern Ireland having retired in 2016 as Director of Human Resources from PSNI, a post which he held from the inception of the service in 2001.

A graduate of Law from Queen's University, Belfast, Joseph was a Director of the Engineering Employers Federation until 1990 and a Director in Harland and Wolff between 1990 and 1995. He was Vice Chairman of the Police Authority from 1989 to 1994 and Chief Executive from 1995 to 2001.

Joseph is Chair of the Governance and Audit Committee of the Agency and in February 2021 was appointed Non-Executive Director and Chair of the Audit Risk and Assurance Committee of the Livestock and Meat Commission Northern Ireland.

Joseph received an OBE in the Queen's Birthday Honours list in 1994.

Paul Cummings

Paul Cummings was Director of Finance, HSCB until his retirement in September 2020. Paul was previously a Director of Finance in the South Eastern, Mater and Ulster Community and Hospitals Trust.

Tracey McCaig

Tracey McCaig has been appointed Interim Director of Finance for the HSCB, delivering services to the PHA with effect from 15 February 2021. Prior to this appointment Tracey held the post of Assistant Director of Finance in the Northern Health and Social Care Trust from May 2017. During her 32 year career in Health and Social Care finance, Tracey, who is a Chartered Management accountant, has headed up a number senior finance roles across the HSC, ranging from internal audit to head accountant roles in the NI Ambulance Service, Health and Social Care Board and Public Health Agency.

Tracey has a proven track record in team leadership, quality improvement, financial governance and multi-disciplinary HSC team working to effect change and improvement in HSC services.

Following the retirement of Paul Cummings and prior to Tracey McCaig's appointment, the Director of Finance role was covered on an interim basis by the Assistant Directors of Finance: Christine Frazer, Lindsay Stead and Colin Bradley.

Marie Roulston OBE

Marie Roulston is Director of Social Care and Children, HSCB. Marie has over 30 years' experience in working with children and families. Marie has worked across the range of children's services and moved into a managerial role as Area Manager in 2002 in the Northern Trust.

Marie was appointed as Assistant Director in the Women and Children's Directorate, in May 2007. She had responsibility for Looked after Children Trustwide, encompassing children in residential care, children in foster care, the Northern Trust Adoption service, recruitment of foster carers and 16+ services.

She took up post as Director of Children's Services/Executive Director Social Work within the Northern Trust in September 2012 and had responsibility for Women, Children & Families from 2015 and in August 2018 took up post as Director of Social Care & Children at HSCB.

Marie was awarded an OBE in the New Year's Honours List (2019) with respect to services to health care and young people.

Related party transactions

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

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

Register of Directors' interests

Details of company directorships or other significant interests held by Directors, where those Directors are likely to do business, or are possibly seeking to do business with the PHA where this may conflict with their managerial responsibilities, are held on a central register.

A copy is available from Stephen Wilson, Interim Director of Operations, and on the PHA website at www.publichealth.hscni.net/lists-and-registers.

Audit Services

The PHA's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office (NIAO) and the notional charge for the year ended 31 March 2021 was £22,000.

Statement on Disclosure of Information

All Directors at the time this report is approved can confirm:

- so far as each director is aware, there is no relevant audit information of which the external auditor is unaware;
- he/she has taken all the steps that he/she ought to have taken as a director in order to make him/herself aware of any relevant audit information and to establish that the external auditor is aware of that information; and
- the annual report and accounts as a whole are fair, balanced and understandable and he/she takes personal responsibility for the annual report and accounts, and the judgements required for determining that it is fair, balanced and understandable.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health has directed the Public Health Agency (PHA) to prepare for each financial year a statement of accounts in the form and on the basis set out in the HSC Manual of Accounts. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the PHA, of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of Government Financial Reporting Manual (FReM) and in particular to:

- Observe the HSC Manual of Accounts issued by the DoH including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on the going concern basis.
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Olive MacLeod as the Accounting Officer for the Public Health Agency. The responsibilities of an Accounting Officer, including responsibility for the regularity and propriety of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the PHA's assets, are set out in the formal letter of appointment of the Accounting Officer issued by the Department of Health, Chapter 3 of Managing Public Money Northern Ireland (MPMNI) and the HM Treasury Handbook: Regularity and Propriety.

As the Accounting Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that PHA's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

As Accounting Officer, I exercise my responsibility by ensuring that an adequate system for the identification, assessment and management of risk is in place. I have in place a range of organisational controls, commensurate with officers' current assessment of risk, designed to ensure the efficient and effective discharge of PHA business in accordance with the law and Departmental direction. Every effort is made to ensure that the objectives of the PHA are pursued in accordance with the recognised and accepted standards of public administration.

A range of processes and systems (including Service Level Agreements (SLAs), representation on PHA Board, Governance and Audit Committee and regular formal meetings between senior officers) are in place to support the close working between the PHA and its partner organisations, primarily the Health and Social Care Board (HSCB) and the Business Services Organisation (BSO), as they provide essential services to the PHA (including the finance function) and in taking forward the health and wellbeing agenda.

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

2. Compliance with Corporate Governance Best Practice

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

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

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

3. Governance Framework

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

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

The PHA Board is comprised of a Non-Executive Chair, seven Non-Executive members, the Interim Chief Executive and three Executive Directors. During 2020/21 the PHA had six serving Non-Executive Directors and are awaiting the appointment of a seventh.

During 2020/21, the PHA Board met on thirteen occasions. The PHA Board meets regularly, usually monthly, with the exception of July; however in 2020/21 there were additional special meetings convened in April 2020 and July 2020. The Board sets the strategic direction for the PHA within the overall policies and priorities of the HSC, monitors performance against objectives, ensures effective financial stewardship, ensures that high standards of corporate governance are maintained, ensures systems are in place to appoint, appraise and remunerate senior executives, ensures effective public engagement and ensures that robust and effective arrangements are in place for clinical and social care governance and risk management. All Board meetings were quorate.

PHA Board Meeting Attendance Register 2020/21

Name	Meetings Attended	Meetings Contracted to Attend
Mr Andrew Dougal (Chair)	12	13
Mrs Olive MacLeod*	13	13
Mr Edmond McClean*	8	8
Mr Stephen Wilson*	4	4
Professor Hugo van Woerden*	8	9
Dr Stephen Bergin*	4	4
Mr Rodney Morton*	10	13
Dr Aideen Keaney**	7	13
Alderman Billy Ashe***	12	13
Mr John Patrick Clayton***	12	13
Ms Deepa Mann-Kler***	13	13
Alderman Paul Porter***	11	13
Professor Nichola Rooney***	13	13
Mr Joseph Stewart***	13	13

* - Executive Director; ** Director; *** Non-Executive Director
Mr Wilson replaced Mr McClean as Interim Director of Operations; Dr Bergin replaced Professor Van Woerden as Interim Director of Public Health

The Governance and Audit Committee's (GAC) purpose is to give an assurance to the PHA Board and Accounting Officer on the adequacy and effectiveness of the PHA's system of internal control. The GAC has an integrated governance role encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by risk management systems. The GAC meets at least quarterly and currently comprises three Non-Executive Directors supported by the PHA's Director of Operations and the HSCB's Director of Finance. Representatives from Internal and External Audit are also in attendance. During 2020/21 the GAC met on five occasions and all meetings were quorate.

The Remuneration and Terms of Service Committee advises the PHA Board about appropriate remuneration and terms of service for the Interim Chief Executive and other senior executives subject to the direction of the DoH. The Committee also oversees the proper functioning of performance appraisal systems, the appropriate contractual arrangements for all staff as well as monitoring a remuneration strategy that reflects national agreement and Departmental Policy and equality legislation. The Committee comprises the PHA Chair and three Non-Executive Directors; it normally meets at least once every 6 months. During 2020/21, the Committee met on one occasion and the meeting was quorate.

4. Framework for Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and ministerial priorities are properly reflected in the management of business at all levels within the organisation.

The PHA *Corporate Plan 2017 – 2021*, setting out the PHA purpose, vision, values and strategic outcomes, was approved by the PHA Board on 20 April 2017 and by the DoH on 26 May 2017.

Due to the impact of COVID-19 and the PHA operating under business continuity arrangements for much of the year, the Annual Business Plan for 2020/21 was not finalised. During the year much normal business had to be paused, as the organisation prioritised its focus on working to control and reduce the transmission of COVID-19. This was agreed with the Department of Health (DoH), and was managed and overseen through the Silver/Gold Emergency Response arrangements and regular meetings between the PHA and the DoH as well as oversight by the PHA Board.

The PHA's Risk Management Strategy and Policy explicitly outlines the PHA risk management process which is a 5 stage approach – risk identification, risk assessment, risk appetite, addressing risk and recording and reviewing risk, as follows:

Stage 1 - Risk Identification

Risks are identified in a number of ways and at all levels within the organisation corporately, by Directorate and by individual staff members. Risks can present as external factors which impact on the organisation but which the organisation may

have limited control over or operational which concern the service provided and the resources/processes available and utilised.

Within the organisation risk identification is related to the organisation's objectives (as detailed in the PHA Corporate Plan). Each risk identified is correlated to at least one of the corporate objectives. Risks are also aligned with the relevant performance and assurance dimensions as identified in the DoH Framework Document.

Stage 2 - Risk Assessment

Each risk is assessed to identify:

- The **impact** that the risk would have on the business should it occur, and
- The **likelihood** of the risk materialising.

The PHA is committed to adhering to best practice in the identification and treatment of risks and works to the principles, framework and processes for Risk Management as contained in ISO 31000: 2018 and also adheres to the HSC Regional Risk Matrix (April 2013; updated June 2016 and August 2018).

Stage 3 - Risk Appetite

The PHA carefully considers its risk appetite, i.e. the extent of exposure to risk that is judged tolerable and justifiable. The PHA recognises that it is operating in an environment where safety, quality and viability are paramount and are of mutual benefit to service users, stakeholders and the organisation alike. Consequently, and subject to controls and assurances being in place, the PHA will generally accept manageable risks which are innovative and which predict clearly identifiable benefits, but not those where the risk of harm or adverse outcomes to service users, the PHA's business viability or reputation is significantly high and may outweigh any benefits to be gained. Risk appetite is built into the risk assessment process as outlined above.

Stage 4 - Addressing the Risk

Whilst there are four traditional responses to addressing risk (terminate, tolerate, transfer and treat), in practice within the PHA the vast majority of risks are managed via the "Treat" or "Tolerate" route, both of which are underpinned by the identification of an action plan to reduce and, if possible, eliminate the risk.

Stage 5 - Recording and Reviewing Risk

Within the PHA the risk management process is recorded and evidenced through the maintenance of Directorate and Corporate level Risk Registers.

To ensure the robustness of the PHA's system of internal control, fully functioning Risk Registers at both Directorate and Corporate levels are reviewed and updated on a quarterly basis, ensuring that risks are managed effectively and efficiently to meet PHA's corporate objectives and to continuously improve the quality of services.

Processes are established within each Directorate enabling risks to be identified, controls and/or gaps in controls highlighted and, where relevant, action to be taken to mitigate the risk. Directors and senior officers also identify risks which require escalation to the Corporate Risk Register.

The Interim Director of Operations is the PHA Executive Board member with responsibility for risk management. The Corporate Risk Registers are reviewed quarterly by the Agency Management Team (AMT) and Governance and Audit Committee (GAC). Directorate Risk Registers are also reviewed by AMT and the GAC on a rotational basis. The minutes of the GAC are brought to the following PHA Board meeting, and the Chair of the GAC also provides a verbal update on governance issues including risk. The Corporate Risk Register is brought to a PHA Board meeting at least annually, most recently on 15 October 2020.

During 2020/21, guidance and support was provided to staff who are actively involved in reviewing and co-ordinating the review of the Directorate and Corporate Risk Registers. A system has been established whereby the Senior Operations Manager meets with the planning and project managers supporting each Directorate and Division at the end of each quarter to ensure feedback and consistency in the review of the Risk Registers, and to share and learn from good practice.

All staff are required to complete the PHA risk management e-learning programme. In addition, staff have also been provided with other relevant training including fire, health and safety, security and fraud awareness.

All policies and procedures in respect of risk management and related areas are available to all staff through the PHA intranet (Connect) site.

Fraud

The Public Health Agency (PHA) takes a zero tolerance approach to fraud in order to protect and support our key public services. We have put in place an Anti-Fraud Policy and Fraud Response Plan to outline our approach to tackling fraud, define staff responsibilities and the actions to be taken in the event of suspected or perpetrated fraud, whether originating internally or externally to the organisation. Our Fraud Liaison Officer promotes fraud awareness, co-ordinates investigations in conjunction with the BSO Counter Fraud and Probity Services team and provides advice to personnel on fraud reporting arrangements. All staff are supported in fraud awareness in respect of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate

A fraud report is brought to the GAC on a regular basis.

5. Information Risk

The PHA has robust measures in place to manage and control information risks. The designated Senior Information Risk Owner (SIRO) for the management of information risk at Board level is the Interim Director of Operations. The Interim Director of Public Health as the Personal Data Guardian (PDG) has responsibility for ensuring that the PHA processes satisfy the highest practical standards for handling personal data. Assistant Directors as Information Asset Owners (IAOs) are responsible for managing and addressing risks associated with the information assets within their function and provide assurance to the SIRO on the management of those assets. The Assistant Director Planning and Operational Services as the Data Protection Officer (DPO) has responsibility for monitoring and advising on data protection.

The PHA's Information Governance Steering Group (IGSG) has the primary role of leading the development and implementation of the Information Governance Framework across the organisation, including ensuring that action plans arising from Internal and External Audit reports and the Information Management Checklist are progressed. The Group is chaired by the SIRO and membership includes all the IAOs, PDG, a Non-Executive Board member and relevant governance staff. The IGSG is scheduled to meet quarterly and provides a report to the GAC following each meeting. During 2020/21 the IGSG met once in the latter part of year with all other formal quarterly meetings suspended due to COVID-19 pressures faced by staff within PHA. During this time Information Governance staff, SIRO, PDG and DPO worked closely with staff across the organisation. The Assistant Director Planning and Operational Services also brought regular updates to the GAC.

The PHA's Information Governance Strategy (incorporating the Information Governance Framework) 2018-2022 sets out the framework to ensure that the PHA meets its obligations in respect of information governance, embedding this at the heart of the organisation and driving forward improvements in information governance within the PHA. The Strategy was reviewed and approved in 2018 in line with UK GDPR and DPA 2018. This is supported by annual Action Plans setting out how it will be implemented. Alongside this, a range of policies and procedures are in place, including Data Protection/Confidentiality Policy, Data Breach Incident Response Policy and a Data Protection Impact Assessment Policy and Guidance.

The PHA has documented and agreed procedures in place to ensure compliance with the requirements of UK GDPR and DPA 2018.

The PHA 'Connect' intranet site provides staff with easy access to the latest PHA policies, news and resources. Through the use of this site the PHA ensures that all staff have access to information governance policies and procedures.

Information asset registers are in place, and are kept under review. Information risks are assessed and control measures are identified and reviewed as required. Where appropriate, information risks are incorporated in the Corporate or Directorate Risk Registers.

The HSC information governance e-learning programme, incorporating Freedom of Information, Data Protection, Records Management and IT Security/cyber security

continues to be rolled out to all staff. Specialised training is also organised for the SIRO and IAOs however, during 2020/21, only one IAO training session took place due to COVID-19 pressures faced by staff within PHA. Uptake of training is monitored by the IGSG.

The PHA is represented on the regional HSC Cyber Security Programme Board, and works with BSO ITS, as our IT provider, to take necessary measures in relation to cyber security risks.

6. Assurance

The Governance and Audit Committee provides an assurance to the Board of the PHA on the adequacy and effectiveness of the system of internal controls in operation within the PHA. It assists the PHA Board in the discharge of its functions by providing an independent and objective review of:

- all control systems;
- the information provided to the PHA Board;
- compliance with law, guidance, Code of Conduct and Code of Accountability; and
- governance processes within the PHA Board.

Internal and External Audit have a vital role in providing assurance on the effectiveness of the system of internal control. The GAC receives, reviews and monitors reports from Internal and External Audit. Internal and External Audit representatives are also in attendance at all GAC meetings.

The Chair of the GAC reports to the PHA Board on a regular basis on the work of the Committee. The PHA Board also receives regular assurances through the financial and performance reports brought to it by the HSCB Director of Finance and PHA interim Director of Operations.

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

The PHA continues to ensure that data quality assurance processes are in place across the range of data coming to the PHA Board. Where gaps are identified, the PHA proactively seeks to address these, for example by the development and regular review of the Programme Expenditure Monitoring System (PEMS) to ensure comprehensive and robust information.

Information presented to the PHA Board to support decision making, is firstly presented to, and approved by, the Agency Management Team (AMT) and the Interim Chief Executive, as part of the quality assurance process. Relevant officers are also in attendance at Board meetings when appropriate, to ensure that members have the opportunity to challenge information presented.

7. Sources of Independent Assurance

The PHA obtains Independent Assurance from the following sources:

- Internal Audit
- Regulation and Quality Improvement Authority (RQIA)

In addition, the PHA receives an opinion on regularity from the External Auditor in the Report to Those Charged with Governance.

Internal Audit

The PHA utilises an Internal Audit function which operates to defined standards and whose work is informed by an analysis of the risk to which the body is exposed and annual audit plans are based on this analysis. In 2020/21 Internal Audit reviewed the following systems:

System reviewed	Level of Assurance received*
Financial Review	Satisfactory
Management of Voluntary & Community Contracts	Satisfactory
Governance during COVID-19	Satisfactory
Risk Management	Satisfactory
Contact Tracing	Satisfactory

* Internal Audit's definition of levels of assurance:
Satisfactory: Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited: There are significant weakness within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable: The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Follow Up on Previous Recommendations:

The Internal Audit Follow Up report on previous Internal Audit Recommendations, issued on 1 April 2021, found that of the 77 recommendations with an implementation date of 31 March 2021 or earlier, 84% were fully implemented and 16% (12 recommendations) were partially implemented. Work will continue during 2021/22 to address those recommendations that have not yet been fully implemented.

One priority one weakness in control remains from the PHA Management of Contracts with the Voluntary/Community Sector audit, relating to the implementation of the PHA Social Care Procurement Plan. The recommendation has been partially implemented, and work continues to fully address this.

BSO Shared Services Audits:

A number of audits (summarised below) have been conducted in BSO Shared Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Services audit reports are the responsibility of BSO Management to take

forward and the reports have been presented to BSO Governance and Audit Committee.

System reviewed	Level of Assurance received*
Accounts Payable Shared Service	Satisfactory
Business Services Team	Satisfactory
Payroll Shared Services	Satisfactory (elementary processes), Limited (End-to-end HSC Timesheet Processing, SAP/HMRC RTI Reconciliation, Overpayments and Holiday Pay)

Overall Opinion:

In their annual report, the Internal Auditor provided the following opinion on the PHA's system of internal control:

*Overall for the year ended 31 March 2021, I can provide **Satisfactory** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.*

RQIA

The HSCB/PHA has a system in place via the Safety and Quality Alerts Team (SQAT) to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented.

This system of assurance takes the form of a 6 monthly report which details the progress on implementation of RQIA recommendations. During 2020/21 this report was not presented due to COVID-19 pressures however, it is anticipated that a report will be presented in early 2021/22.

External Audit

For the year ended 31 March 2020, the Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the PHA's accounts with no recommendations made.

8. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the Internal Auditors and the executive managers within the PHA who have responsibility for the development and maintenance of the internal control framework, and comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governance and Audit Committee and a plan to address weaknesses and ensure continuous improvement to the system is in place.

9. Internal Governance Divergences

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

EU Exit

On 29 March 2017, the UK Government submitted its notification to leave the EU in accordance with Article 50. On 31 January 2020, the Withdrawal Agreement between the UK and the EU became legally binding and the UK left the EU. The transition period ended on 31 December 2020, and the Northern Ireland Protocol became operational from 1 January 2021. At this stage there has been no adverse implications for the PHA. While the PHA will continue to monitor the situation, working with the Department of Health and other HSC organisations, it is not considered an internal governance divergence at this stage.

Business Services Transformation Project/Shared Services (Payroll)

The audit assignment finalised in March 2017 on Payroll Shared Services resulted in an unacceptable level of assurance being received from the Internal Auditor. While the issues raised in this audit report had less impact on the PHA than some other HSC organisations, it was of some concern that progress on issues identified previously had not been made. As a result of this Payroll audit, an action plan was developed by BSO to attempt to address the control and system stability issues identified.

Internal Audit subsequently provided limited assurance in the 2017/18 audits of Payroll Shared Services and have continued to provide this level of assurance until the latest report finalised in April 2020. In this report, Internal Audit provided satisfactory assurance in respect of elementary PSSC processes. Internal Audit continue to provide limited assurance in respect of timesheets, management of overpayments and reconciliations on Real Time Information (RTI) between the payroll system and HMRC data. Due to the nature of the working patterns of staff within PHA, these areas do not have a significant impact on the daily operational requirements of PHA. Therefore, this matter is considered to be resolved.

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

Financial Performance (Previously 'Quality, Quantity and Financial Controls')

While acknowledging the difficulties in commissioning and supporting services provided to the population of Northern Ireland in an environment where demand for these services continues to increase and the budget available for commissioning them remains constrained, the actions taken by the PHA during 20/21 enabled it to maintain the integrity of existing services commissioned and to ensure that additional priorities were implemented and progressed, within budget.

The budget for Health and Social Care in Northern Ireland continues to be challenging and set in the context of managing significant additional financial pressures relating to the response to the COVID-19 pandemic. To ensure that resources are used to their maximum benefit for the population of NI, the PHA continued to work closely and proactively with the DoH, Trusts and our Community and Voluntary Sector partners in order to address the difficulties faced. However, looking ahead to 2021/22 the budget settlement, financial pressures and uncertainties in view of the ongoing COVID-19 response will require ongoing prioritisation and careful financial management.

The Assembly passed the Budget Act (Northern Ireland) 2021 in March 2021 which authorised the cash and use of resources for all departments and their Arms' Length Bodies for the 2020/21 year, based on the Executive's final expenditure plans for the year. The Budget Act (Northern Ireland) 2021 also authorised a Vote on Account to authorise departments and their Arms' Length Bodies' access to cash and use of resources for the early months of the 2021/22 financial year. This will be followed by the 2021/22 Main Estimates and the associated Budget (No. 2) Bill before the summer recess which will authorise the cash and resource balance to complete for the remainder of 2021/22 based on the Executive's 2021/22 Final Budget.

Management of Contracts with the Community and Voluntary Sector

Previous Internal Audit reports on the management of health and social wellbeing improvement contracts have provided satisfactory assurance on the system of internal controls over the PHA's management of health and social wellbeing contracts reflecting the significant work that has been undertaken by the PHA. Service level Agreements are in place, appropriate monitoring arrangements have been developed, and payments are only released on approval of previous progress returns. During 2020/21, in response to the exceptional circumstances of the COVID-19 pandemic, there was regional agreement that service providers should continue to be paid full contract value to ensure organisations remained financially stable and could continue to pay staff and cover other core costs. Over this period, the PHA has worked closely with providers to review contract activity and agree revised performance measures based on individual organisations ability to continue to deliver core services or re-purpose their resources to support wider emergency response plans. The PHA has also highlighted to providers their legal duty to ensure they did not access duplicate funding under the Furlough scheme or other grant schemes available to cover costs already covered by PHA funding. An audit of the processes put in place to manage the COVID-19 response has recently been completed and no significant issues have been identified.

Work continues to fully address the partially implemented priority one weakness in control relating to the implementation of the PHA Social Care Procurement Plan. The PHA's ability to continue to implement the Procurement Plan since March 2020, has however been significantly impacted by the need to prioritise staffing resources to respond to the COVID-19 pandemic. The ongoing social distancing restrictions also make it difficult to undertake the appropriate engagement with stakeholders that is necessary to inform the planning and procurement process. During 2020/21, the PHA Procurement Board has continued to progress plans for the re-tender of Drug and Alcohol services, Relationship and Sexual Education services and the Self-Harm

Intervention programme. Further to a recent engagement with stakeholders on the drug and Alcohol re-tender process, the PHA is reviewing the proposed approach for taking forward this work, given the need to take into account the new regional Drug and Alcohol strategy to be finalised shortly by DoH and the need to consider how these services should link with wider mental health services. The PHA is also continuing to take forward preparatory work for mental health and suicide prevention support services linked to the delivery of the Protect Life 2 strategy.

The report of a Task and Finish Group established to review how the PHA could improve its planning and procurement processes continues to be implemented. Actions progressed include: a baseline review of the Procurement Plan timelines and development of a Thematic Planning timetable; awareness training for PHA staff in planning and Procurement processes was undertaken in January and February 2020; and, the appointment of 2 new senior planning posts will provide additional specialist capacity to support planning for procurement.

The PHA will continue to work closely with colleagues in HSCB, BSO (Directorate of Legal Services and Procurement and Logistics service), HSC Trusts and the DoH, to ensure that procurement processes continue to meet regional policy and guidance.

Neurology Call Back

Due to concerns being raised in relation to the practice of a consultant neurologist at the Belfast Trust, including work he undertook on behalf of other Trusts and in relation to his private practice, the HSCB and PHA, at the direction of the DoH, established a regional Coordination Group (which included representatives from each of the five Trusts and relevant independent sector providers) to co-ordinate the work necessary to complete a call-back review of those patients who remained under active review of the consultant (phase 1) followed by a call-back of a defined cohort of patients who had been discharged by the consultant (phase 2). The PHA has been working closely with the HSCB, Trusts and independent providers to ensure that a consistent approach is taken relating to the call back and review of patients who may be affected including providing consistent situation reports to the DoH on activity and progress.

Phase 1 of the call-back exercise was completed in 2018 and a report on the activity and outcomes associated with Phase 1 was published.

Phase 2 was completed in October 2019 and a report submitted in January 2020. The PHA and HSCB continue to work with the DoH, BHSCT and relevant private providers to confirm the next steps on this matter.

PHA Staffing Issues

The PHA has continued to work closely with DoH colleagues to take actions to address the number of vacancies and posts filled on a temporary basis across all Directorates and at all levels of the organisation. It has been noted that budget reductions over the past number of years and on-going budget constraints have curtailed the ability to further develop and grow the workforce to meet new and

increasing demands. This has impacted on the work of the PHA through constrained capacity across a number of key areas and functions.

While significant progress was made during 2019/20 to address staffing issues, most notably with the appointment of a number of new permanent and locum health protection and service development consultants, and measures to recruit permanent staff to fill health improvement posts currently filled on a temporary basis (during 2020/21), it is recognized that some longer term actions are still required.

With the emergence of COVID-19 in early 2020 additional pressure was placed on PHA staff, particularly the health protection team. While a number of temporary staff were recruited during 2020/21, including staff redeployed from other organisations to support the PHA response to COVID-19, it is recognised that further work is required to enhance a number of key functions in the PHA including Health Protection, Nursing/AHP and Communications. This was highlighted in the report on the 'Rapid, focused external review of the Public Health Agency's resource requirement to respond to the COVID-19 pandemic over the next 18 – 24 months' conducted by Dr R Hussey in December 2020. Business cases have been submitted to the DoH for recurrent funding.

Additionally there has been significant change in the PHA senior management team over the past year, with three interim appointments (Chief Executive, Director of Operations and Director of Public Health). The recruitment process for a new Chief Executive has recently completed, with the new Chief Executive to take up post July 2021.

PHA will continue to work with DoH colleagues to progress these issues.

COVID-19

The World Health Organisation (WHO) declared the outbreak of Coronavirus disease (COVID-19) a global pandemic on 11 March 2020. Following which the Department of Health and its ALBs immediately enacted emergency response plans across the NI Health sector. There is a UK-wide coordinated approach guided by the scientific and medical advice from respective Chief Medical Officers and Chief Scientific Advisers informed by the emergent evidence nationally and internationally. Evidence-based UK-wide policies and guidelines continue to be carefully followed in conjunction with the PHA issuing local guidelines and ensuring readily accessible and continually updated advice.

The pandemic has had extensive impact on the health of the population, all health services and the way business is conducted across the public sector. Protecting the population, particularly the most vulnerable, ensuring that health and social care services are not overwhelmed, saving lives through mitigating the impact of the pandemic and patient and staff safety has remained at the forefront throughout health's emergency response.

Contingency arrangements were put in place across all HSC organisations, including the PHA. Given the wide ranging impact and the need to react immediately to rapidly

changing developments, this had an effect on the ability to conduct routine health business in order to re-direct resources to deal with the pandemic.

The PHA instigated business continuity arrangements for most of the year, as the organisation refocused to respond to COVID-19. Additionally, in line with the Government advice to work from home where possible, to reduce the transmission of COVID-19, the majority of staff have been working remotely for most of the year.

There have been substantial resourcing impacts across the Department and ALBs to scale up the response and to ensure adequate staff resourcing to meet increasing demands which included calling on volunteers, retired medical staff and medical students to rally together to strive to enable an optimum response to the pandemic. In the case of the PHA, additional temporary and fulltime staff had to be recruited to operate the contact tracing service and to enhance the health protection team to respond to the pandemic.

The Department prepared a COVID-19 Test, Trace and Protect Strategy (May 2020) which sets out the public health approach to minimising COVID-19 transmission in the community in Northern Ireland. The Department continues to have responsibility for oversight of the operation of the various elements of this Strategy.

The Strategy includes the COVID-19 testing arrangements. The Department's Expert Advisory Group has overseen the strategic approach in NI, working with the UK Coronavirus National Testing Programme. PHA staff have worked closely with Departmental colleagues as part of both the strategic and operational management of the testing programme.

The Northern Ireland Contact Tracing Service, operated by the PHA, began contact tracing all confirmed cases of COVID-19 on 18 May 2020. The team continues to be flexible as it strives to ensure that every conceivable effort is made to continue to limit transmission.

In December 2020, the first COVID-19 vaccine was approved, with supplies received in Northern Ireland and the mass vaccination programme (for all adults) commenced. The COVID-19 vaccination programme is led by the Department of Health and delivered by both HSC Trusts and primary care. The PHA is represented on the programme board and implementation group, with responsibilities including the management of a sessional COVID-19 vaccinator workforce to support primary care.

While numbers are expected to continue to reduce over the coming months, it is clear that COVID-19 will remain prevalent in the community for a substantial period to come. Maintaining the contact tracing services, ensuring public awareness and engagement with core public health guidance, wider health protection response and contribution to the vaccination programme will continue to be both a focus and a challenge during 2021/22, as the organisation also seeks to restart other core business.

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

HSCQI

The establishment of the HSCQI function was a key action from 'Health and Wellbeing 2026: Delivering Together'. The DoH established the HSCQI within the PHA, providing temporary funding through transformation monies for the Director of HSCQI and a number of additional posts. (The Safety Forum, already within the PHA, also became part of the new HSCQI Directorate.)

The indicative budget allocation for 2021/22 includes funding for some HSCQI posts, however it does not cover the totality of posts required. While the PHA welcomes the funding allocation, given the remaining gap in funding, it will still be challenging for the HSCQI to deliver on the design intent. There is therefore a risk that the HSCQI will be unable to fulfil its core function, service corporate requirements or undertake additional requests from the HSC system to support work and training.

The PHA Interim Chief Executive and Director HSCQI will continue to work with the Department to agree the priorities for HSCQI (in light of constrained resources) and to discuss funding for HSCQI.

Staff Resilience during COVID-19

As a result of the necessary response to COVID-19 the PHA was required to move to 7 day working in April 2020. While organisations are no longer required to maintain a 7 day working pattern, staff in the PHA have continued to face significant work pressures throughout the year, as they have worked to control and reduce the spread of COVID-19.

PHA has however limited staff capacity, and while additional staff have been brought in during the year, including through redeployment and some honorary contracts, there is concern that in order to maintain this response a significant number of staff have had to work additional hours over a long, and sustained, period. It is noted that staff are tired, with many also unable to take all their leave during 2020/21, and therefore there is a risk that staff may become ill and/or no longer be able to continue.

The PHA will continue to work with HR and the wider HSC and the Department to support staff and seek ways to build resilience and maintain the required and necessary response to COVID-19.

Cyber Security Incident at Queens University Belfast

A cyber security incident took place at Queens University Belfast (QUB) in February 2021. As the HSC has multiple contractual interactions with QUB, some concerning personal information, the HSC technology teams, with the backing of the HSC SIROs, undertook a number of actions to reduce potential disruption to HSC

services, and continue to liaise with QUB on the impact of the cyber incident. The impact on the HSC is being fully investigated, and there may be a financial risk in relation to possible future liability, for potential claims for loss of personal data. As the breach occurred in a third party's systems the potential for liability is unclear and any financial impact is unquantifiable at present.

10. Conclusion

The PHA has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in Managing Public Money NI (MPMNI).

Further to considering the accountability framework within the PHA and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the PHA has operated a sound system of internal governance during the period 2020/21.

REMUNERATION AND STAFF REPORT

Remuneration Report

A committee of Non-Executive board members exists to advise the full Board on the remuneration and terms and conditions of service for Senior Executives employed by the Public Health Agency (PHA).

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

DoH Circulars on the 2016/17 and 2017/18 Senior Executive pay awards were issued towards the end of March 2021, but related payments were not made to Executive Directors in 2020/21. Circulars in relation to the 2018/19, 2019/20 and 2020/21 Senior Executive pay awards have not been issued.

The 2015/16 Senior Executive's pay award was set out in DoH circular HSC(SE) 1/2016 and was paid in line with the Remuneration Committee's agreement on the classification of Executive Directors' performance, categorised against the standards of 'fully acceptable' or 'incomplete' as set out within the circular.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the PHA received any other bonus or performance related pay in 2020/21. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

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

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2020/21.

Membership of the Remuneration and Terms of Service Committee:

Mr Andrew Dougal - Chair
Alderman William Ashe – Non-Executive Director
Alderman Paul Porter – Non-Executive Director
Professor Nichola Rooney – Non-Executive Director

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

Senior Employee's Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the PHA were as follows, it should be noted that there were no bonuses paid to any Director during 2020/21 or 2019/20.

Non Executive Members (Table Audited)

	2020/21				2019/20			
Name	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**
Mr Andrew Dougal (*Chair*)	30-35	-	-	30-35	35-40	-	-	35-40
Alderman Paul Porter	5-10	-	-	5-10	5-10	-	-	5-10
Alderman William Ashe	5-10	-	-	5-10	10-15	-	-	10-15
Mr Leslie Drew (Left 31 March 2020)	-	-	-	-	5-10	100	-	5-10
Ms Deepa Mann-Kler	5-10	-	-	5-10	5-10	100	-	5-10
Professor Nichola Rooney	5-10	-	-	5-10	5-10	-	-	5-10
Mr John-Patrick Clayton	5-10	-	-	5-10	5-10	-	-	5-10
Mr Joseph Stewart	5-10	-	-	5-10	5-10	-	-	5-10

Notes

Some non-executive members may have received benefits in kind below £50 – this will be rounded down to nil as specified in the 2nd column of the table above.

Executive Members (Table Audited)

	2020/21				2019/20			
Name	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (to nearest £100)**	**Pension Benefits (to nearest £1,000)**	**Total £000s**
Mrs Olive MacLeod *Interim Chief Executive* (Started 1 Apr 2020)	110-115	-	188,000	295-300	-	-	-	-
Dr Adrian Mairs *Acting Director of Public Health* (Left 29 Feb 2020)	-	-	-	-	135-140 (145-150 FYE)	-	-	135-140
Professor Hugo van Woerden *Director of Public Health* (Retired 31 Dec 2020)	160-165 (215-220 FYE)	-	-	160-165	10-15 (160-165 FYE)	-	-	10-15
Dr Stephen Bergin *Interim Director of Public Health* (Started 30 Nov 2020)	60-65 (180-185 FYE)	-	(10,000)	50-55	-	-	-	-
Dr Aideen Keaney *Director of HSCQI*	90-95	-	43,000	130-135	35-40 (65-70 FYE)	-	-	35-40
Mr Edmond McClean *Director of Operations / Interim Deputy Chief Executive* (Retired 30 Sep 2020)	40-45 (85-90 FYE)	100	-	40-45	85-90	-	-	85-90
Mr Stephen Wilson *Interim Director of Operations* (Started 14 Dec 2020)	20-25 (80-85 FYE)	-	21,000	45-50	-	-	-	-
Mr Rodney Morton *Director of Nursing & Allied Health Professionals*	80-85	6,600	86,000	175-180	20-25 (80-85 FYE)	-	8,000	25-30
Mrs Briege Quinn *Interim Director of Nursing & Allied Health Professionals* (Left 31 Mar 2020)	-	-	-	-	40-45 (80-85 FYE)	3,000	154,000	195-200
Mrs Mary Hinds *Director of Nursing & Allied Health Professionals* (Retired 27 Sep 2019)	-	-	-	-	50-55 (100-105 FYE)	-	-	50-55

Notes

FYE – Full Year Equivalent

Pensions of Senior Management (Table Audited)

	2020/21				
Name	**Real increase in pension and related lump sum at age 60 £000**	**Total accrued pension at age 60 and related lump sum £000**	**CETV at 31/03/20 £000**	**CETV at 31/03/21 £000**	**Real increase in CETV £000**
Mrs Olive MacLeod *Interim Chief Executive*	7.5-10 pension 25-27.5 lump sum	30-35 pension 95-100 lump sum	583	794	211
Dr Aideen Keaney *Director of Quality Improvement*	2.5-5 pension 0-2.5 lump sum	45-50 pension 90-95 lump sum	773	846	40
Dr Stephen Bergin *Interim Director of Public Health*	0-2.5 pension	60-65 pension 145-150 lump sum	1,229	1,285	4
Mr Stephen Wilson *Interim Director of Operations*	0-2.5 pension 0-2.5 lump sum	30-35 pension 65-70 lump sum	555	600	22
Mr Rodney Morton *Director of Nursing & Allied Health Professionals*	2.5-5 pension 7.5-10 lump sum	40-45 pension 115-120 lump sum	754	868	84

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to transfer of pension rights, but include actuarial uplift factors and therefore can be positive or negative.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are a member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves the scheme and chooses to transfer their benefits accrued in their former scheme.

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

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

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It does not include the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pension contributions deducted from individual employees are dependent on the level of remuneration receivable and are deducted using a scale applicable to the level of remuneration received by the employee.

Fair Pay Disclosures (Table Audited)

The relationship between remuneration of the most highly paid director and the median remuneration of the workforce is set out below.

	2021	2020
Band of Highest Paid Director's Remuneration (band in £000s)	215-220	160-165
Median Total Remuneration (£)	40,894	38,365
Ratio	5.28	4.20

The change to the ratio is impacted by the increase in the highest paid director's remuneration.

No employee received remuneration in excess of the highest paid director, and remuneration ranged from £6,559 to £216,071 in 2020/21. The lowest salary relates to Safeguarding Board lay members.

Staff Report

Staff Costs (Table Audited)

PHA staff costs comprise:

	2021			2020
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	18,806	2,652	21,458	15,295
Social security costs	1,910	269	2,179	1,674
Other pension costs	3,348	472	3,820	3,256
Total staff costs reported in Statement of Comprehensive Net Expenditure	**24,064**	**3,393**	**27,457**	**20,225**
Less recoveries in respect of outward secondments			(489)	(330)
Total net costs			**26,968**	**19,895**

The PHA participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

The Public Service Pensions Act (NI) 2014 provides the legal framework for regular actuarial valuations of the public service pension schemes to measure the costs of the benefits being provided. These valuations inform the future contribution rates to be paid into the schemes by employers every four years following the scheme valuation. The Act also provides for the establishment of an employer cost cap mechanism to ensure that the costs of the pension schemes remain sustainable in future.

The Government Actuary's Department (GAD) is responsible for carrying out scheme valuations. The Actuary reviews employer contributions every four years following the scheme valuation. The 2016 scheme valuation was completed by GAD in March 2019. The outcome of this valuation was used to set the level of contributions for employers from 1 April 2019 to 31 March 2023.

The 2016 Scheme Valuation requires adjustment as a result of the 'McCloud remedy'. The Department of Finance have also commissioned a consultation in relation to the Cost Cap Valuation which will close on 25 June 2021. By taking into account the increased value of public service pensions, as a result of the 'McCloud remedy', scheme cost control valuation outcomes will show greater costs than otherwise would have been expected. On completion of the consultation the 2016 Valuation will be completed and the final cost cap results will be determined.

Average Number of Persons Employed (Table Audited)

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

	2021			2020
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	452	61	**513**	**346**
Less average staff number in respect of outward secondments	(9)	-	**(9)**	**(5)**
Total net average number of persons employed	**443**	**61**	**504**	**341**

Reporting of Early Retirement and other Compensation Schemes – Exit Packages (Table Audited)

Exit package cost band	**Number of compulsory redundancies**		**Number of other departures agreed**		**Total number of exit packages by cost band**	
	2021	**2020**	**2021**	**2020**	**2021**	**2020**
Total number of exit packages by type	**0**	**0**	**0**	**0**	**0**	**0**
Total resource cost £000s	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

The table above shows the total cost of exit packages agreed and accounted for in 2020/21 and 2019/20. No exit costs were paid in 2020/21, the year of departure (2019/20, nil).

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation (Northern Ireland) Order 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the PHA and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The PHA had no staff benefits in 2020/21 or 2019/20.

Retirements due to ill-health

During 2020/21, there were no early retirements from the PHA agreed on the grounds of ill-health.

Staff Composition

The staff composition broken down by male/female and whole time equivalent (WTE) as at 31 March 2021 was as follows:

Gender	Headcount	Whole Time Equivalent
Female	381	322.8
Male	111	100.7
Grand Total	**492**	**423.5**

Staff Gender Breakdown within PHA 2020/21 Senior Management (excl. Board Members)*		
Gender	**Headcount**	**Whole Time Equivalent**
Female	31	28.3
Male	15	14.5
Grand Total	**46**	**42.8**

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

Sickness Absence Data

The corporate cumulative annual absence level for the PHA for the period from 1 April 2020 – 31 March 2021 is 2.39% (2019/20 4.24%).

There were 14,554 hours lost due to sickness absence or the equivalent of 42.8 hours lost per employee. Based on a 7.5 hour working day, this is equal to 5.7 days per employee (2019/20 10.4 days).

Staff Turnover Percentage

For a given period, the total turnover figure is calculated as the number of leavers within that period divided by the average employee headcount over the period. Voluntary turnover includes leavers classified under the categories of resignation, retirement or ill-health retirement. Involuntary turnover includes leavers classified

under the categories of dismissal, end of fixed term contract or ill-health termination. This information has been included for the 2020/21 financial year for the first time and comparators are not currently available.

Staff Turnover %	2021
Total Staff Turnover	11.82%
Split between:	
Voluntary Turnover	9.16%
Involuntary Turnover	2.66%

Staff Engagement Scores

HSC organisations do not monitor Employee Engagement on an annual basis, but there is a *Regional Staff Survey* conducted every 3 years. The PHA employee engagement score from the most recent staff survey (2019) was 3.70 out of a possible 5. The response rate was 52%.

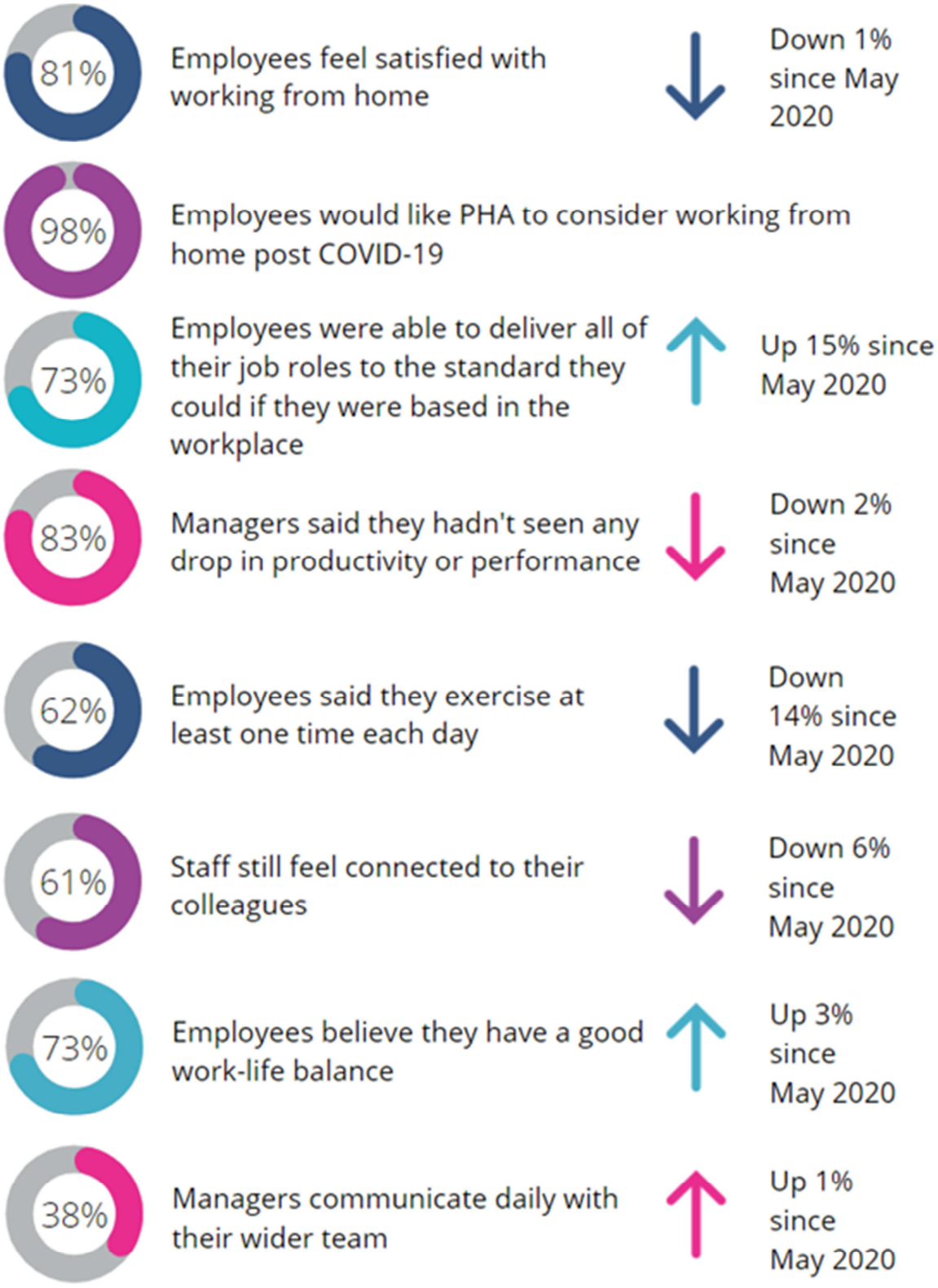
In addition to the regional survey, the PHA conducted a Cultural Assessment survey which measured the culture within the organisation across 8 dimensions. Each of the 8 dimensions was scored out of 5 and the table below shows the scoring against each dimension within PHA. The response rate for this survey was 37.4%.

Because of the pandemic, PHA conducted the Cultural Assessment twice to see if, and how, culture was impacted. Reassuringly, the scores improved against most dimensions when the survey was completed for the second time in November 2020.

Dimension	Feb 2020 Score	Nov 2020 Score	Change
Values	3.35	3.46	+ 0.23 ↑
Vision	2.51	2.73	+ 0.21 ↑
Goals & Performance	3.92	3.61	+ 0.17 ↓
Quality & Innovation	2.96	3.09	+ 0.24 ↑
Team Working	3.59	3.68	+ 0.11 ↑
Compassionate Care	3.95	4.01	+ 0.14 ↑
Compassionate Leadership	3.4	3.47	+ 0.15 ↑
Collective Leadership	3.12	3.30	+ 0.19 ↑

Due to COVID-19, the way PHA staff work changed dramatically in 2020 with many staff working remotely from home. This was a new way of working and the organisation recognised that some staff may have found this shift challenging. In order to help address this, two "*Working from Home*" surveys were conducted, one in the summer and one in winter, to get feedback from staff about how they are managing while working from home during the pandemic. Some high level findings are noted below.

PHA Results


81%
Employees feel satisfied with working from home
Down 1% since May 2020
98%
Employees would like PHA to consider working from home post COVID-19
73%
Employees were able to deliver all of their job roles to the standard they could if they were based in the workplace
Up 15% since May 2020
83%
Managers said they hadn't seen any drop in productivity or performance
Down 2% since May 2020
62%
Employees said they exercise at least one time each day
Down 14% since May 2020
61%
Staff still feel connected to their colleagues
Down 6% since May 2020
73%
Employees believe they have a good work-life balance
Up 3% since May 2020
38%
Managers communicate daily with their wider team
Up 1% since May 2020

Staff Policies / Employment and Occupation

During the year the PHA ensured internal policies gave full and fair consideration to applications for employment made by disabled persons having regard to their particular aptitudes and abilities. In this regard the PHA is fully committed to promoting equality of opportunity and good relations for all groupings under Section 75 of the Northern Ireland Act 1998.

The PHA has a range of policies in place that serve to advance this aim, including, on the employment side, the Equality of Opportunity Policy. More information is available on the PHA's website at www.publichealth.hscni.net.

Where an employee has become disabled during the course of their employment with the PHA, the organisation works closely with Human Resources (BSO HR Shared Services) who are guided by advice from Occupational Health.

Subsequently, reasonable adjustments can be made to accommodate the employee such as reduced hours, work adjustments including possible redeployment, in line with relevant disability legislation. This legislation is incorporated into selection and recruitment training and induction training and is highlighted in relevant policies where necessary.

The PHA is fully committed to the ongoing training and development of all members of staff and through the performance appraisal system all staff are afforded this opportunity irrespective of ability/disability as well as having the same opportunities to progress through the organisation.

The PHA also participates in the Disability Placement Scheme which provides a six month placement for those with a disability wishing to return to the workplace. During their placement they receive support and guidance – for example, guidance on the completion of application forms when applying for future posts.

Expenditure on Consultancy

The PHA had no expenditure on External Consultancy during 2020/21 (2019/20, nil).

Off-Payroll Engagements

The PHA is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed which cost more than £245 per day and lasted longer than 6 months during the financial year, which were not paid through the PHA Payroll. There were no such 'off-payroll' engagements in 2020/21 or 2019/20.

ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure

The PHA has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit, and during 2020/21 there has been no evidence of irregular expenditure occurring.

Losses and Special Payments (Table Audited)

Losses Statement	2020/21	2019/20
Total number of losses	-	4
Total value of losses (£)	-	£2,629

There were no individual losses over £250k in the 2020/21 financial year (2019/20, nil).

Special Payments

There were no other special payments or gifts made during the year (2019/20, nil).

Other Payments and Estimates

There were no other payments made during the year (2019/20, nil).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 19 of the financial statements, the PHA also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability. As at 31 March 2021, the PHA is not aware of any remote contingent liabilities, and there were none in 2019/20.

Olive MacLeod OBE

Interim Chief Executive

Date 17th June 2021

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

Opinion on financial statements

I certify that I have audited the financial statements of Public Health Agency for the year ended 31 March 2021 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRS) as adopted by the European Union and interpreted by the Government Financial Reporting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of Public Health Agency's affairs as at 31 March 2021 and of the Public Health Agency's net expenditure for the year then ended; and

- have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate.

My staff and I are independent of Public Health Agency in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2019, and have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that Public Health Agency's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Public Health Agency 's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements, the parts of the Accountability Report described in that report as having been audited, and my audit certificate and report. The Board and the Accounting Officer are responsible for the other information included in the annual report. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my report I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and

- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Public Health Agency and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report. I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the parts of the Accountability Report to be audited are not in agreement with the accounting records; or
- certain disclosures of remuneration specified by the Government Financial Reporting Manual are not made; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with the Department of Finance's guidance.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Board and the Accounting Officer are responsible for:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- such internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free form material misstatement, whether due to fraud of error;
- assessing the Public Health Agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by the Public Health Agency will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Public Health Agency through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health directions issued thereunder;

- making enquires of management and those charged with governance on Public Health Agency's compliance with laws and regulations;

- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;

- completing risk assessment procedures to assess the susceptibility of Public Health Agency's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, expenditure recognition and posting of unusual journals;

- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;

- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;

- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial

statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;

- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Report

I have no observations to make on these financial statements.

K J Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
1 Bradford Court
Galwally
BELFAST
BT8 6RB

Date 30 June 2021

PUBLIC HEALTH AGENCY

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2021

FOREWORD

These accounts for the year ended 31 March 2021 have been prepared in a form determined by the Department of Health (DoH) based on guidance in the Government Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2021

This account summarises the expenditure and income generated and consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

		2021	2020
Income	**NOTE**	**£000**	**£000**
Revenue from contracts with customers	4.1	3,471	3,096
Other operating income (excluding interest)	4.2	489	330
Total operating income		3,960	3,426
Expenditure			
Staff costs	3	(27,457)	(20,225)
Purchase of goods and services	3	(53,938)	(53,161)
Depreciation, amortisation and impairment charges	3	(200)	(187)
Provision expense	3	0	(10)
Other expenditures	3	(2,881)	(3,153)
Total operating expenditure		(84,476)	(76,736)
Net Expenditure		**(80,516)**	**(73,310)**
Finance income	4.2	0	0
Finance expense	3	0	0
Net expenditure for the year		(80,516)	(73,310)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(19,706)	(18,942)
South Eastern Health & Social Care Trust		(5,386)	(5,113)
Southern Health & Social Care Trust		(7,929)	(7,473)
Northern Health & Social Care Trust		(9,445)	(9,966)
Western Health & Social Care Trust		(7,981)	(8,201)
NIAS Health & Social Care Trust		(87)	(93)
NI Medical & Dental Training Agency		(167)	(138)
PCC		(35)	0
Total RRL issued		(50,736)	(49,926)
Total Commissioner resources utilised		(131,252)	(123,236)
Revenue Resource Limit (RRL) received from DoH	22.1	131,358	123,355
Surplus / (Deficit) against RRL		**106**	**119**

OTHER COMPREHENSIVE EXPENDITURE		**2021**	**2020**
		£000	**£000**
Items that will not be reclassified to net operating costs			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	87	4
Net gain/(loss) on revaluation of intangibles	6.1/8/6.2/8	0	0
Net gain/(loss) on revaluation of financial instruments	7/8	0	0
Items that may be reclassified to net operating costs:			
Net gain/(loss) on revaluation of investments		0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(80,429)**	**(73,306)**

The notes on pages 92 to 120 form part of these accounts.

Statement of Financial Position for the Year Ended 31 March 2021

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

	NOTE	2021 £000	£000	2020 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	736		315	
Intangible assets	6.1/6.2	390		110	
Total Non Current Assets			1,126		425
Current Assets					
Trade and other receivables	12	4,154		2,611	
Other current assets	12	12		21	
Cash and cash equivalents	11	471		887	
Total Current Assets			4,637		3,519
Total Assets			**5,763**		**3,944**
Current Liabilities					
Trade and other payables	13	(15,551)		(10,882)	
Total Current Liabilities			(15,551)		(10,882)
Total assets less current liabilities			**(9,788)**		**(6,938)**
Non Current Liabilities					
Provisions	14	0		0	
Other payables > 1 yr	13	0		0	
Total Non Current Liabilities			0		0
Total assets less total liabilities			**(9,788)**		**(6,938)**
Taxpayers' Equity and other reserves					
Revaluation reserve		141		54	
SoCNE reserve		(9,929)		(6,992)	
Total equity			**(9,788)**		**(6,938)**

The financial statements on pages 88 to 120 were approved by the Board on 17 June 2021 and were signed on its behalf by:

Signed  (Chairman) Date 17th June 2021

Signed (Chief Executive - Interim) Date 17th June 2021

The notes on pages 92 to 120 form part of these accounts.

Statement of Cash Flows for the Year Ended 31 March 2021

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Public Health Agency during the reporting period. The statement shows how the Public Health Agency generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Public Health Agency. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Public Health Agency's future public service delivery.

	NOTE	2021 £000	2020 £000
Cash flows from operating activities			
Net surplus after interest/Net operating expenditure	SoCNE	(80,516)	(73,310)
Adjustments for non cash costs	3	223	219
(Increase)/decrease in trade and other receivables	12	(1,531)	(1,271)
Increase/(decrease) in trade payables	13	4,669	3,385
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment	13	10	(10)
Movements in payables relating to the purchase of intangibles	13	(560)	9
Use of provisions	14	0	(10)
Net cash outflow from operating activities		(77,705)	(70,988)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(495)	(70)
(Purchase of intangible assets)	6	230	(20)
Net cash outflow from investing activities		(265)	(90)
Cash flows from financing activities			
Grant in aid		77,554	71,394
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements			
Net financing		77,554	71,394
Net increase (decrease) in cash & cash equivalents in the period		(416)	316
Cash & cash equivalents at the beginning of the period	11	887	571
	11	**471**	**887**

The notes on pages 92 to 120 form part of these accounts.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2021

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

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2019		**(5,098)**	**50**	**(5,048)**
Changes in Taxpayers' Equity 2019/20				
Grant from DoH		71,394	0	71,394
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(73,310)	4	(73,306)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	22	0	22
Balance at 31 March 2020		**(6,992)**	**54**	**(6,938)**
Changes in Taxpayers' Equity 2020/21				
Grant from DoH		77,554	0	77,554
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(80,513)	87	(80,426)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	22	0	22
Balance at 31 March 2021		**(9,929)**	**141**	**(9,788)**

The notes on pages 92 to 120 form part of these accounts.

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

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

The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Public Health Agency (PHA) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the PHA are described below. They have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

In addition, due to the manner in which the PHA is funded, the Statement of Financial Position will show a negative position. In line with the FReM, sponsored entities such as the PHA which show total net liabilities, should prepare financial statements on a going concern basis. The cash required to discharge these net liabilities will be requested from the Department when they fall due, and is shown in the Statement of Changes in Taxpayers' Equity.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and inventories.

1.2 Currency and Rounding

These accounts are presented in UK Pounds (£) sterling. The figures in the accounts are shown to the nearest £1,000, which may give rise to rounding differences.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Buildings, Plant & Machinery, Information Technology, and Furniture & Fittings.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the PHA;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and

- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

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

Valuation of Land and Buildings

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

Assets under Construction (AUC)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use. The PHA had no AUC in either 2020/21 or 2019/20.

Short Life Assets

Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where estimated life of fixtures and equipment exceed 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of "non-current assets held for sale" are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the PHA expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

The following asset lives have been used.

Asset Type	Asset Life
Freehold Buildings	25 – 60 years
IT assets	3 – 10 years
Intangible assets	3 – 10 years
Other Equipment	3 – 15 years

1.5 Impairment loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure (SoCNE). If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the SoCNE and an amount up to the value of the impairment in the revaluation reserve is transferred to the SoCNE Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the SoCNE to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.6 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure which meets the definition of capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the PHA's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and intangible Assets under

Construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the PHA's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life.

They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the PHA where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition may be capitalised if the group is at least £5,000 in value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current assets held for sale

The PHA had no non-current assets held for sale in either 2020/21 or 2019/20.

1.9 Inventories

The PHA had no inventories as at 31 March 2021 or 31 March 2020.

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed necessary in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to

determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

Income relates directly to the activities of the PHA and is recognised when, and to the extent that a performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised.

Where the criteria to determine whether a contract is in existence are not met, income is classified as Other Operating Income within the Statement of Comprehensive Net Expenditure (SoCNE) and is recognised when the right to receive payment is established.

Income is stated net of VAT.

Grant in aid

Funding received from other entities, including the DoH is accounted for as grant in aid and is reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The PHA did not hold any investments in either 2020/21 or 2019/20.

1.12 Research and Development expenditure

Research and development expenditure is expensed in the year it is incurred in accordance with IAS 38.

Following the introduction of the 2010 European System of Accounts (ESA10) from 2016/17, there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure. As a result, additional disclosures are included in the notes to the accounts.

1.13 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The PHA as lessee

The PHA held no finance leases during 2020/21 or 2019/20.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and buildings components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general principle set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The PHA as lessor

The PHA did not have any lessor agreements in either 2020/21 or 2019/20.

1.16 Private Finance Initiative (PFI) transactions

The PHA had no PFI transactions during 2020/21 or 2019/20.

1.17 Financial instruments

- Financial assets

Financial assets are recognised on the Statement of Financial Position when the DoH body becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. IFRS 9 requires consideration of the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the PHA's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument, where judged necessary.

Financial assets are classified into the following categories:

- financial assets at fair value through Statement of Comprehensive Net Expenditure;
- held to maturity investments;
- available for sale financial assets; and
- loans and receivables.

- Financial liabilities

The PHA had no financial liabilities in 2020/21 or 2019/20.

- Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with the DoH, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the PHA is not exposed to the degree of financial risk faced by business entities.

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

- Currency risk

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

- Interest rate risk

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

- Credit and liquidity risk

Since the PHA receives the majority of its funding from the DoH, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the PHA has a present legal or constructive obligation as a result of a past event, it is probable that the PHA will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting year, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows as at 31 March 2021, using the discount rates issued by the Department of Finance (DoF) below.

Rate	Time period	Real rate
Nominal	Short term (0 – 5 years)	(0.02)%
	Medium term (5 – 10 years)	0.18%
	Long term (10 - 40 years)	1.99%
	Very long term (40+ years)	1.99%
Inflationary	Year 1	1.2%
	Year 2	1.6%
	Into perpetuity	2.0%

Note that the Public Expenditure System (PES) issued a combined nominal and inflation rate table to incorporate the two elements – please refer to this table as necessary, as included within issuing e-mail of circular HSC(F) 40-2020.

The discount rate to be applied for employee early departure obligations is -0.95% for 2020/21.

The PHA has also disclosed the carrying amount at the beginning and end of the year, additional provisions made, amounts used during the year, unused amounts reversed during the year and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the PHA has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the PHA develops a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it.

The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the PHA.

1.19 Contingent liabilities/assets

In addition to contingent liabilities disclosed in accordance with IAS 37, the PHA discloses for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the PHA discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the PHA. A contingent asset is disclosed where an inflow of economic benefits is probable.

The PHA had no contingent liabilities or assets as at 31 March 2021 or 31 March 2020.

1.20 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2021. Untaken flexi leave is estimated to be immaterial to the PHA and has not been included.

Retirement benefit costs

Past and present employees are covered by the provisions of the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the PHA and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The PHA is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Pension Scheme can be found in the HSC Pension Scheme Statement in the Departmental Resource Account for the Department of Health.

The costs of early retirements, except those for ill-health retirements, are met by the PHA and charged to the Statement of Comprehensive Net Expenditure at the time the PHA commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years. However, it has been noted

in HM Treasury guidance that the validation and processing of some of the Schemes' data may not be finalised until after the 2020/21 accounts are laid. Schemes are not automatically required to reflect 2020 scheme valuation data in the 2020/21 accounts. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in 2020/21 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

1.22 Value Added Tax (VAT)

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.23 Third party assets

The PHA had no third party assets in 2020/21 or 2019/20.

1.24 Government Grants

The PHA had no government grants in 2020/21 or 2019/20.

1.25 Losses and Special Payments

Losses and special payments are items that the Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the PHA not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.26 Accounting standards that have been issued but have not yet been adopted

Under IAS 8 there is a requirement to disclose those standards issued but which are either not yet effective or adopted.

IFRS 16 *Leases* replaces IAS 17 *Leases* and is effective with EU adoption from 1 January 2019. In line with the requirements of the FReM, IFRS 16 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2022.

IFRS 17 *Insurance Contracts* will replace IFRS 4 *Insurance Contracts* and is effective for accounting periods beginning on or after 1 January 2023. In line with the requirements of the FReM, IFRS 17 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2023.

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

1.27 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2021. Due to changes in the template, there have been amendments to the layout and display of some figures.

NOTE 2 - ANALYSIS OF NET EXPENDITURE BY SEGMENT

The PHA has identified 4 segments: Commissioning, Family Health Services (FHS), Administration, and Safeguarding Board NI - an independent body hosted by the PHA. Net expenditure is reported by segment as detailed below:

Summary	NOTE	2021 £000	2020 £000
Commissioning	2.1	97,948	97,243
FHS	2.2	2,983	2,352
Agency Administration	2.3	29,592	22,027
Safeguarding Board NI	2.4	729	1,614
Total Commissioner Resources utilised		**131,252**	**123,236**

2.1 Commissioning

Expenditure	NOTE	2021 £000	2020 £000
Belfast Health & Social Care Trust	SoCNE	19,706	18,942
South Eastern Health & Social Care Trust	SoCNE	5,386	5,113
Southern Health & Social Care Trust	SoCNE	7,929	7,473
Northern Health & Social Care Trust	SoCNE	9,445	9,966
Western Health & Social Care Trust	SoCNE	7,981	8,201
NIAS Health & Social Care Trust	SoCNE	87	93
NI Medical & Dental Training Agency	SoCNE	167	138
PCC	SoCNE	35	0
Other	3.1	50,682	50,413
		101,418	100,339
Income			
Revenue from contracts with customers	4.1	3,471	3,096
Commissioning Net Expenditure		**97,948**	**97,243**

2.2 FHS

FHS Net Expenditure	3.1	**2,983**	**2,352**

NOTE 2 - ANALYSIS OF NET EXPENDITURE BY SEGMENT

2.3 Agency Administration

Expenditure	NOTE	2021 £000	2020 £000
Salaries and wages		27,050	19,411
Operating expenditure	3.2	2,808	2,727
Non-cash costs	3.3	22	33
Depreciation	3.3	201	186
		30,081	22,357
Other Operating Income			
Staff secondment recoveries	4.2	489	330
Administration Net Expenditure		**29,592**	**22,027**

2.4 Safeguarding Board NI

Expenditure			
Salaries and wages	3.2	407	814
Operating expenditure	3.2	322	502
Programme Expenditure	3.1	0	298
		729	1,614
Safeguarding Board NI Net Expenditure		**729**	**1,614**

NOTE 3 EXPENDITURE

3.1 Commissioning:	2021 £000	2020 £000
General Medical Services	2,983	2,352
Other providers of healthcare and personal social services	39,893	39,827
Research & development capital grants	10,789	10,884
Total Commissioning	**53,666**	**53,063**

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	21,458	15,295
Social security costs	2,179	1,674
Other pension costs	3,820	3,256
Supplies and services - general	272	98
Establishment	2,159	2,350
Transport	3	13
Premises	546	666
Rentals under operating leases	150	102
Total Operating Expenses	**30,587**	**23,454**

3.3 Non cash items:		
Depreciation	150	124
Amortisation	50	62
Loss on disposal of property, plant & equipment (including land)	1	1
Increase / Decrease in provisions (provision provided for in year less any release)	0	10
Cost of borrowing of provisions (unwinding of discount on provisions)	0	0
Auditors remuneration	22	22
Total non cash items	**223**	**219**
Total	**84,476**	**76,736**

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

During the year the PHA paid its share of regional audit services (£1250) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and this amount is included in operating costs above.

Reclassification of R&D as commissioning expenditure has changed the expenditure analysis above

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers	2021	2020
	£000	£000
R&D	3,421	2,833
Other income from non-patient services	50	68
Social Investment Fund	0	195
Total	**3,471**	**3,096**

4.2 Other Operating Income	2021	2020
	£000	£000
Seconded staff	489	330
Total	**489**	**330**

TOTAL INCOME	**3,960**	**3,426**

NOTE 5.1 - Property, Plant & Equipment - Year Ended 31 March 2021

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2020	215	650	38	903
Indexation	0	0	1	1
Additions	0	470	15	485
Transfers	0	90	0	90
Disposals	(3)	(218)	0	(221)
At 31 March 2021	**212**	**992**	**54**	**1,258**
Depreciation				
At 1 April 2020	136	433	19	588
Indexation	0	0	0	0
Transfers	0	4	0	4
Disposals	(3)	(217)	0	(220)
Provided during the year	41	101	8	150
At 31 March 2021	**174**	**321**	**27**	**522**
Carrying Amount				
At 31 March 2021	**38**	**671**	**27**	**736**
At 31 March 2020	**79**	**217**	**19**	**315**
Asset financing				
Owned	38	671	27	736
Carrying Amount				
At 31 March 2021	**38**	**671**	**27**	**736**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £nil (2020 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2020 - £nil).

NOTE 5.2 - Property, Plant & Equipment - Year Ended 31 March 2020

	Buildings (excluding dwellings) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation				
At 1 April 2019	206	639	31	876
Indexation	9	0	0	9
Additions	0	74	7	81
Disposals	0	(63)	0	(63)
At 31 March 2020	**215**	**650**	**38**	**903**
Depreciation				
At 1 April 2019	92	416	13	521
Indexation	5	0	0	5
Disposals	0	(62)	0	(62)
Provided during the year	39	79	6	124
At 31 March 2020	**136**	**433**	**19**	**588**
Carrying Amount				
At 31 March 2020	**79**	**217**	**19**	**315**
At 1 April 2019	**114**	**223**	**18**	**355**
Asset financing				
Owned	79	217	19	315
Carrying Amount				
At 31 March 2020	**79**	**217**	**19**	**355**
Asset financing				
Owned	114	223	18	355
Carrying Amount				
At 1 April 2019	**114**	**223**	**18**	**355**

NOTE 6.1 - Intangible Assets - Year Ended 31 March 2021

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2020	91	298	389
Indexation	0	0	0
Additions	237	93	330
Disposals	(63)	(99)	(162)
At 31 March 2021	**265**	**292**	**557**
Amortisation			
At 1 April 2020	72	207	279
Indexation	0	0	0
Disposals	(63)	(99)	(162)
Provided during the year	10	40	50
At 31 March 2021	**19**	**148**	**167**
Carrying Amount			
At 31 March 2021	**246**	**143**	**390**
At 31 March 2020	**19**	**91**	**110**
Asset financing			
Owned	246	143	390
Carrying Amount			
At 31 March 2021	**246**	**143**	**390**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2020 - £nil).

NOTE 6.2 - Intangible Assets - Year Ended 31 March 2020

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2019	91	287	378
Additions	0	11	11
At 31 March 2020	**91**	**298**	**389**
Amortisation			
At 1 April 2019	63	154	217
Provided during the year	9	53	62
At 31 March 2020	**72**	**207**	**279**
Carrying Amount			
At 31 March 2020	**19**	**91**	**110**
At 31 March 2019	**28**	**133**	**161**
Asset financing			
Owned	19	91	110
Carrying Amount			
At 31 March 2020	**19**	**91**	**110**
Asset financing			
Owned	28	133	161
Carrying Amount			
At 31 March 2019	**28**	**133**	**161**

NOTE 7 - FINANCIAL INSTRUMENTS

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

NOTE 8 - IMPAIRMENTS

The PHA had no impairments in 2020/21 or 2019/20.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

The PHA did not hold any assets classified as held for sale in 2020/21 or 2019/20.

NOTE 10 - INVENTORIES

The PHA did not hold any inventories as at 31 March 2021 or 31 March 2020.

NOTE 11 - CASH AND CASH EQUIVALENTS

	2021 £000	2020 £000
Balance at 1st April	887	571
Net change in cash and cash equivalents	(416)	316
Balance at 31st March	**471**	**887**

The following balances at 31 March were held at	2021 £000	2020 £000
Commercial banks and cash in hand	471	887
Balance at 31st March	**471**	**887**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2021 £000	2020 £000
Amounts falling due within one year		
Trade receivables	665	133
Deposits and advances	259	282
VAT receivable	549	361
Other receivables - not relating to fixed assets	2,681	1,835
Trade and other receivables	**4,154**	**2,611**
Prepayments and accrued income	12	21
Other current assets	**12**	**21**
TOTAL TRADE AND OTHER RECEIVABLES	**4,154**	**2,611**
TOTAL OTHER CURRENT ASSETS	**12**	**21**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**4,166**	**2,632**

The balances are net of a provision for bad debts of £nil (2020 £nil).

NOTE 13 TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2021 £000	2020 £000
Amounts falling due within one year		
Other taxation and social security	502	545
Trade capital payables - property, plant and equipment	0	10
Trade capital payables - intangibles	565	5
Trade revenue payables	8,730	5,211
Payroll payables	2,565	1,179
BSO payables	172	2,069
Other payables	2,800	1,269
Accruals	0	0
Deferred Income	217	594
Trade and other payables	**15,551**	**10,882**
Total payables falling due within one year	**15,551**	**10,882**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**15,551**	**10,882**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2021

	Other £000	2021 £000
Balance at 1 April 2020	0	0
Provided in year	0	0
(Provisions not required written back)	0	0
(Provisions utilised in the year)	0	0
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2021	**0**	**0**

Comprehensive Net Expenditure Account charges	2021 £000	2020 £000
Arising during the year	0	10
Reversed unused	0	0
Cost of borrowing (unwinding of discount)	0	0
Total charge within Operating expenses	**0**	**10**

Analysis of expected timing of discounted flows

	Other £000	2021 £000
Not later than one year	0	0
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2021	**0**	**0**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2020

	Other £000	2020 £000
Balance at 1 April 2019	0	0
Provided in year	10	10
(Provisions not required written back)	0	0
(Provisions utilised in the year)	(10)	(10)
Cost of borrowing (unwinding of discount)	0	0
At 31 March 2020	**0**	**0**

Analysis of expected timing of discounted flows

	Other £000	2020 £000
Not later than one year	0	0
Later than one year and not later than five years	0	0
Later than five years	0	0
At 31 March 2020	**0**	**0**

NOTE 15 - CAPITAL AND OTHER COMMITMENTS

The PHA did not have any capital or other commitments as at 31 March 2021 or 31 March 2020.

NOTE 16 - COMMITMENTS UNDER LEASES

16.1 Finance Leases

The PHA had no finance leases in 2020/21 or 2019/20.

16.2 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise	2021 £000	2020 £000
Buildings		
Not later than 1 year	221	106
Later than 1 year and not later than 5 years	39	67
Later than 5 years	0	0
	260	**173**

16.3 Commitments under Lessor Agreements

The PHA had no lessor obligations in either 2020/21 or 2019/20.

NOTE 17 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT

The PHA had no commitments under PFI or service concession arrangements in either 2020/21 or 2019/20.

NOTE 18 - OTHER FINANCIAL COMMITMENTS

The PHA did not have any other financial commitments at either 31 March 2021 or 31 March 2020.

NOTE 19 - CONTINGENT LIABILITIES

Employers' liability

	2021 £000	2020 £000
Employers' liability	2	2
Amount recoverable through non cash RRL	(2)	(2)
Total	0	0

In addition to the above contingent liability, provision for employers' liabilites is given in Note 14. Other litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

A cyber security incident took place at Queen's University Belfast (QUB) in February 2021. As the HSC has multiple contractual interactions with QUB, some concerning personal information, the HSC technology teams, with the backing of the HSC SIRO's, took a number of actions to reduce potential disruption to HSC services, and continue to liaise with QUB on the impact of the cyber incident. The impact on the HSC is being fully investigated, and there may be a financial risk in relation to possible future liability, for potential claims for loss of personal data. As the breach occurred in a third party's systems the potential for liability is unclear and any financial impact is unquantifiable at present.

NOTE 20 - RELATED PARTY TRANSACTIONS

The PHA is an arms length body of the Department of Health and as such the Department is a related party with which the PHA has had various material transactions during the year. In addition, the PHA has material transactions with HSC Trusts.

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

NOTE 21 - THIRD PARTY ASSETS

The PHA had no third party assets in 2020/21 or 2019/20.

NOTE 22 - FINANCIAL PERFORMANCE TARGETS

22.1 Revenue Resource Limit

The PHA is given a Revenue Resource Limit which it is not permitted to overspend.

The Revenue Resource Limit (RRL) for PHA is calculated as follows:

	2021 Total £000	2020 Total £000
DOH (excludes non cash)	117,983	109,793
Other Government Departments	496	486
Non cash RRL (from DOH)	223	219
Total agreed RRL	118,702	110,498
Adjustment for Research and Development under ESA10	12,656	12,857
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**131,358**	**123,355**

22.2 Capital Resource Limit

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

	2021 Total £000	2020 Total £000
Gross capital expenditure	815	92
Net capital expenditure	815	92
Capital Resource Limit	13,719	12,942
Adjustment for Research and Development under ESA10	(12,656)	(12,852)
Overspend/(Underspend) against CRL	**(248)**	**2**

22.3 Financial Performance Targets

The PHA is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits.

	2021 £000	2020 £000
Net Expenditure	(131,252)	(123,236)
RRL	131,358	123,355
Surplus / (Deficit) against RRL	106	119
Break Even cumulative position(opening)	1,715	1,596
Break Even cumulative position (closing)	**1,821**	**1,715**

Materiality Test:	2020/21 %	2019/20 %
Break Even in year position as % of RRL	0.08%	0.10%
Break Even cumulative position as % of RRL	1.39%	1.39%

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

NOTE 23 - EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period having a material effect on the accounts.

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 30th June 2021.