Health and Social Care Board

2019/20

ANNUAL REPORT & ACCOUNTS

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2020

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ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2020

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PERFORMANCE REPORT

Welcome to the Health and Social Care Board's Annual Report covering the financial year 2019/20.

About the Health and Social Care Board

The Health and Social Care Board (HSCB) is a non-profit making statutory body responsible for the commissioning of health and social care services for the population of Northern Ireland. The role of the HSCB is broadly contained across three functions:-

1. To arrange or 'commission' a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland.

2. To performance manage Health and Social Care Trusts that directly provide services to people and support service improvements in pursuit of optimal quality and value for money, in line with relevant government targets.

3. To effectively deploy and manage its annual funding from the Northern Ireland Executive – currently around £5.6 billion – to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

The HSCB is accountable to the Department of Health (DoH) and for translating the vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

The work of the HSCB has the potential to reach everyone at some point in their lives – its expenditure amounts to around £15 million on every single day of the year – as it strives to ensure that services provided daily, to people in their homes, by their GP, in hospital or in the community, deliver what is expected of them.

The HSCB is required by statute to prepare and publish a Commissioning Plan in response to the DoH issuing a Commissioning Plan Direction, setting out the range of services to be commissioned and the associated costs of delivering these. The HSCB prepares the annual Commissioning Plan in partnership with the Public Health Agency (PHA) and publishes this Commissioning Plan on the website www.hscboard.hscni.net.

The HSCB and PHA take forward the regional commissioning agenda through a series of integrated service teams. The HSCB's commissioning processes are currently underpinned by the five Local Commissioning Groups (LCGs) which are

Committees of the HSCB, and are responsible for ensuring that the health and social care needs of local populations across Northern Ireland are addressed. The groups are geographically coterminous with each of the five Health and Social Care Trusts that directly provide services to the community.

The LCGs incorporate a range of professional interests such as GPs, nurses, dentists, pharmacists and social workers, as well as voluntary and elected representatives, to ensure that the work of the HSCB has sensitivity and influence at a local level. The PHA is also represented on each of the five LCGs.

All of the service teams responsible for commissioning services are comprised of HSCB and PHA staff, demonstrating the common agenda shared by both organisations and the close working with one another.

The HSCB also commissions services from voluntary and community organisations. This feeds directly into local economies and is responsive to local demands. These approaches are underpinned by effective stakeholder engagement and Personal and Public Involvement.

The HSCB is committed to embedding Personal and Public Involvement into its culture and practice. It is currently implementing a joint Personal and Public Involvement Strategy with the Public Health Agency (available online at www.hscboard.hscni.net/publications). This Strategy aims to ensure that service users, carers and the public influence the planning, commissioning and delivery of health and social care services in ways that are meaningful to them.

Welcome to the Health and Social Care Board's Annual Report covering the financial year 2019/20.

Objectives for 2019/20

The HSCB's Corporate Plan sets out the key objectives, grouped under six themes, which reflect how the organisation will conduct its business and manage its resources to ensure that the HSCB commissions, and supports, the delivery of high quality health and social care services.

The six themes are:-

Theme 1: Ensure high quality, safe, accessible and integrated health and social care services, and performance manage delivery to achieve quality outcomes.

Theme 2: To improve the health and social wellbeing of the population of Northern Ireland with a focus on prevention and health inequalities, promoting equality, human rights and diversity in all the HSCB's functions.

Theme 3: Provide value for money through the effective use of resources ensuring robust financial management.

Theme 4: Effectively working in partnership with key stakeholders in an open and transparent manner, particularly with those who are representative of the lived and learned experience of services, sharing decision making and benefiting from their personal experiences to identify and drive improvements in outcomes.

Theme 5: Maintain and develop effective internal systems and processes and maximise the potential of our staff by ensuring that they are skilled, motivated and valued.

Theme 6: Delivering Together Transformational Activity

Chair's Report

It is with great pleasure that I present to you the Annual Report of the Health and Social Care Board for 2019/20.

I came on board as chairman in the midst of the biggest challenge for the health and social care system in Northern Ireland in a generation. Every day, I am humbled by the dedication of staff across the entire system in their tireless effort during the COVID19 pandemic.

The HSCB has played a key role in supporting Trusts and the wider system in relation to the coronavirus (COVID-19) outbreak.

However, I would like to take the opportunity to acknowledge and celebrate other achievements and successes of the past year.

One of the key success stories over the past year has been the transition of services to a community or primary care setting to reduce waiting times for patients, in line with the Delivering Together plan to transform health and social care.

The roll out of multidisciplinary teams within GP practices has enabled patients to be seen by a wider range of health professionals such as pharmacists, physiotherapists, social workers, mental health practitioners alongside nurses and GPs.

Minor surgery services being delivered via GPs practices now include gynaecology, dermatology and vasectomy. More than 9000 patient assessments and treatments were carried out in 2019/20 with GPs being upskilled to deliver this.

In dental care provision, we see waiting times for oral surgery reduced from at least 52 weeks to approximately 8 to 10 weeks, when oral surgery procedures are delivered by specially trained high street dentists instead of in hospitals.

As non-executive board members, representing the interests of the public, we believe that meaningful engagement with patients, their families and carers, is key to the effective planning and design of quality health and social care services. Our ongoing commitment to this is reflected under Theme 4 of this report and in Section 6 of the Governance Statement. These illustrate a range of initiatives involving key stakeholders in the development, co-ordination and improvement of services.

Despite ongoing pressures and demands, I am pleased to report that the HSCB has met its financial commitments, achieved by significant effort on the part of the Finance Directorate, working closely with staff across the organisation. Further details about the financial position are shown under Theme 3.

Over the last four years, the Health and Social Care Board (HSCB) has been going through a major period of transition following the announcement in November 2015 that the organisation was to close.

The Department of Health has confirmed that we are now working towards a closure date of March 2022 dependent on the necessary legislation.

The imminent closure has continued to present risks to business continuity and the workforce in the last 12 months. I appreciate the dedication demonstrated by our staff for their sustained hard work during these unsettled times and I am confident they will continue to commission and support the delivery of health and social care services for the people of Northern Ireland.

I would also like to thank my predecessor, Ian Clements, for his guidance and careful stewardship of the organisation and non-executive directors, Robert Gilmore and Brendan McKeever, whose terms ended this year, for their contribution in strengthening governance.

I am grateful too, to both the executive team and my fellow non-executive board members for their support during these uncertain and changing times, as I step into the role.

Les Drew

Chair

Overview from Chief Executive

The 2019/2020 year has certainly turned out far more eventful than many of us would have anticipated. It would be fair to say that the COVID-19 pandemic has overshadowed much of the other progressive work that has gone on this year.

The entire HSC system has worked creatively, flexibly and cooperatively to ensure the people of Northern Ireland continue to access health and social care services.

The pandemic shone a light on the dedication and commitment of health and social care workers right across Northern Ireland who went above and beyond to save lives, care for the sick and minimise the spread of infection.

It also highlighted the great affection that exists for the HSC amongst the Northern Ireland public.

It is, however, very important to highlight some of the challenges and achievements of 2019/2020 against the delivery of key objectives set out in the HSCB Corporate Plan.

Waiting times across Northern Ireland for outpatient, diagnostic, inpatient and day cases remain a significant challenge.

During 2019/20, there was also a significant rise in the number of patients who waited longer than 12 hours to be seen, treated or discharged in Emergency Departments. These waiting times should be seen in the context of the number of patients attending which has increased by 10% over the last five years.

These pressures are a symptom of the wider challenges faced throughout primary, secondary, community and social care, which can only be solved by continuing to transform the way we deliver services.

And I very much welcome the proactive work ongoing to change how we design, deliver and access services. For example:

- The introduction of the Virtual Fracture Clinic has helped reduce demand in fracture clinics by about 25%.
- Prototypes for Day Case Surgery hubs for varicose vein and cataract procedures have been operational since December 2018. The hubs provide day procedures on a fewer number of specialised sites, separated from emergency care, to maximise activity and minimise the risk of cancellations.
- A number of reviews in areas such as stroke, breast assessment and urgent and emergency care are ongoing to ensure services are configured best to meet future demand.

The multidisciplinary team model continues to be rolled out across Northern Ireland and involves physiotherapists, mental health specialists and social

workers working from GP practices. The model also provides significant investment in additional nursing specialist roles such as health visiting, benefitting approximately 675,000 people.

The encompass Programme, an HSC-wide digital transformation initiative continues at pace. In February 2020, the South Eastern Health and Social Care Trust was selected as the first HSCNI organisation to implement the integrated digital patient record which will allow healthcare professionals to access patient information on a range of devices, wherever they are, safely and securely.

In response to the significant pressures facing the social care sector, which have been starkly highlighted during the current pandemic, the Health Minister has announced that he plans to move ahead with reform and investment plans, subject to the necessary financial support being provided by the Executive.

This has to be very much welcomed and essential transformation of the sector will continue to be supported by the HSCB and the wider HSC.

Over the winter period, we also had to manage the impact of industrial action, which began in November, and had a serious impact across all HSC Trusts with significant disruption to many services. It was a major undertaking by all HSC organisations to manage the situation and plan for contingencies and I welcome the pay award deal and the commitment on safe staffing levels which was agreed between the Department of Health and the unions, endorsed by the Executive

Despite the challenging financial position, I'm pleased to say that with careful financial management, at the end of 2019/20, the wider HSC showed a breakeven position.

Looking forward to 2020/21, one of our key challenges will be to manage the recovery of post-pandemic services, balancing that against the continuing threat of COVID-19 and a background of challenging waiting lists and times.

We will need to retain significant capacity and flexibility while separating COVID care and non-COVID care as much as is feasibly possible. It will require time and patience and ongoing funding but as the Minister of Health has said, this is also an opportunity for us to do things differently and embrace the important innovations that have been introduced in the midst of this emergency.

The current financial context will significantly limit additional resources available for health and social care development. As has been so often said in recent years, money alone will not solve the health crisis in Northern Ireland. Additional investment will be very welcome, but the long term answer remains in the transformation of services.

The anticipated closure date of the Health and Social Care Board remains March 2022 subject to the relevant legislation being in place. Engagement is ongoing with key stakeholders on the future model of planning services.

Overview of Organisational Performance

Corporate Objectives

Our Corporate Objectives are grouped under six key themes set out within the overview. The HSCB Corporate Plan for 2019/20 was approved by the Board of the HSCB at its meeting in June 2019 and subsequently approved by the Department of Health.

Financial Management

The HSCB received an opening allocation for 2019/20 of £5.1bn from the DoH to commission health and social care services for the population of Northern Ireland. During the year this funding was supplemented by £500m of non-recurrent allocations, comprising the second year of the transformation funding relating to the Confidence & Supply agreement between the Conservative Party and the Democratic Unionist Party (£94m); Pay Review (£120m) and various other allocations.

In addition to this, the HSCB received £57m of income from other sources, which primarily consisted of £26m from the Department for Education for the delivery of Early Years Children's Services (SureStart) and £26m of Family Health Service receipts, mainly relating to dental and medical services.

At the end of 2019/20 the HSCB achieved a financial position of £22.3m surplus against its Revenue Resource Limit (RRL) of £5.6bn. This position has been carefully managed in conjunction with colleagues in the Department of Health to ensure the wider HSC achieves a breakeven position for the year. Of the £22.3m surplus, £21.7m was held to offset pressures in Trusts, with the remaining £0.6m arising from surpluses on internal budgets with HSCB.

Developing Services

The HSCB working with the Public Health Agency, Trusts and other key partners have played a key role in developing a range of new and innovative health and social care services aimed at keeping people well; providing care closer to communities in the first place; and ensuring that when people need specialist care it is organised and available in a way that leads to the best possible outcomes. The Performance Analysis report below provides examples of these developments.

Key Issues and Risks

During 2019/20, we have continued to drive forward improved outcomes for patients and service users in line with Departmental direction. We remain committed to creating a modern 'patient centred' system that is able to respond to increasing demand, whilst ensuring the best and most effective use of resources for the population.

Whilst we continued to address a number of key corporate risks throughout the year, the emergence of the Novel Coronavirus – COVID-19 in late February/March 2020 has had a significant impact on the operations of the organisation.

Directorate Business Continuity Plans have been initiated and available resources were diverted to respond to the developing situation and to ensure that critical and statutory functions are delivered during this period of interruption to normal business.

Section 10b of the Governance Statement provides full details of key issues and risks.

PERFORMANCE ANALYSIS

The performance analysis has been carried out in line with the 2019/20 Corporate Plan and the 2019/20 Commissioning Plan.

Large scale industrial action during December 2019 and January 2020 and the impact of COVID-19 response began to be evidenced in performance across all HSC sectors within the final 4-6 weeks of the 2019/20 year.

Theme 1 – Providing high quality, safe and accessible care

The provision of high quality, safe and accessible care through commissioned services delivered by the Trusts and other stakeholders remains a key priority for the HSCB. The HSCB is responsible not just for the performance management of services delivered through hospital-based care, but also care delivered in the community by GPs, dentists, pharmacists, ophthalmology and social care services. The performance of the six Trusts, including the NI Ambulance Service, is reported on a monthly basis and these reports are available on the HSCB website. A number of key areas of work are highlighted below.

1.1 Enhancing Unscheduled Care

Pressures on our emergency services continue across Northern Ireland, similar to other regions of the UK and Ireland. During 2019/20, there was a significant rise in the number of patients who waited longer than 12 hours in an Emergency Department (ED) (from 25,326 in 2018/19 to 45,442 in 2019/20) and performance against the 4-hour target remained below the level required – during 2019/20, 65% of patients attending an ED were either treated and discharged home, or admitted, within four hours of their arrival (target: 95%).

While the number of ED attendances fell slightly to 814,702 in 2019/20 from 822,847 in 2018/19 (-1.1%), the overall number of ED attendances in Northern Ireland has increased by 10% in the last five years. The reduction seen in 2019/20 may be partially explained by the drop in attendances during March 2020, due to pandemic-related concerns.

Despite the move out of the winter period, pressures continued in unscheduled care. In particular, hospitals across Northern Ireland are facing ongoing pressures, resulting in growing numbers of patients waiting longer to be seen, treated, and either discharged or admitted to hospital. The pressures are in part due to an increase in the number of older, sicker people with more complex needs attending EDs and being admitted to hospital, and the challenges in supporting them to return home when they are medically fit.

In preparation for the 2019/20 winter period, the HSCB worked with Trusts to develop detailed plans to enhance the resilience of the system to respond to expected increased pressures during this period.

Furthermore, Transformation Funding was used to fund the following projects in 2019/20:

- In-hospital flow initiatives to support timely management of patient flow and discharge including Phase 2 of the implementation of 7/7 working on base wards; "Control Room / Hub" support; and, Phase 1 of outpatient parental antibiotic therapy (OPAT) which is used to administer non-oral antibiotics without a need for ongoing hospitalisation. OPAT is particularly useful in people who are not severely unwell, but do require a prolonged course of treatment that cannot be given in oral form.
- Further roll-out/expansion of acute/enhanced care at home across four Trusts and introduction of acute care at home services in the Northern Trust to provide both admission avoidance and ability to discharge patients to their home environment to support timely discharge.
- Ambulatory Care – additional and new pathways that facilitate patients who would have previously been admitted to hospital to be managed in an ambulatory service.

Planned, longer term measures will also ease the burden on EDs. Under the Transformation agenda, the Department has been undertaking a clinically led Review of Urgent and Emergency Care services across Northern Ireland. The Review team was targeting submission of its initial report and recommendations to the Department of Health by April 2020, with the aim of then holding a consultation exercise on proposals to develop a sustainable regional care model for the next 10-15 years. Whilst the timeline for the completion of the review has been interrupted due to the need to respond to the COVID-19 pandemic, it is envisaged that some of the early proposals emerging from the work of the review team will be considered as part of ongoing planning for the rebuilding of urgent and emergency care services in the prevailing context of COVID-19.

1.2 Elective Care (Primary Care/Primary & Secondary Care Interface/ Secondary Care)

The Commissioning Plan Direction 2019/20 required that, by March 2020:

- 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;
- 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks; and
- 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment and no patient waits longer than 52 weeks.

At 31 March 2020:

- 21% of patients were waiting less than nine weeks for a first outpatient appointment, compared to 26% at the end of March 2019; 242,864 patients were waiting longer than nine weeks compared to 213,708 at the end of March 2019; and, 117,066 were waiting more than 52 weeks, up from 97,851.
- 46% of patients were waiting less than nine weeks for a diagnostic test compared to 51% at the end of March 2019; 58,639 patients were waiting longer than nine weeks compared to 54,243 at the end of March 2019; and, 28,130 were waiting more than 26 weeks, up from 23,718. While regionally the number of people waiting more than nine and 26 weeks has increased compared with last year, the waiting time position improved during the final quarter of 2019/20 with the number of patients waiting longer than nine and 26 weeks reducing from 69,620 and 36,573 respectively at the end of December 2019.
- 29% of patients were waiting less than 13 weeks for inpatient or day case treatment compared to 34% at the end of March 2019; 66,872 patients were waiting longer than 13 weeks compared to 56,871 at the end of March 2019; and, 30,696 were waiting more than 52 weeks, up from 22,350.

It is unacceptable that any patient has to wait longer than they should for assessment or treatment, and ensuring that patients have access to safe, quality and timely care remains a key priority for the HSC. However, as demand for elective care services continues to exceed health service capacity for both new outpatients and inpatient/daycase treatments, regrettably it is inevitable that waiting times are expected to increase.

Trusts utilised £17.6m non-recurrent funding available from the Confidence and Supply Transformation Fund in 2019/20 to undertake additional elective care activity. As in previous years, this funding was targeted at those with the highest clinical need including those with suspect or confirmed cancer. As a result of this investment, an additional 86,000 assessments, diagnostic tests, inpatient/day case and AHP treatments have been delivered.

Whilst this non-recurrent investment has been helpful and slows the growth in waiting times in the short term, longer term solutions are required to sustain services in the future. The Elective Care Plan (published in February 2017) is still the roadmap for change. While progress to implement the Plan has been slower than hoped, there have been a number of key developments including:

- A pain specific section has gone live on the MyNI website to help people self-manage painful and disabling illnesses.

- Capacity and capability in primary care has been expanded to allow more people to be seen or treated in the GP setting rather than referral to hospital waiting list.
- MDTs are now in place in five GP Federation areas across the province (Derry, Down, Causeway, Newry & District, and West Belfast), one in each Trust area. Not only does this ease pressure for GPs and allows patients to access more services closer to home, but in time will reduce referrals to secondary care.
- GPs can now seek advice from colleagues in secondary care electronically to manage patients locally.

Work has also been taken forward to modernise and reform secondary care:

- The introduction of the Virtual Fracture Clinic has helped reduce demand in fracture clinics by about 25%;
- Prototypes for Day Case Surgery hubs for varicose vein and cataract procedures have been operational since December 2018; and
- A number of reviews in areas such as stroke, breast assessment and urgent and emergency care are ongoing to ensure services are configured best to meet future demand.

Towards the end of 2019/20, the COVID-19 outbreak has placed unprecedented demands on acute services with elective work reduced or postponed in an attempt to free up capacity including staff, beds and critical care services. The need to prioritise resources for coronavirus patients has had a direct impact on those non-coronavirus patients who have been waiting for elective assessment and/ or treatments. As a result, it is inevitable that waiting times for elective care will increase in the coming months as the HSC responds to the current pandemic.

In relation to cancer services, data published by the NI Cancer Register indicates continued improvement in survival for the commonest cancers and that further improvement is expected. To ensure that patients receive the best possible service the performance standards set in relation to access to cancer services are challenging.

Regionally, during 2019/20, 86% of urgent breast cancer referrals were seen within 14 days compared to 92% in 2018/19 (target: 100%). The regional position in 2019/20 is as a result of performance in the Northern HSC Trust (46%) which has been impacted by increased demand and staffing issues. All other Trusts saw 100% of urgent referrals within 14 days during 2019/20.

A public consultation on the proposals for the future model of breast assessment services for the population of Northern Ireland was undertaken during the year. Any changes to the service will be considered in the context of dealing with and addressing the aftermath of the pandemic.

Over the year 93% of people received their first definitive treatment within 31 days (target: 98%) which is broadly unchanged from the 2018/19 (94%) position despite an increase in demand for treatment.

Increased demand for services coupled with recruitment challenges has impacted negatively on 62-day performance (target: 95%). Performance in 2019/20 (51%) was significantly lower than 2018/19 (63%), largely as a result of diagnostic delays, in particular, access to scopes.

In addition to the £17.6m investment from the Transformation Fund for additional elective activity in 2019/20 which was targeted at patients with the highest clinical risk including those with suspected or confirmed cancer, the HSCB allocated non-recurrent funding (£4.3m) to enable Trusts to undertake additional red flag and urgent activity to reduce waiting times for those patients waiting for an endoscopy procedure.

Notwithstanding the pressures associated with the ongoing COVID-19 outbreak, the HSC is continuing to prioritise suspect cancer patients and is using local Independent Sector capacity to procure additional capacity. However, the recovery of elective surgery depends on local capacity and availability of clinical and other services necessary for the delivery of surgery.

1.3 Integrated Care Partnerships (ICPs)

In May 2019, the very welcome confirmation was received that ICPs are now funded on a recurrent basis enabling the Partnerships to be refreshed and to further evolve to reflect the ever changing health and social care environment. An ICP work plan for 2019/20 has been agreed which will see ICPs focus on delivering against a number of transformation priorities in an integrated way at a local level.

ICPs are also contributing to a new area of work sponsored by the Transformation Implementation Group (TIG) to test the development of an Integrated Care System prototype in the Northern area. This programme is being led by the Northern Trust and will test a new way of working which will facilitate much more collaboration and integration in both the planning and the delivery of improved health and wellbeing for the population of Northern area. It is grounded in some of the lessons learned through the ICP programme to date.

1.4 Advances in eHealth

During the year the e-health team continued to develop a wide range of initiatives to support improvement in the delivery of health and social care services.

One example of this was the launch in October 2019, of the apps4dementia library, a new digital service offering support for people living with dementia and their carers.

The encompass Programme continues to progress. This HSC-wide initiative, introducing a digital integrated care record to NI, supports the transformation of health and social care in order to improve health outcomes and create better experiences for those receiving, using and delivering services. In February the South Eastern Health and Social Care Trust was selected as the first HSCNI organisation to implement the digital record.

Following a rigorous and lengthy procurement process to select the right partner to deliver and implement the new system, Epic, was announced in June as the preferred supplier. Development work on the Full Business Case continued and was formally submitted to the Department of Health at the end of July.

1.5 Primary Care

Work continues to transform care within GP practices across Northern Ireland.

In October 2019, it was announced that the multi-disciplinary teams (MDTs) initiative was being expanded into two new areas. The inclusion of Causeway and Newry and District MDTs means approximately 600,000 people will now be able to avail of MDT services on full implementation. MDTs involve the establishment of practice based physiotherapists, mental health specialists and social workers within GP practices. The model also provides significant investment in additional nursing specialist roles such as health visiting.

The primary care infrastructure programme continues and supports service integration and bringing care closer to home, through the co-location of GP services with Trust, community and outpatient services via a “hub and spoke” model.

Investment through refurbishment and extension of existing premises as well as new developments have been taken forward in 2019/20 as part of the rolling programme of investment which is planned to continue over a ten year period. The Lisburn Hub is under construction and business cases have been completed for an additional 2 Hub developments with a further 2 business cases under development.

Ring-fenced funding was secured in 2019/20 for investment in spoke facilities, a total of 67 premises received investment. Business Cases have also been developed for priority investment planned for 2020/21. This investment has addressed urgent need for additional capacity within GP practices as well as enabling additional capacity to support the roll out of multi-disciplinary working to

the first five federation areas (Derry/Londonderry, Down, Belfast (West), Causeway and Newry & District).

Challenges remained in 2019/20 regarding GP recruitment and retention. Work is ongoing to address future GP workforce demands. To further support workforce capacity issues, the GP Retainer scheme was extended from two to three years. There are 25 places available on the scheme, of which 22 places have been filled.

In 2018/19, the HSCB commissioned the Northern Ireland Medical and Dental Training Agency (NIMDTA) to develop a three year pilot scheme. The scheme is intended to help practising GPs who need mentoring support in addressing the challenges that they face. The mentors are GPs and trained appraisers with a broad range of experience. To date:

- 21 mentors have been trained
- 24 GP mentees are engaged in the programme
- 6 mentees have completed mentoring
- 36 mentoring sessions were delivered in 2019/20

1.6 Local Commissioning Groups

The HSCB's commissioning processes are underpinned by the five Local Commissioning Groups (LCGs). LCGs are responsible for ensuring that the health and social care needs of local populations across Northern Ireland are addressed.

Theme 2 – Improving Health and Reducing Inequalities

One of the key priorities for the HSCB, working closely with the PHA, is improving the health and wellbeing of the population of Northern Ireland and reducing inequalities for people living in more deprived communities and circumstances.

Northern Ireland has a population of approximately 1.8 million people and this is projected to rise by a further 5.3% by 2024 (Office for National Statistics). Deprivation has a large impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem, unhealthy lifestyle choices, risk taking behaviour and poor access to health information and quality services. Improving health, and reducing health inequalities, requires us to coordinate action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors.

Major health challenges, as identified in the HSCB Commissioning Plan 2019/20 at www.hscboard.hscni.net, are consistent across our five localities. They include:-

- Changing demographics including a growing ageing population with escalating and complex health needs.
- Poor health compared to the rest of the UK. A major risk to health and wellbeing in Northern Ireland comes from lifestyle factors such as obesity, smoking and alcohol abuse.
- Excess deaths, particularly from heart disease, cancer and respiratory problems. We have increasing numbers of people living with long term conditions or multiple conditions such as COPD, diabetes, stroke, asthma and hypertension.
- An over-reliance on hospital care.
- Health inequalities across the province.

Despite these challenges, in 2019/20 the HSCB worked with other agencies across the health and social care system to deliver some innovative, and life changing, work to improve the health and wellbeing of the population, which is highlighted within the section below.

2.1 Community Planning

The HSCB continues to engage with its Community Planning partners in fulfilment of its obligations, working in partnership with the wider health and social care family, local Councils and other statutory partners, to help implement Community Plans. The plans will provide a shared, long term vision to improving social, health, education, economic and environmental wellbeing and will help to reduce duplication of services and create new and innovative ways of working.

2.2 Social Care

Transformation of Care Homes

In 2019/20, the HSCB, in conjunction with the PHA, held a series of community networking events, aimed at starting a conversation about how people living in a care home setting can be more connected with their local community and have easier access to the many supports available in that community.

Regional Trauma Network

In June 2019, the Health and Social Care Board launched a public consultation on a proposed new service delivery model for trauma services in Northern Ireland. The consultation closed in September 2019 and the responses will be considered in the new financial year.

2.3 High Street Oral Surgery Pilot

In 2019/20 the High Street Oral Surgery Pilot continued. This was implemented in October 2017 to improve access to oral surgery and pre-orthodontic treatment normally outside the competency of General Dental Services but not sufficiently complex to justify referral to Secondary Care. From April 2019 to March 2020 15,600 Health Service patients were treated representing 30% more than in the 2016/17 pre-pilot year. The average waiting time for a patient to be seen under the pilot was 8-10 weeks. Without the pilot most of the additional 3,730 patients would have been referred to Secondary Care where treatment costs are much greater and where over half of Oral Surgery patients currently wait 52 weeks or longer for a first appointment. Feedback from patients, the profession and Trusts in relation to the service delivered through the pilot is very positive. Funding has been approved by DoH to run the scheme for a further 12 months from 1 April 2020, while in parallel a tender is being prepared for a longer-term scheme to run beyond March 2021.

2.4 Pharmacy and Medicines Management

During 2019/20 the Pharmacy First service was available from November 2019 until March 2020. This service allows patients to have a consultation in a private area with their local community pharmacist for advice and treatment for common ailments.

Community pharmacy also launched a flu vaccination pilot, providing flu vaccines to frontline health and social care workers.

Early evaluation of further development of the GP practice based pharmacist role in 2019/20 demonstrated significant benefits. This workforce has demonstrated delivery against objectives and further expansion took place in 2019/20, with yet

further planned, albeit with careful consideration of the emerging pressures on the pharmacy workforce as a whole.

Work also continues with primary care providers and the public to reduce medicine waste. Substantial efficiencies have been achieved through optimising prescribing choice, increasing generic prescribing and the review of unnecessary medicines.

There have also been challenges in seeking the expansion of certain drug misuse schemes such as the needle and syringe exchange service. Through pro-active community engagement, it is anticipated that further sites will be identified leading to reduction in the risk of discarded drugs paraphernalia and reduction of risk of hepatitis and other blood borne diseases for those who are injecting drugs.

2.5 Building Capacity in Ophthalmology Services

The significant project to establish Cataract Daycase Elective Care Centres was realised in 2019/20.This initiative is one of the prototypes for wider elective care reform. As envisaged in 'Health and Wellbeing 2026 - Delivering Together' and the subsequent Elective Care Plan, the aim is to eventually provide capacity for up to 100,000 elective assessments and procedures annually, delivered in non-acute centres of excellence geographically distinct from acute centres with Category 1 Emergency Departments.

Theme 3 - Providing value for money through the effective use of resources ensuring robust financial management

The HSCB is responsible for balancing the challenges of commissioning safe and sustainable services which meet the emerging and changing needs of local populations within the financial resource constraints and the aim of ensuring resources available are maximised.

The Finance Directorate of the HSCB works closely with the DoH to deliver financial planning and financial management of the overall HSC budget.

3.1 Financial Planning

The HSCB worked closely with DoH and Trusts to prepare a Financial Plan for 2019/20, taking into account the significant budgetary constraints and varied and mounting pressures across the HSC sector. This Financial Plan was supported by the development of Trust Delivery Plans (TDPs) which were scrutinised by the HSCB and DoH.

Looking forward into 2020/21, the current financial context significantly limits the additional resources available for health and social care developments and requires the HSC system to deliver very challenging financial savings targets.

The ongoing response to the COVID-19 pandemic will severely limit opportunities for the health and social care system to identify cash releasing savings, as well as bringing with it a range of additional 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 impact on the quality and safety of health and social care services which the HSCB, along with the sector, continues to try to mitigate.

3.2 HSC Financial Stability

The HSCB works with the DoH to ensure the overall financial stability of the health and social care system within Northern Ireland including the Trusts, HSCB and the PHA. The significant and ongoing financial constraints required rigorous planning, monitoring, management and decision making with respect to the budget by the HSCB and DoH during 2019/20.

Throughout the year, the HSCB worked closely and proactively with all Trusts and the DoH in order to address the ongoing severe financial challenges faced by the HSC system. The financial position was formally monitored on a monthly basis and appropriate actions taken. Through careful financial management, at the end of 2019/20 the wider HSC showed a breakeven position.

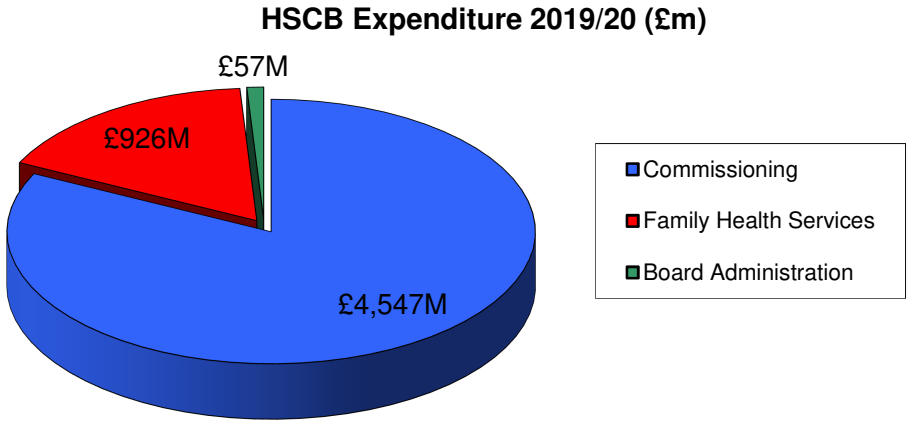
3.3 HSCB Breakeven Duty

During 2019/20, the HSCB received a budget of £3.9m capital resource and £5,600m revenue resource from the DoH, along with income from other sources of £57m. The financial statements presented in this Annual Report and Accounts show a surplus of £22.3m. The surplus held by HSCB offsets the £21.7m control total for the Western Health and Social Care Trust, which has been authorised by the Department of Health in 2019/20. This has ensured that the HSC achieved a breakeven position across all organisations.

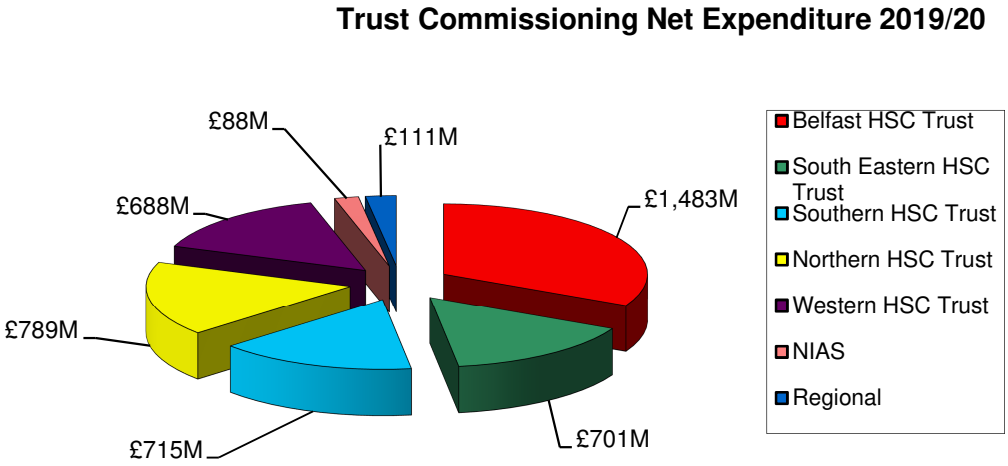
This was achieved by significant effort on the part of the Finance Directorate and all budget holders in managing the wide range of pressures and demands, and the delivery of significant efficiencies in both the Family Health Services (FHS) and Management and Administration budgets.

The following charts highlight how the HSCB's revenue funds have been utilised during 2019/20.

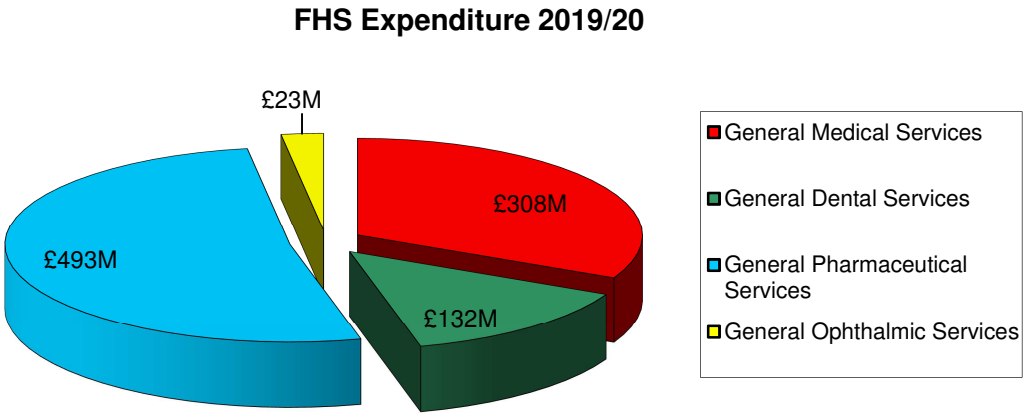
a. HSCB Net Revenue Expenditure 2019/20



b. Commissioning Expenditure Analysis by Provider 2019/20



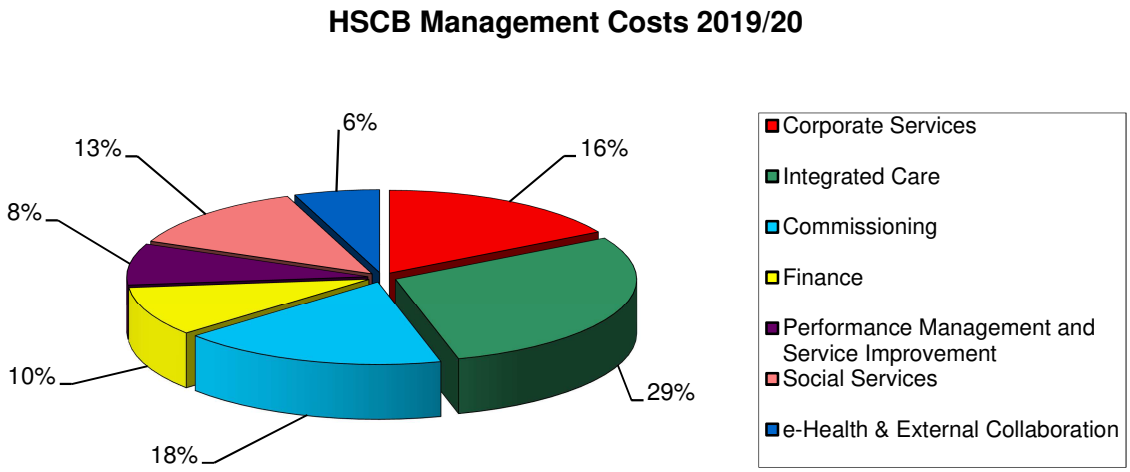
c. Family Health Services Expenditure 2019/20



During the 2019/20 financial year, the HSCB continued with the difficult task of managing to successfully deliver its many and complex functions within a significantly reduced Management and Administration budget. Delivery of these savings, set against the backdrop of significant organisational uncertainty regarding the closure of the HSCB, has created a significant and ongoing challenge for the HSCB to ensure that core functions continue to be delivered and governed to the standard that its stakeholders expect.

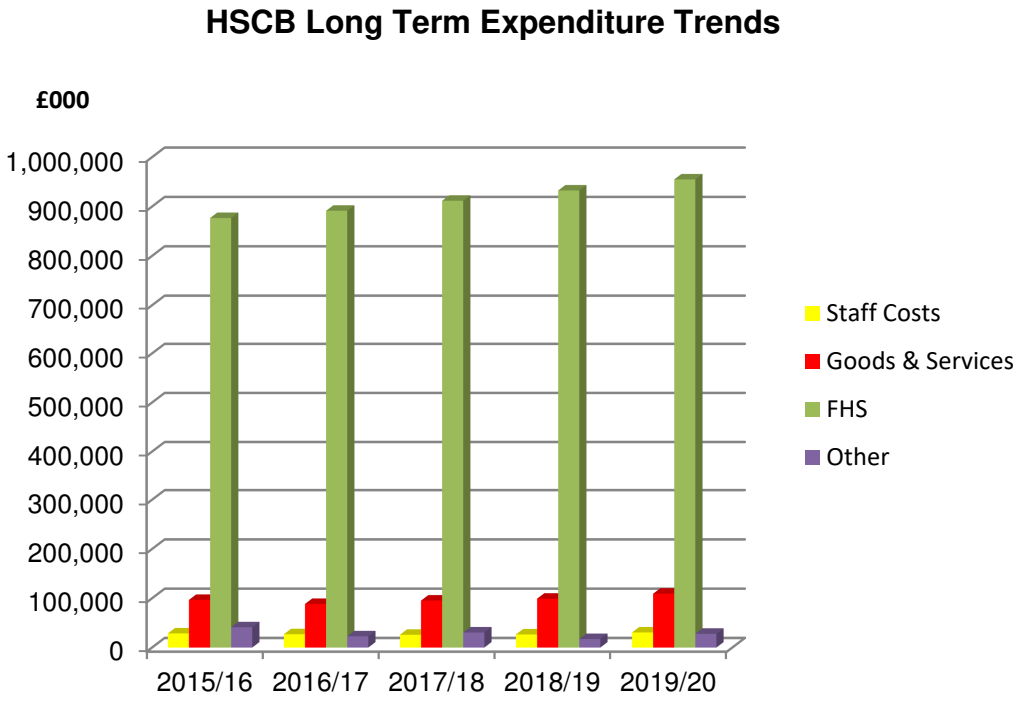
This challenge has been compounded in 2019/20 by first, a period of sustained sector wide industrial action, followed by the emergence of the COVID-19 pandemic, which has dramatically increased the pressures on the organisation. These are likely to continue throughout 2020/21, and make for a difficult context in which to deliver further system efficiencies.

d. HSCB Management Costs 2019/20



3.4 Long Term Expenditure Trends

The following bar 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 HSCB.



3.5 Prompt Payment Performance

a) Public Sector Payment Policy - Measure of Compliance

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

	2020 Number	2020 Value £000s	2019 Number	2019 Value £000s
Total bills paid	15,819	118,816	14,192	102,755
Total bills paid within 30 day target or under agreed payment terms	14,719	114,455	13,073	97,078
% of bills paid within 30 day target or under agreed payment terms	**93.0%**	**96.3%**	**92.1%**	**94.5%**
Total bills paid within 10 day target	12,695	102,088	11,016	86,146
% of bills paid within 10 day target	**80.3%**	**85.9%**	**77.6%**	**83.8%**

b) The Late Payment of Commercial Debts Regulations 2002

The HSCB did not pay any compensation or interest for payments made late in either 2019/20 or 2018/19.

Theme 4 –Engaging with stakeholders, particularly service users and carers, in an open and transparent manner

The HSCB is committed to involving patients, carers and the public in the design and delivery of health and social care services. The section below covers the initiatives we are undertaking to listen to, and engage with, patients and their families, as well as identifying learning opportunities and improving outcomes from Serious Adverse Incidents (SAIs) and complaints for which we have overall responsibility, along with the PHA, for all the health and social care family.

Recognising the value of partnership with service users, carers and staff

Regional Learnings from Serious Adverse Incidents

The HSCB/PHA remain committed to identifying learning from Serious Adverse Incidents (SAIs), to improve services for service users and their families and to reduce the risks of recurrence by working collaboratively with the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

During 2019/20, the HSCB/PHA issued a number of alerts in the form of reminders of best practice and professional letters, which were issued across the HSC and to primary care practitioners. Learning from SAIs, which fell within a specialist area, were also shared with relevant networks and fora. Learning Matters Newsletters were issued which covered a range of topical areas all of which related to learning from SAIs. One biannual SAI learning report was issued for the period 1 October 2018 to 31 March 2019. A further report covering the period 1 April 2019 – 31 March 2020 will be issued over the coming months.

The 5th Annual Regional SAI Learning Event was held on 29 May 2019 which was attended by approximately 180 delegates from across the wider HSC system. This year the event was a joint event on learning from both complaints and SAIs. The aim of the event was to use collaborative learning and an open approach to:-

- Share learning from a number of Complaints / SAIs and identify themes to drive improvement.
- Improve ability to disseminate learning across the system.
- Develop and agree a high quality, robust, insightful approach to the review of Complaints / SAIs across the HSC system.

In September 2018, an outline business case was approved by the DoH for the Alignment of Adverse Incident Coding and Datix Systems across HSC organisations and has been led to date by the HSCB and PHA. As from 1 April 2019 all Trusts are using the same risk management software for incident reporting using the same common classification system codes. In doing so, this

has enabled Trusts to provide regular test data to the HSCB/PHA with on Adverse Incidents during 2019/20 to assess if the level of data is sufficient to facilitate the identification of regional learning.

Complaints

During 2019/20, 29 complaints were received regarding the HSCB. These related to policy, commercial and purchasing decisions of the Board, as well as staff attitude and communication.

In addition, the Board is able to act as an 'honest broker' in complaints concerning Family Practitioner Services (FPS), with the agreement of both the complainant and Practice. During this period the Board acted as an honest broker in relation to 62 complaints regarding General Medical Practitioners; the main categories of complaint were treatment and care, communication and staff attitude. In respect of General Dental Practitioners, the Board acted as honest broker in relation to 5 complaints, the main category of complaint was treatment and care. The Board also acted as honest broker in relation to 3 complaints concerning Pharmacies, which related to staff attitude, communication and treatment and care.

As part of the Board's requirement to have oversight of complaints in HSC, it also receives anonymised copies of written complaints and responses from FPS Practices. During this period the Board received 131 returns from General Medical Practitioners and 9 returns from General Dental Practitioners. No returns were received from Pharmacies or Opticians during this period.

Complaints of a clinical nature are shared with the Board's Medical Advisers to review and to advise if there are any clinical/professional/regulatory issues and to recommend any further action.

Public Stakeholder Involvement

The HSCB is cognisant of recent policy developments in this wider area, such as 'The Co-production Guide for Northern Ireland – Connecting and Realising Value through People'. This DOH publication is a practical guide to support the application of a Co-Production approach across the health and social care system.

Recent examples of stakeholder involvement include engagement events to support a new model for community care and consultation on a new regional sign language interpretation service.

Theme 5 – Developing and maintaining internal systems and maximising the potential of our staff

5.1 Valuing Staff

The HSCB remains committed to ensuring that robust systems and processes are in place to maximise the potential of its staff ensuring that they are skilled, motivated and valued. As outlined in Section 2.0 of the Overview of Organisational Performance, the Permanent Secretary has confirmed the HSCB planned closure date of March 2022. With this in mind, the Chief Executive, the Chair and Senior Management Team have engaged with staff and Trade Unions regarding the future closure of the HSCB ensuring staff are kept fully informed and supported through this time of change and that any impact is minimised.

In 2019/20, BSO have continued to provide HR services including pay and conditions, employee relations (both improvement of working relationships and resolution of individual cases) and retained recruitment (i.e. quality assurance role in respect of posts advertised and job evaluations). This involved working with managers, staff and Trade Union organisations. HR services have also had to respond to the ongoing COVID-19 pandemic, and its profound impact on all staff. A number of guidance documents have been issued and a dedicated HSC Staff Health and Wellbeing Hub created across HSCB, PHA and BSO, whose role is to consider the needs of staff during the current crisis.

5.2 Preparing for Change: Organisational and Workforce Design

The Recruitment Scrutiny Group involving senior management and HR continues to meet regularly to manage the recruitment process taking into account transitional arrangements and the provision of business continuity, whilst awaiting the development and implementation of future models of care.

As an Equal Opportunities employer, training and development opportunities are available and offered to all staff throughout the year. HR staff support and work with HSCB colleagues to improve the health and wellbeing of staff through a number of initiatives. This is delivered via the Attendance Management Policy, Occupational Health Service and external support organisations as and when required. BSO HR also assists in the provision of short information sessions to address targeted health issues identified through attendance monitoring.

During 2019/20 HSCB staff had access to workplace wellbeing services such as mental health support, counselling and other therapeutic interventions through partnership working with Inspire.

Equality, Human Rights and Diversity

During 2019/20, the HSCB continued to engage with staff on equality and disability responsibilities. Staff are required to attend face-to-face training which

raises awareness of the needs and experiences of equality target groups and provides a summary of equality legislation, its key concepts and requirements. The HSCB continued to facilitate and support Tapestry, the Disability Staff Network for the 11 regional Health and Social Care organisations. The main aim of the Network is to raise awareness of disability and to act as a contact point for staff with a disability. The development of the dedicated website https://tapestry.hscni.net/ provides a safe space and shares informal peer support and information, e.g. Disability Action Plans, Access to Work and Placement Schemes. Meeting quarterly the Tapestry Disability Staff Network also makes recommendations on relevant workplace policies.

5.3 Emergency Preparedness

Health Silver was established in November 2019, for a period of 10 weeks, in response to an episode of wide-spread industrial action by health and social care staff.

It was re-established on 23 January 2020, under the chair of the Public Health Agency, during the 'contain' phase of the COVID-19 pandemic, and transferred to HSCB chair in mid-March 2020.

A number of operational cells have been established within the HSCB and PHA, in response to the pandemic. These cells, along with HSC Trusts, provide regular situation reports to Health Silver, who in turn escalate issues through to DoH Gold.

EU Exit

The HSCB has participated fully in processes established by the Department of Health working with Department of Health and Social Care to prepare for EU Exit. Preparations have focussed on:

a) Medicines supply
b) Potential disruption to movement of people
c) Data

Relevant staff within HSCB (and BSO in the case of human resources issues), have participated in specific workstreams focusing on each of these issues.

The HSCB has confirmed to DoH that it would not be appropriate for the HSCB to provide assurance to DoH with regard to the preparedness of Trusts since the DoH has engaged directly with Trusts in this regard.

Planning for a 'No Deal' Exit from the EU was formally stood down by the Executive Office in late December 2019 and the ALB EU Exit forum stood down in January 2020.

5.4 Departmental/Private Office and Freedom of Information Requests

During 2019/20, 84 FOI requests were received by the Health and Social Care Board with 76% being answered within 20 working days. 17 Subject Access Requests were also received with 77% being answered within one calendar month. One serious personal data related incident occurred during 2019/20 – the incident was investigated internally and reported to the Information Commissioners Office. A review was undertaken and new processes implemented as a result.

Sustainability

The HSCB is committed to sustainability, environmental, social and community issues and to support this, a number of key policies and protocols are in place. The principles are also embedded within the business principles.

The HSCB has continued to implement a number of energy saving initiatives which support the policies on environmental and waste management. The HSCB continued to encourage staff initiatives in an effort to reduce its carbon footprint. The use of tele-conferencing and video-conferencing facilities in each of the four HSCB offices has reduced the need to travel for business purposes. The investment in these facilities has proved particularly useful in the current COVID-19 environment, where the majority of staff are now working from home for at least part of their working week.

The Sustrans workplace initiative "Leading the Way with Active Travel" encourages more sustainable travel by staff within Belfast, and the Cycle to Work Scheme also promotes a healthier lifestyle. The Business Rail Translink Scheme encourages staff to make use of public transport to help reduce environmental pollution.

Mandatory sustainability and environmental requirements are also included in tender processes for all prospective contractors and considered in the award of contracts.

Rural Needs Act

During the period 1 April 2019 – 31 March 2020, the HSCB carried out 4 Rural Needs Impact Assessments. The HSCB has a statutory duty under the Rural Needs Act (Northern Ireland) 2016, which became operational for the HSCB from 1 June 2018. This requires the HSCB to have due regard to rural needs defined in the Act as the 'social and economic needs of persons in rural areas'. The HSCB has adopted a Rural Needs Impact Assessment process to ensure this information is captured for inclusion in its 2019/20 Rural Needs Annual Monitoring Report. This process is undertaken when developing, adopting, implementing or reviewing policies, and any strategies or plans to design and deliver public services.

In compliance with Section 3 of the Act, the information in the template below will be provided to the Department of Agriculture, Environment and Rural Affairs (DAERA) for inclusion in its 2019/20 Rural Needs Annual Monitoring Report.

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***
Changes to the NI Regional Capitation Formula: • Family and Child Care • Acute Services	Health and Social Care	Family and Child Care: The differential costs of health service provision in rural areas are addressed in the Rurality and Economies of Scale cost adjustments in the Regional Capitation Formula. The rurality cost adjustment was updated in the previous Regional Capitation Formula review. Acute Services: The differential costs of health service provision in rural areas are addressed in the Rurality and Economies of Scale cost adjustments in the Regional Capitation Formula.
Regional Trauma Network Service Delivery Model	Health and Social Care	The Health and Social Care (HSC) element of the Service Delivery Model will enhance the provision of psychological therapy and mental health services in Northern Ireland for children, young people and adults who experience significant levels of psychological trauma. Social issues – geographical and social isolation, mental health support and economic needs – costs associated with travel, access to services, such as child/other caring arrangements and amenities have been identified. In mitigation, the HSC element will be available across the region and access to services will be based solely on clinical need, regardless of geographical location or socio-economic needs associated with rural living. The comprehensive assessment process for each individual will ascertain if any barriers to accessing treatment exist, and flexibility of service provision will enable these to be overcome.
Parental Participation	Health and Social Care	Key points identified: 80% of landmass and 35% of population of NI are defined as rural; the rural population is growing at twice the rate of

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***
		urban; both male and female life expectancy is higher in rural areas; access to primary and secondary healthcare services may be difficult for isolated rural communities; emergency response times are higher in rural areas; some rural dwellers may be at higher risk of loneliness and social isolation; social deprivation is often hidden in rural areas; around 70% of rural working age population is in employment but generally, there is a lower level of income in rural areas; rural households tend to be larger and; access to services is more limited including availability of public transport. The Parental Participation Service will be offered via telephone, email, face-to-face meetings, home visits and community- based events. A planned outcome is that all parents will have a role in informing and contributing to regional service planning by identifying what their needs are and how best these can be met. Monitoring and review of service data will provide a detailed insight into needs and characteristics of service-users in rural areas.
Independent Information, Advice, Advocacy Service to Support Independent Living	Health and Social Care	Key points identified: 80% of landmass and 35% of population of NI are defined as rural; the rural population is growing at twice the rate of urban; both male and female life expectancy is higher in rural areas; access to primary and secondary healthcare services may be difficult for isolated rural communities; emergency response times are higher in rural areas; some rural dwellers may be at higher risk of loneliness and social isolation; social deprivation is often hidden in rural areas; around 70% of rural working age population is in employment but generally, there is a lower level of income in rural areas; rural households tend to be larger and; access to services is more limited including availability of public transport. These circumstances affect service users and carers accessing Self Directed Support and who

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***
		may need or wish to access this Service. In order to mitigate against reliance on public transport the Service will be offered via telephone, email, face-to-face meetings, home visits and potential drop-in clinics. Information on accessing the Service and engaging in an assessment for Self-Directed Help will be provided in multiple formats.
Advocacy Service for Deaf Adults	Health and Social Care	Key points identified: 80% of landmass and 35% of population of NI are defined as rural; the rural population is growing at twice the rate of urban; both male and female life expectancy is higher in rural areas; access to primary and secondary healthcare services may be difficult for rural isolated communities; emergency response times are higher in rural areas; some rural dwellers may be at higher risk of loneliness and social isolation; social deprivation is often hidden in rural areas; around 70% of rural working age population is in employment but generally, there is a lower level of income in rural areas; rural households tend to be larger and; access to services is more limited including availability of public transport. These circumstances affect deaf adult service users accessing Health and Social Care and who may need or wish to access the Advocacy Service. In order to mitigate against reliance on public transport the Service will be offered via email, video-based and/or social media information dissemination, face-to-face meetings, home visits and information sessions. Limited access to high quality broadband will be mitigated by the provision of the service via other methods including written materials, email communication, face-to-face meetings, home visits and information sessions. To mitigate against hidden poverty and deprivation, HSCB will maintain the current

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*
		expectation i.e., that the supplier should have a detailed understanding of HSC services and local networks of accessible support and assistant to which individuals can be signposted and referred as required.

Mrs Valerie Watts

Chief Executive

Date 7th July 2020

ACCOUNTABILITY REPORT – GOVERNANCE REPORT

DIRECTORS' REPORT

The Board of the HSCB is made up of a Non-Executive Chair, seven Non-Executive Directors and five Executive Directors, including the Chief Executive.

The Chief Executive is directly accountable to the Chair and Non-Executive Directors for ensuring that Board decisions are implemented, that the organisation works effectively in accordance with government policy and public service values, and for the maintenance of proper financial stewardship.

Executive Directors are senior members of the HSCB's full time staff who have been appointed to lead each of the major professional and corporate functions.

The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The Chair is accountable to the Minister/Department of Health.

Non-Executive Directors are appointed by the Health Minister in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The Non-Executive Directors are independent and reflect wider outside and community interests in the decision making of the Board.

During the period 1 April 2019 to 31 March 2020, Board membership comprised the following Directors:

Non-Executive Directors

Dr Ian Clements
Chairman

Mr Robert Gilmore

Mr Stephen Leach

Dr Melissa McCullough

Mr Brendan McKeever

Mr John Mone

Mrs Stephanie Lowry

Executive Directors

Mrs Valerie Watts
Chief Executive

Ms Marie Roulston
Director of Social Care and Children

Mr Paul Cummings
Director of Finance

Dr Miriam McCarthy
Director of Commissioning

Mrs Lisa McWilliams
Interim Director of Performance Management and Service Improvement

A number of officers from the HSCB and PHA Senior Management Team also attend its meetings; these individuals are as follows:

- Dr Sloan Harper, Director of Integrated Care, HSCB
- Director of Public Health, Public Health Agency
- Director of Nursing and Allied Health Professionals, Public Health Agency
- Ms Louise McMahon, Director, HSCB

In addition, meetings of the Board are also attended by the Chairperson of each of the Board's five Local Commissioning Groups, and by representatives of the Patient and Client Council.

Board of Directors

Dr Ian Clements OBE, Chairman

Dr Clements lives in Newtownards, where he had practised as a GP for 27 years. Throughout his GP career, Dr Clements has continually sought to improve health and care services for patients through his involvement in the commissioning process. He also contributed his expertise as a doctor over many years, to a wide array of leading health and care organisations. Dr Clements received an OBE for Services to Healthcare and the Community in Newtownards in the Queen's Birthday Honours List in 2018. Dr Clements completed his term of office as Chair of the HSCB on 31 March 2020.

Mrs Valerie Watts, Chief Executive

Valerie Watts took up post as Chief Executive of the Health and Social Care Board in July 2014. Mrs Watts has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital where she oversaw competitive tendering for ancillary support services, and having worked in local government since 1989. Most recently, Mrs Watts was Chief Executive of Aberdeen City Council (2011- 2014) and formerly Town Clerk and Chief Executive of Derry City Council (2009-2011) where she was instrumental in securing the UK City of Culture for 2013 and developing a strategic economic masterplan for the North West.

Mr Robert Gilmore OBE, FCIS, FCMI, Non-Executive Director

Mr Gilmore lives in Co. Down and is a Public Sector Advisor and former Local Authority Chief Executive. He has been a Non-Executive Director of the HSCB since April 2009 and was previously a lay member of the Southern Local Commissioning Group (Health and Social Services). He was formerly a Director in a Local Enterprise Agency, a Governor in a Further and Higher Education Institute, a Commissioner in the Local Government Staff Commission and an Independent Board Member in the Department for Infrastructure. Mr Gilmore's term of office as a Non-Executive director finished on 31 March 2020.

Mr Stephen Leach CB, Non-Executive Director

Mr Leach lives in North Down and has been a Non-Executive Director of the HSCB since 2009. He is a former senior civil servant and was Chair of the Northern Ireland Criminal Justice Board from 2000 to 2009. He was a Parole Commissioner for Northern Ireland from 2009 to 2015 and was the Northern Ireland Commissioner on the UK Criminal Cases Review Commission from 2014 to 2019.

Mrs Stephanie Lowry, Non-Executive Director

Mrs Lowry has 30 years' experience working in both the private and public sector throughout her career. She has held several public appointments in a variety of areas, including Independent Board Member with the Department of Culture, Arts and Leisure; Deputy Chair of the Health and Safety Executive and was a member of the Office of the First Minister and Deputy First Minister (OFMDFM) Audit Committee and an Independent Assessor for Public Appointments.

Dr Melissa McCullough PhD, MSc Clinical/Bioethics, LLB, Non-Executive Director

Dr McCullough lives in Belfast and is a Visiting Lecturer at the Royal College of Surgeons in Ireland. Melissa was appointed to the National Institute for Clinical and Care Excellence (NICE, London) Guideline Committee for Lyme Disease in 2016, and has recently been appointed as a Panel Assessor and Chair for Undergraduate Medical Education with the Medical Council Ireland. Melissa has worked as a senior academic in medical education specialising in ethics & law, professionalism and leadership in medical schools in the UK and Ireland since 2005, and her teaching and research interests are primarily in clinical ethics, public health ethics, human rights & healthcare, diversity & inclusion, equality and justice in health and social care and health policy. She also has an interest in public engagement including performing arts & ethics and works with local voluntary bodies in Belfast and the USA.

Mr Brendan McKeever MSc, PGCE, Non-Executive Director

Mr McKeever is a User Consultant at Queen's University and the Ulster University and has undertaken work to support projects to improve the care of people with disabilities. He has written widely on these matters and continues to assist organisations that provide and develop services for users and carers. Mr McKeever's term of office as a Non-Executive director finished on 31 March 2020.

Mr John Mone MSc, BA, Non-Executive Director

Mr Mone lives in Co Armagh. He is a Non-Executive Director of the HSCB since 2009. He spent his career in the health service and is a former Director of Nursing. He is a primary school governor and a member of the NI Research Ethics Committee.

Mr Paul Cummings, Director of Finance / Deputy Chief Executive

Mr Cummings trained as an accountant with Northern Ireland Electricity before joining the Eastern Health and Social Services Board in 1987. Previous posts include Director of Finance, Technology and Estates to the South Eastern Health and Social Care Trust, Director of Finance and Information for the Ulster Community and Hospitals Trust, and Director of Finance and Contracting, Mater Hospital. In 2003 Paul served as the National Chairman of Healthcare Financial Management Association (HFMA), the first person outside the English NHS to receive such an honour.

Ms Marie Roulston OBE, Director of Social Care and Children

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

Marie 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 and Families from 2015 and in August 2018 took up post as Director of Social Care and Children at HSCB. She was awarded an OBE in the New Year's Honours List (2019) with respect to services to health care and young people.

Dr Miriam McCarthy, Director of Commissioning

Miriam McCarthy is the Director of Commissioning at the HSCB, having taken up post in December 2017. Miriam is a medical doctor trained in both general practice and public health. While she has spent most of her career working in Northern Ireland, she has also worked and studied for many years in the USA. Miriam has extensive experience in policy and strategy development.

As a senior civil servant during the period 1998-2011 she led many high profile service reviews which have shaped the direction of acute and specialist hospital services in Northern Ireland. She subsequently took up a position as consultant in public health, based at the PHA where she worked in partnership with commissioners in shaping and developing hospital services across NI, with particular focus on specialist services, cancer and medicines management. Miriam has also been closely involved with the work of the National Institute for Health and Care Excellence (NICE) and was a member of a Technology Appraisal Committee between 2013 and 2017. In her role as Director of

Commissioning Miriam provides leadership to improve patient care, ensure sustainable services and transform the delivery of care.

Mrs Lisa McWilliams, Interim Director of Performance Management and Service Improvement

An economist by training Lisa worked in the private and public sector before joining the HSC in 2004. Lisa has been the Interim Director of Performance Management and Service Improvement for the Health and Social Care Board since April 2018. Lisa's substantive post is the Assistant Director of Scheduled Care for the Health and Social Care Board and had responsibility for elective care reform, service improvement and performance management. Lisa previously held the post of HSCB Assistant Director of Commissioning overseeing clinical networks and NICE processes. Prior to that Lisa was the lead for Northern Ireland's Managed Clinical Network for Cancer Services where she led a number of regional service improvement initiatives and became a peer reviewer with the NHS England Peer Review Team.

Related Parties Transactions

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

Mr Danny Power (Interim Chair of Belfast Local Commissioning Group) is a member of the Board of Directors of Clan Mor Surestart and the West Belfast Partnership Board, both of which are organisations that do business with the HSCB.

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 HSCB.

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 HSCB where this may conflict with their managerial responsibilities, are held on a central register.

A copy is available on the HSCB website at www.hscboard.hscni.net.

Audit Services

The Health and Social Care Board's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office and the notional charge for the year ended 31 March 2020 was £53,000.

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 HSCB 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 HSCB, of its income and expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

- Observe the 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, unless it is inappropriate to presume that the HSCB will continue in operation.*
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the HSCB.
- Pursue and demonstrate value for money in the services the HSCB provides and in its use of public assets and the resources it controls.

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

* In 2015, the then Health Minister announced that the HSCB would be closed and its functions would in the future be delivered by the Department of Health and the Public Health Agency. However, given the current status of the Northern Ireland Assembly it has not been possible for the necessary legislation to be passed to allow for the closure of the HSCB. Therefore, the timing for the anticipated closure date of the HSCB has now been revised to March 2022. The HSCB will, therefore, continue as constituted for the 2020/21 financial year and the financial statements have been prepared on a going concern basis.

GOVERNANCE STATEMENT

1. Introduction/Scope of Responsibility

The Board of the HSCB is accountable for internal control. As Accounting Officer and Chief Executive of the HSCB, 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).

Processes in place by which the HSCB works with partner organisations

Public Health Agency (PHA)

Under Section 8 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, the HSCB is required to produce an annual Commissioning Plan in accordance with the Commissioning Direction as issued by the DoH, and in full consultation and agreement with the PHA. In practice the employees of the HSCB and the PHA work in fully integrated multi-disciplinary teams to support the commissioning process at both local and regional levels.

Business Services Organisation (BSO)

The BSO provides a broad range of support functions for the HSCB under a service level agreement between the two organisations. Functions include: financial services; human resource management; training; equality and human rights; information technology; procurement of goods and services; legal services; internal audit and fraud prevention.

Health and Social Care Trusts

Trusts provide services in response to the Commissioning Plan and must meet the standards and targets set by the Health Minister. In order that these obligations are met, service and budget agreements (SBAs) between Trusts and the HSCB are established setting out the range, quantity and quality of services to be provided, linking volumes and outcomes to cost.

Working in close collaboration with the PHA, the HSCB has in place a robust performance management framework. The framework provides the mechanism for managing and monitoring the achievement by Trusts of agreed objectives and targets and also provides a process whereby the HSCB and PHA can work closely in supporting Trusts to improve performance and achieve desired outcomes.

Inter-relationship with DoH and HSCB

The HSCB and DoH engage in a collaborative relationship to ensure that progress towards the achievement of all objectives is fully communicated.

The HSCB provides the DoH with prescriptive monthly financial monitoring returns highlighting financial performance and reporting progress towards the achievement of the statutory duty to break-even.

In addition, the HSCB provides the DoH with quarterly (or as required) assessments of the progress being made in the delivery of DoH strategic objectives and relevant targets in the current Programme for Government, Public Service Agreements (PSAs) and Commissioning Directions, demonstrating how resources are being used to achieve these objectives.

Senior HSCB officers attend bi-annual accountability reviews, with senior DoH officials, to discuss the HSCB's operational and financial performance; policy developments and corporate control issues.

In September 2019, a Memorandum of Understanding was agreed between the DoH and HSCB which set out the respective responsibilities in respect of the Digital Health and Care Team for Northern Ireland.

2. Compliance with Corporate Governance Best Practice

The Board of the HSCB applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The Board of the HSCB does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by having in place the following:

Standing Orders

The Standing Orders, reserved and delegated powers and Standing Financial Instructions provide a comprehensive business framework for the HSCB and enable the organisation to discharge its functions. They reflect the following: Framework Document (September 2011); Management Statement/Financial Memorandum; Code of Conduct and Code of Accountability for Board Members of HSC bodies (2011); 7 Nolan Principles; Public Service Values and Code of Openness.

The HSCB Standing Orders and Standing Financial Instructions are reviewed on an annual basis, considered by the HSCB Audit Committee and approved at the subsequent public Board Meeting. Section 6 of the Standing Orders relates to the Conduct of Board Business and includes, amongst others, potential conflicts of interest. This section also applies to the conduct of public meetings of the Local Commissioning Groups (LCGs).

The Standing Financial Instructions were considered by the HSCB Audit Committee at its meeting on 6 February 2020: the HSCB Standing Orders will be considered by the HSCB Audit Committee at a future meeting and both the Standing Financial Instructions and Standing Orders will be submitted for approval at a HSCB public Board Meeting later in 2020.

During the period there were no conflicts of interests and one dissention from voting declared at the Board meeting on 12 December 2019.

Register of Interests

The HSCB has in place Registers of Interests for the following groups – Directors, Committee members, staff and non-HSCB officers involved in Board Committees. The Registers are reviewed annually and are available on the HSCB's website (with the exception of staff and the non-HSCB officers involved in Board Committees).

Gifts and Hospitality Policy

The HSCB Gifts and Hospitality Policy was published in April 2012 and is compliant with the following circulars issued by DoH - HSS (F) 49/2009, HSS (F) 35/2009 and FD (DFP) 19/09. A nominated Officer in each HSCB Directorate maintains a log with a periodic report reviewed by the Governance Committee.

Performance Appraisal System

The DoH carried out its annual appraisal with the HSCB Chair who, in turn, carried out an annual assessment of each Non-Executive Director.

Interim LCG Chairs continued to meet with the HSCB Chair on a regular basis during the period under review.

Training

'Essential Skills' refresher training planned for HSCB Board, Committee and Senior Management Team members in autumn 2019 was postponed and will be re-scheduled during 2020-21.

Self-Assessment

The Audit Committee completed the National Audit Office self-assessment checklist and assurance is provided within the Mid-Year Assurance Statement.

A Board Governance Self-Assessment Tool is a retrospective review exercise. The Self-Assessment Tool covering the period 2018/19 was approved by the Governance Committee at its meeting on 26th March 2020.

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through a system of corporate governance which includes:-

- A schedule of matters reserved for Board decisions, some of which may have been delegated to Committees.
- A scheme of delegation, which devolved decision making authority within set parameters to the Chief Executive and other officers.
- Standing Orders and Standing Financial Instructions, which set out the HSCB's governance regulations (referred to above).
- The operation of a Governance Committee and an Audit Committee (comprised of Non-Executive Directors) to assure adherence to those regulations (as above).
- The adoption of a Governance Framework which consists of a suite of documents that provides the Board with the necessary assurances that the organisation is discharging its functions in a way which ensures that risks are managed as effectively and efficiently as possible to acceptable standards of quality.

The Governance Framework aims to protect the organisation against loss, the threat of loss and the consequence of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The current version of the Framework, which reflects the HSC Risk Management Model, was approved by the Governance Committee in February 2019 and will be subject to review January 2021.

The following describe in more detail the role of the Board of the HSCB, its Committee structure and attendance during the reporting period.

The Board

The Board has corporate responsibility for ensuring the HSCB fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient economic and effective use of staff and other resources by the HSCB. The Board of Directors is comprised of a Non-Executive Chair, seven Non-Executive Directors, the Chief Executive and four Executive Directors – the Director of Finance, Director of Commissioning, Director of Social Care and Children and Director of Performance and Service Improvement. From 1 October 2017 there has been one Non-Executive Director vacancy. There has been no governance risk associated with this vacancy and this will continue to be assessed.

A number of Directors from the HSCB's Senior Management Team also attend Board meetings including the Director of Integrated Care, the Director responsible for Community Planning, the Executive Medical Director/Director of

Public Health (PHA) and the Director of Nursing and Allied Health Professionals (PHA).

Name	Title	Meetings attended	Meetings scheduled to attend
Dr Ian Clements	Chair	8	10
Mr Robert Gilmore	Non Executive Director	10	10
Mr Stephen Leach	Non Executive Director	9	10
Mrs Stephanie Lowry	Non Executive Director	9	10
Mr John Mone	Non Executive Director	10	10
Mr Brendan McKeever	Non Executive Director	9	10
Dr Melissa McCullough	Non Executive Director	6	10
Mrs Valerie Watts	Chief Executive	7	10
Mr Paul Cummings	Director of Finance	10	10
Dr Miriam McCarthy	Director of Commissioning	7	10
Mrs Lisa McWilliams	Interim Director of Performance Management & Service Improvement	9	10
Ms Marie Roulston	Director of Social Care & Children	8	10

In addition, meetings of the Board are also attended by the Interim Chairperson of each of the HSCB's five Local Commissioning Groups (the Interim posts for the Northern and South Eastern Local Commissioning Groups were vacant during 2019/20) and by representatives of the Patient Client Council.

During the period 1 April 2019 to 31 March 2020, the Board met on ten occasions and was quorate on each occasion. In addition, one special confidential Board meeting was held on 19 February 2020.

Role of the Audit Committee

The role of the Audit Committee is to support the Board and Accountable Officer in respect of their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. The Audit Committee comprises of four Non-Executive Directors. The Director of Finance has a standing invitation to attend, with the exception of the annual meeting with the External and Internal Auditors, and the Committee is also attended by other relevant Finance and Internal Audit staff. The External Auditor is invited to attend all meetings of the Committee.

The Terms of Reference of the Audit Committee are in accordance with the Good Practice Principles contained within the Audit and Risk Assurance Committee Handbook (NI) and are kept under review in light of any emerging or changing accountability arrangements for the HSCB. The Code of Conduct and Code of

Accountability for Board Members of HSC Bodies (July 2011) clarifies the composition and role of the Audit Committee is reflected in the HSCB Standing Orders.

Since 2011/12 the Board has had separate Governance and Audit Committees. This ensures that equal weight is afforded to all of the governance domains including financial, organisational and clinical and social care, thereby allowing the Board to ensure a balanced and proportionate consideration of the full range of its corporate governance responsibilities, particularly those concerning safety and quality.

During the 2019/20 the Audit Committee met on five occasions with 100% attendance at four meetings and 75% attendance at one meeting along with a joint meeting with the Governance Committee on 10 October 2019 to consider the mid-year Assurance Statement. The Audit Committee assessed itself against the five good practice principles published in the Audit and Risk Assurance Committee Handbook (NI) and can demonstrate adherence to these principles covering:

- Membership, independence, objectivity and understanding.
- Skills.
- The role of the Audit Committee.
- Scope of work.
- Communication and reporting.

Role of the Governance Committee

The Governance Committee supports the Board in all aspects of corporate and clinical and social care governance by:

- Seeking assurances and advising the Board on the scope and effectiveness of the system of internal control.
- Ensuring an assurance framework is in place for the organisation relating to the corporate and clinical and social care governance, and that it is both effective and robust.
- Seeking assurances and advising the Board on the strategic processes in place for the management of risk and corporate governance requirements for the organisation.
- Reviewing the content of the annual Governance and mid-year assurance statements.
- Approving the Governance Framework, Governance Strategy and other governance related policies and procedures. These include reviewing Board officers' responses and actions in relation to regional procedures in respect of the management and follow up of serious adverse incidents and complaints where the HSCB has a regional responsibility.

- Seeking assurances and advising the Board on protocols in respect of the HSCB's social care statutory responsibilities.

In the 2019/20 year, the Governance Committee met on four occasions with 100% attendance at two meetings and 75% attendance at two meetings.

In addition to the overarching Governance and Audit Committees, the other Committees of the Board are:-

- Disciplinary Committee
- Assessment Panel
- Local Commissioning Groups
- Pharmacy Practices Committee
- Reference Committee
- Remuneration and Terms of Service Committee
- Review Panel

The Disciplinary Committee, the Assessment Panel and Review Panel, which meet on an ad-hoc basis, did not meet during the 2019/20 financial year. The other Committees have complied with their Terms of Reference, with minutes and reports provided at Board meetings.

Each Committee, with the exception of the Disciplinary Committee, is chaired by a Non-Executive Director and the Terms of Reference are kept under review throughout the year. The Chair of the Disciplinary Committee is an independent professional with the required relevant expertise.

4. Business Planning and Risk Management

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

Business Planning

The HSCB has a range of statutory duties and shall, as a corporate body, exercise the functions assigned to it by the DoH, including those set out in Article 8 (1-7) of the Health and Social Care Reform Act (NI) 2009 and any other statutory provision deemed by the DoH to be the functions of the HSCB, including the Government Resources and Accounts Act (NI) 2001.

Commissioning Plan

In line with the above statute, the HSCB is required to prepare and publish an annual Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery. The preparation of the Commissioning Plan is done in partnership with the PHA and is implemented through a series of integrated service teams. It takes full account of the financial

parameters set by the DoH and is consistent with the direction and priorities, as set out in the Commissioning Plan Direction, which was published by the DoH on 9 April 2019. It incorporates the system transformation agenda, to ensure that the HSCB, as the commissioner of health and social care services, is able to make the best use of the resources available to support the continued reform and modernisation of HSC services.

The Commissioning Plan 2019/20 was formally submitted to DoH on 28 August 2019 following approval by HSCB Board on 8 August 2019 and approval by PHA Board on 15 August 2019.

The Commissioning Plan describes the actions that will be taken across health and social care during the current financial year to ensure continued improvement in the health and wellbeing of the people of Northern Ireland, within the available resources. The Plan has been developed in partnership by the HSCB and the PHA and responds to the DoH Commissioning Plan Direction.

Driving improvement in population health and in health and social care services underpins all of the objectives contained within the Plan. The 2019/20 Plan sets out measures to promote good health and well-being, prevent illness, prevent harm to those receiving care and prevent complications of long term conditions. In essence the Plan sets out the priorities for health and social care to improve the experience of people at all stages of their life and their healthcare journey.

Specifically, the Plan identifies the key priority areas to be commissioned regionally and locally, with a particular emphasis on how providers will respond to demographic changes, service risks to the delivery of the modernisation and transformation agenda.

Throughout the Plan, explicit reference is made to the HSCB and PHA's specific priorities in relation to strategic service developments, patient pathways, transforming services and skill mix/workforce initiatives. Service providers are expected to provide detailed delivery plans which respond to these priorities through TDPs or ICP work plans. During 2019/20 it proved challenging to get the TDPs approved as it was difficult for Trusts to confirm they could achieve the objectives in the Commissioning Plan

Community Planning

The Local Government Act (NI) 2014 requires Community Planning partners to participate in Community Planning, to the extent that it is connected to their functions, and the partners must assist the council in carrying out its Community Planning duties. All organisations involved in Community Planning must have regard to their legal obligations and the potential impact on the Community Planning process. The HSCB is a statutory partner listed in the legislation. Partners should actively seek to integrate Community Planning into their corporate and business planning regimes, as per the Statutory Guidance for Operation of Community Planning, Department of the Environment, Oct. 2015 (issued under Section 111 of the Act).

Corporate Plan

Many of the HSCB's objectives and responsibilities for the year 2019/20 are reflected in the Commissioning Plan. The Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

As such, the Corporate Plan includes objectives that primarily relate to how the HSCB will seek to commission the delivery of high quality health and social care services for the population of Northern Ireland, and how it conducts its business and ensures that its organisational arrangements are fit for purpose. Taken together with the Commissioning Plan and policies for the effective and efficient management of resources, the Corporate Plan provides an overarching planning framework for the work of the HSCB.

The key objectives for the focal year 2019/20 have been subject to a bi-annual review. This was carried out as at 30 September 2019 and was approved by the Governance Committee at its meeting on 6 February 2020. The year-end review, as at 31 March 2020 and planning for the 2020/21 Corporate Plan, has been suspended in light of the COVID-19 response. The pausing of ALB's governance and sponsorship activities, to facilitate a focus on their COVID-19 response, was outlined in DoH correspondence, dated 20 April 2020, from the Director of Corporate Management.

Business Continuity Plan

The Board Corporate Business Continuity Management System (Policy and Plan) is aligned to the requirements of the International Standards Organisation (ISO) 22301. The Plan identifies the HSCB functions deemed as 'critical', which must continue to be delivered during an interruption to normal business. During 2019/20, each Directorate undertook a risk analysis and developed strategies and tactics to detail how the critical functions would be delivered during an interruption. This included the development of a specific resilience plan for a protracted period of industrial action during the period and contingency planning for potential impacts of EU Exit. The Business Continuity Plan is available on the HSCB intranet site, along with guidance for staff.

Risk Management

The HSCB recognise that risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible. Therefore, the HSCB has in place a process for the management of Board-wide risks as part of its Governance Framework.

The purpose of risk management is not to remove all risk, but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles of the regionally agreed HSC Regional Model for Risk Management. This model is based on the principles of the ISO 31000:2018 standard which largely has the same broad principles, framework and processes which the former AS/NZ standard used.

In implementing this model, the HSCB has agreed (along with all other Departmental Arm's Length Bodies) to adopt the 'spirit' of ISO 31000:2018, by applying the principles of the standard, but will not be seeking accreditation. This will ensure there continues to be a systematic and unified process for the management of risks across all areas of the Board's activity by having in place a fully functioning risk register at both directorate and corporate levels.

Risk Management Leadership

The Board exercises strategic control through a system of corporate governance, by which the organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

It is vital the HSCB establishes robust governance arrangements to ensure it discharges its functions in a way which ensures that risks are managed as effectively and efficiently as possible and to acceptable standards of quality. The specific objective is to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The adoption of an overarching Governance Framework, which was revised in February 2019, ensures the HSCB has the basic building blocks in place for good governance; to lead, direct and control its functions in order to achieve organisational objectives and by which it relates to its partners and the wider community. The Framework highlights the key components that underpin a sound system of governance and internal control, and embraces the structure and process for managing and leading risk throughout the organisation.

An e-learning risk management awareness programme has been developed within the HSCB and is mandatory for all HSCB staff. Completion rates are actively monitored with 82% of staff trained. Training in risk management is also incorporated in the overarching corporate induction programme. The HSCB has been working with some Trusts who have already launched a new e-learning package in line with the new regionally approved HSC Risk Management Standard.

The HSCB working in conjunction with the PHA has in place a robust structure to support safety and quality. This consists of a range of forums inclusive of an overarching Quality, Safety and Experience (QSE) group. The main objective of this group is to consider learning from good or poor practice, patterns, themes or

areas of concern from all sources of information and to agree appropriate actions to be taken.

Categorisation of Risk

All risks do not carry the same likelihood of occurrence or degree of impact (consequence) in terms of actual or potential impact on service users, patients, staff, visitors, the organisation, or its reputation or assets.

Once the organisation's objectives have been approved and a consensus on principal risks reached, it is important to ensure a consistent and uniform approach is taken in categorising risks in terms of their level of priority in order that appropriate action is taken at the appropriate level of the organisation.

The HSC Regional Risk Matrix August 2018, adopted by the HSCB, is included as an appendix to the Governance Framework and is consistent with DoH mandatory guidance 'An Assurance Framework: A Practical Guide for Boards of DoH Arm's Length Bodies'. This matrix which is used to categorise potential risks, incidents, complaints and claims, facilitates the prioritisation of risk in terms of likelihood and impact (consequence). In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

Risk Appetite

The HSCB recognises that it is impossible and not always desirable to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health and social care benefits for the local population.

From time to time the HSCB may be willing to accept a certain level of risk. For example: promoting independence for individuals; or in order to take advantage of a new and innovative service; or due to the high costs of eliminating a risk in comparison with the potential threat. In these circumstances the risk will continue to remain on the Risk Register and will be monitored and reviewed at regular intervals.

However, as a general principle the HSCB will seek to eliminate and control all risks which have the potential to:

- Harm staff, service users, patients, visitors and other stakeholders.
- Result in loss of public confidence in the HSCB and/or its partner agencies or would have severe financial consequences and which would prevent the HSCB from carrying out its functions on behalf of the population.

Embedding of Risk

Risk Registers continue to be monitored on a quarterly basis, with the reviews at the end of March and September requiring a substantive review, and the reviews for June and December quarters being reported on by exception only.

The most recent review was undertaken at 31 December 2019 and whilst this review was by exception reporting only, it involved the review of both Directorate and Corporate Risks and making the necessary additions/amendments in respect of:

- Identification/removal of risk
- De-escalation/escalation of risk
- Existing controls
- Internal and external assurances
- Gaps in controls and assurances
- Action being taken forward

The Governance Committee approved the review as at 31 December 2019 electronically by email, as the scheduled meeting of the Committee 26 March 2020 was cancelled in light of COVID-19 arrangements being in place.

The review, as at 31 March 2020, has been suspended in light of the COVID-19 response. The pausing of ALB's governance and sponsorship activities, to facilitate a focus on their COVID-19 response, was outlined in DoH correspondence, dated 20 April 2020, from the Director of Corporate Management.

Stakeholder Risk

Public stakeholders are involved in managing risks which affect them; this includes the arrangements in place for:

- Management and Follow up of Serious Adverse Incidents (SAIs)
- HSC Complaints
  (Interim arrangements have been put in place during for the above during the COVID-19 crisis)
- Emergency Preparedness Plans

Fraud

The HSCB 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 (FLO) 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 provided with mandatory fraud awareness training in support of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate.

5. Information Risk

The identification and management of information risks is a key element of the HSCB's overall Information Governance Framework. Structures, policies, procedures and guidance have all been developed and implemented to facilitate the identification, management, monitoring and where necessary the escalation of information risks.

Structures include the roles of Senior Information Risk Owner, Data Protection Officer, Personal Data Guardian, Information Asset Owners and Administrators all of which are supported by an Information Governance Team. Escalation and de-escalation of information risks is facilitated via a range of fora across all levels of the organisation. Examples include the Records Management Working Group, Information Governance Steering Group, Senior Management Team and the HSCB Governance Committee.

2019/20 saw continued maintenance and update of the HSCB Information Asset Register. Data flow analysis and risk assessments were completed and reviewed as necessary for all information assets. Treatment plans were produced to highlight and address any identified risks. Identified actions were agreed with Information Asset Owners who in turn provided assurance to the Senior Information Risk Owner on progress.

The HSCB deploys mandatory Information Governance e-learning training to staff. An updated Information Governance Awareness e-learning programme, developed regionally by HSC Information Governance staff, was issued in October 2019. Completion rates, as at 31 December 2019, after the recent issue in October 2019 were 51%. Completion rates are actively monitored and reported to the HSCB Senior Management Team and Governance Committee as Key Performance Indicators (KPIs).

The Accounting Officer and Board received assurances on information risk via formal reporting mechanisms. The Information Governance Steering Group, chaired by the Senior Information Risk Owner, met quarterly with updates provided as necessary at each meeting. Reports to the HSCB Governance Committee were provided from the Senior Information Risk Owner who attends both groups.

6. Public Stakeholder Involvement

The HSCB, working collaboratively with the PHA, recognises that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of HSC services. PPI is the active and meaningful involvement of service users, carers and the public in those processes. All commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work, ensuring that the input of service users and carers underpins the identification of commissioning priorities and in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements.

The HSCB is also cognisant of recent policy developments in this wider area, such as "The Co-Production Guide for Northern Ireland - Connecting and Realising Value through People". This DoH publication is a practical guide to support the application of a Co-Production approach across the health and social care system and was developed as part of the Department's programme of work to transform health and social care provision as envisaged in "Delivering Together 2026". The HSCB is committed to integrating this partnership based ethos into the culture and ethos of the organisation.

The HSCB funds a service, currently provided by a community and voluntary sector provider, to support the voices of children and young people with disability. This service provides input both to the HSCB and Children and Young People's Strategic Partnership to ensure the duties in respect of the United Nations Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities are complied with in terms of the child's wishes and views being included in areas of impact. The HSCB also ran a series of engagement events to support the development of a new model of domiciliary care/care and support at home. These events were attended by service users, their carers, families, advocates and front line staff. In addition, Age NI was commissioned to conduct face-to-face interviews with service users and a telephone survey was conducted with those people who were unable to attend a focus group.

Extensive stakeholder engagement is also ongoing in the area of physical and sensory disability services. Two key examples of this work are: the Regional Sensory Group, convened by the HSCB to drive forward continuous improvement in services for people with sensory disability, involving representatives from Trust and community/voluntary services as well as several service users; and the ongoing Regional Communication Support Service project to deliver a new regional sign language interpretation service through the Business Services Organisation. The HSCB has conducted extensive service user engagement in relation to this project, including 10 regional outreach events over the period November 2019 to January 2020, which were attended by approximately 300 d/Deaf service users and their carers and families.

7. Assurance

Assurance Framework

As part of the overarching Governance Framework, the HSCB has in place an Assurance Framework (the Framework).

The Framework has been compiled in conjunction with all Directorates and provides the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control, by highlighting the reporting and monitoring mechanisms that are necessary to ensure the achievement of corporate objectives and the commissioning and delivery of high quality health and social care.

The Framework is reviewed annually by the Governance Committee and provides a clear, concise structure for reporting key information to the Board, Committees of the Board, SMT and other groups/forums. It also identifies which of the organisation's objectives are at risk because of any inadequacies in the operation of controls, or where the Board has insufficient assurance about them. In conjunction with the Board's Corporate Risk Register and Corporate and Commissioning Plans it also provides structured assurance about how risks are managed effectively to deliver agreed objectives.

The Assurance Framework is reviewed on an annual basis. However, the review, as at 31 March 2020, has been suspended in light of the COVID-19 response. The pausing of ALB's governance and sponsorship activities, to facilitate a focus on their COVID-19 response, was outlined in DoH correspondence, dated 20 April 2020, from the Director of Corporate Management.

Quality of Board Papers

Section 3.4 of the Governance Self-Assessment tool refers to the 'Quality of Board papers and timeliness of information'. Board members gave this a 'green' rating and indicated their satisfaction with the information received quoting evidence to support as follows:-

- Documented information requirements (standing agenda items).
- Evidence of challenge e.g. from Board minutes.
- Board Meeting timetable.
- Process for submitting and issuing Board papers.
- Content of Board papers.
- Data quality updates (performance reports).

Delegated Statutory Functions

Trusts submit an annual monitoring report on the delivery of statutory functions with a mid-year return on Corporate Parenting. This is analysed by HSCB and an overview report on findings was considered by the Board at its meeting on 12 September 2019 and submitted to DoH. Trusts have developed action plans where remedial action was required. The quality of supporting data has continued to improve and together with regular monitoring meetings, ensures that this area is kept under constant review.

8. Sources of Independent Assurance

The HSCB obtains independent assurance from the following sources:

- Internal Audit
- Regulation and Quality Improvement Authority (RQIA)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

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

Internal Audit

The HSCB has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the HSCB is exposed and annual audit plans are based on this analysis.

In 2019/20 Internal Audit performed the following audit assignments, with overall levels of assurance given as shown:-

- Visits to Sure Starts and Bright Starts - Satisfactory for 3 out of 6 organisations visited, Limited for the remaining 3 organisations visited;
- Complaints Management - Limited;
- Patient Travel - Satisfactory;
- Absence Management and Recruitment - Limited;
- Risk Management - Satisfactory;
- Claims Management - Satisfactory;
- Financial Support for GP Premises - Limited;
- Financial Review – Satisfactory; and
- eHealth – Cyber Security Follow Up Review - Limited.

In the Annual Report, the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the HSCB's objectives. There were no Priority 1 findings and recommendations identified within the audits carried out during 2019/20. Management regularly review and are working towards the implementation of all recommendations made by Internal Audit.

Regulation Quality Improvement Authority (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 six monthly report which details the progress on implementation of RQIA recommendations. The most recent report for the period ending 30 June 2019 was approved by the joint AMT/SMT on 21 January 2020 and noted at the Governance Committee at its meeting on 6 February 2020.

Whilst the above report is an internal HSCB/PHA assurance report, HSCB/PHA also complete a separate report for DoH. This report is more detailed and also includes individual feedback on Trust's progress on RQIA recommendations.

In order to avoid unnecessary duplication, QSE have agreed all future reports to QSE, SMT and Governance Committee should be based on the one report that is submitted to the DoH.

National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD)

A similar system is in place for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports whereby all NCEPOD reports are considered by the HSCB/PHA Safety and Quality Alerts Team (SQAT) to review the reports and confirm the relevant Director/Lead and any actions required through SQAT, other existing structures, or bespoke Task and Finish Groups.

This system of assurance takes the form of a six -monthly report which details the progress on implementation of NCEPOD recommendations. The most recent report on progress for the period ending 31 March 2019 was approved by the joint AMT/SMT on 21 January 2020 and noted at the Governance Committee at its meeting on 6 February 2020.

The frequency of submission of the above assurance reports (RQIA & NCEPOD) is currently under review with the view to providing annual updates.

External Audit

For the year ended 31 March 2019, the Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the HSCB's accounts. The Report to Those Charged with Governance identified three findings – two Priority 1 issues and one Priority 2 issue.

9. 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 HSCB 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 Audit and Governance Committees and a plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

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

Integrated Care Partnerships (ICPs)

"Failure to provide continued support to Integrated Care Partnerships to ensure continued delivery of agreed objectives as set by DoH and HSCB for the clinical priority areas as detailed in the Corporate Plan."

This risk was removed from the corporate risk register as recurrent funding has now been made available for ICPs, so that a full ICP support team can be recruited on a permanent basis which will provide more consistent support to the work of ICPs. The availability of the recurrent funding has also sent a strong message to the range of partners ICPs work with, about the value of the ICP work programme which has resulted in greater engagement and commitment to their role within ICPs.

Transformation Implementation Group (TIG) have also supported the development of the Integrated Care System Prototype in the Northern area which provides an important opportunity to test the model for the future development of ICPs and to address some of the challenges faced to date. An ICP work plan which provides clear direction to the work of ICPs is now also agreed on an annual basis with SMT, AMT and TIG.

(b) An update on prior year control issues which continue to be considered control Issues

Quality, Quantity and Financial Controls

This issue reflects the continued and increasing difficulty faced by the HSCB in fully commissioning and supporting levels of health and social care services provided to the population of Northern Ireland by Health and Social Care Trusts, providers of Primary Care services and other independent health and social care providers within available resources.

Health and Social Care in Northern Ireland continued to face very significant financial challenges during 2019/20. The HSCB worked closely and proactively with all Trusts and the DoH throughout the year in order to address the difficulties faced. This collaborative approach enabled the HSC system to achieve financial breakeven for the 2019/20 year. However, in view of the COVID-19 emergency, the outlook for 2020/21 is uncertain.

The Assembly passed the Budget Act (Northern Ireland) 2020 in March 2020 which authorised the cash and use of resources for all departments and their Arms' Length Bodies for the 2019/20 year, based on the Executive's final expenditure plans for the year. The Budget Act (Northern Ireland) 2020 also authorised a Vote on Account to authorise departments' access to cash and use of resources for the early months of the 2020/21 financial year. While it would be

normal for this to be followed by the 2020/21 Main Estimates and the associated Budget (No. 2) Bill before the summer recess, the COVID-19 emergency and the unprecedented level of allocations which the Executive has agreed in response, has necessitated that the Budget (No. 2) Bill is instead authorising a further Vote on Account to ensure departments and their Arms' Length Bodies have access to the cash and resources through to the end of October 2020, when the Main Estimates will be brought to the Assembly and the public expenditure position is more stable.

Western Trust Financial Support

Since 2018/19 up until the present, the Western Health and Social Care Trust has been experiencing increasingly significant financial difficulties. Despite significant additional non-recurrent financial support in 2018/19, the DoH (who have overall strategic financial responsibility for the HSC) approved a control total of £24.4m for the Trust with the consequence that financial balance was not achieved for 2018/19.

Whilst a number of HSC Trusts continued to require significant interventions over recent years and specifically additional assistance in 2018/19 and 2019/20, the level provided to the Western Trust has consistently remained above that provided to other Trusts during that time. DoH had approved that the Trust enter into a three year financial recovery process (2019/20 – 2021/22) and a draft recovery plan was submitted to DoH for approval during 2019/20.

In support of this process, an initial control total of £15m had been agreed with the Trust for 2019/20. However due to continuing financial difficulties, a revised control total of £21.7m was agreed with the Trust and as a result financial balance was not achieved for 2019/20. HSCB will continue to work with the Trust and DoH in relation to improving the Trust's financial position and performance; this will include working through the implications of COVID-19 on the Trust's financial recovery process.

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 HSCB 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 Centre (PSSC) and have continued to provide this level of assurance until the latest report finalised in April 2020. For the first time since the establishment of PSSC, Internal Audit can provide 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.

Health Visiting

The Child Health Promotion Programme (CHPP) requires universal health visitor contacts to be offered to all families with pre-school children. As a result of significant workforce pressures the child health promotion programme was not being fully delivered. Decrease in CHPP delivery creates risk to children and families from a prevention and early intervention perspective, as well as placing undue pressure on other services such as Primary Care Teams, Paediatrics, Emergency Departments, Allied Health Professionals and Social Services.

Investment has resulted in the regional health visiting workforce standing now at 397.5 WTE, resulting in an average WTE caseload of 250 preschool children. The PHA continues to work closely with the DoH, HSCB and Trusts to increase health visiting capacity and compliance with the child health promotion programme. The introduction of the enhanced Multidisciplinary teams (MDTs) in Primary Care has secured funding for additional funding for the Health Visiting Service in line with the Delivering Care Phase 4 Framework. When the Health Visiting staff are fully employed within the MDTs, it will allow the testing of the Delivering Care Phase 4 Workforce Framework.

Regular workforce updates from Trusts continue to be analysed. Due to nursing workforce pressures and demands on the nursing education commissioning budget the number of student health visitors available is less than is needed. An additional Health Visiting course commenced in January 2019 to prepare the additional workforce requirement for the Down and Derry MDTs. This additional course will hopefully provide an additional 19 students who will complete the course in January 2020.

Compliance with the Child Health Programme per Trust and regionally continues to be measured on a three monthly basis using regionally agreed Indicator of Performance tolerances. Improvements continue to be made in compliance with contacts.

The PHA continues to work with DoH and Trusts to support the delivery of the Child Health Promotion Programme. The additional Health Visiting posts in the Multi-disciplinary teams has had a positive impact on the coverage of the Universal Child Health Promotion programme

GP Out of Hours (OOH) Services

The OOH service remains under considerable challenge due the difficulty filling clinical shifts. There is also a general shortage of GPs in Northern Ireland leading to medical workforce recruitment and retention issues. The causes are multifactorial and include busier and more complex daytime general practice, together with shifting attitudes in relation to work life balance. It should be noted that recent pension taxation changes continue to have an adverse impact on the GP OOH GP workforce.

Not all GP OOH providers are meeting KPI standards set out in the Service Specification. Concerns relate to the 20 minute and 1 hour triage targets, particularly during busy times such as weekends and public holidays.

From 1 January - 31 December 2019, 85% of urgent calls have been responded to within 20 minutes and 72% of routine calls have been responded to within 1 hour. Patient satisfaction remains high.

On occasion GP OOH bases must be closed when insufficient staff is available. The high demand for the service at peak times such as weekends and public holidays coupled with the lack of medical capacity has led to significant delays in some services thereby increasing clinical risk.

A range of actions required to improve the situation has been identified. There is a need to update and agree a regional GP pay structure for GP Out of Hours provision. Two Business Cases have been submitted to the Department of Health (DOH) in September 2018.

Similar to the past 3 years, the HSCB made available a sum of £1.7million in 2019-20 to GP OOH Providers to enable them to pay an incentive to GPs. The HSCB again made available £500k to fund GP OOH Local Enhanced Services (LESs) in 2019-20. These enhanced services will be evaluated in terms of numbers of additional GP hours or sessions secured at the end of March 2020, as appropriate, and revised on the basis of outcomes.

In November 2019, the HSCB allocated a sum of £850k to support GP OOH providers in meeting the increased demands on the service during the busy winter period.

The HSCB's GP OOH Regional Team has, once again, secured support from the HSC Leadership Centre to run a Quality Improvement (QI) Programme in GP OOH. The aim of the programme was to provide an overview of QI methodology and how these could support GP OOH services regionally, with a view to designing and supporting QI programmes for GP OOHs services in 2019-20. The objectives of the project were to improve sharing of best practice and reduce variation regionally.

The GPOOH has been reviewed by RQIA and their report is due in the near future.

Service and Budget Agreements

Service and Budget Agreements (SBAs) have been issued to all Trusts in February 2020. The HSCB recognises that SBAs should ideally be issued as early in the year as possible. The HSCB is committed to issuing SBAs earlier in the 2020/21 financial year, but notes these can only be issued following completing and approval of Trust Delivery Plans which will similarly need to be earlier in the year.

Continuity of Transformation Initiatives - As part of the UK government's Confidence and Supply agreement, the Department of Health secured transformation funding on a non-recurrent basis for the financial years 2018/19 and 2019/20. The Department expects the HSCB and Trusts to ensure most of the initiatives continue beyond the end of the funding period. This is highly likely

to result in a substantial unfunded recurrent pressure resulting from the transformation programme beyond March 2020; requiring financial contingency measures which could impact significantly on existing services.

GP Workforce

A shortage of GPs continues to impact on service delivery in year. This includes both the level of supply of sessional doctors available to provide day time locum sessions in practices and difficulties which all practices are experiencing in recruiting new partners. Out of Hours (OOH) providers have also continued to report difficulty in filling shifts.

In response to workforce capacity concerns, the number of WTE GP training places has been increased from 65 (which had been the intake for several years until 2015/16) to 85 in 2016/17, 95 in 2017/18, 111 per year in 2018/19 and 111 again in 2019/20. There are currently a total of 318 trainees. In 2016/17, 48 new GPs qualified, this increased to 57 in 2017/18, 65 in 2018/19 and 83 in 2019/20.

A GP Retainer Scheme with 25 places was developed and introduced in 2016 to support the retention of qualified GPs by providing a two year programme of stable work in general practice. In addition to this, a further 25 places were made available in 2018/19. These GP Retainers are attached to a practice and also commit to a number of Out of Hours sessions and to a mandatory Continuing Professional Development (CPD) programme.

Late 2018/19 saw the launch of a GP Retention Scheme, initially with an additional 25 places, subsequently reduced to 11 due to funding pressures, targeted specifically at doctors who may be considering retirement, leaving general practice or reducing their current sessional commitment. The scheme operates in the same way as the GP Retainer Scheme.

Again as previously noted, growth in the GP workforce has not kept pace with rising patient demand in recent years and there remain significant signs that the speciality is under considerable and growing pressure. Locally, anecdotal evidence suggests that recently trained GPs may be leaving general practice to return to work in staff grade posts in Trusts or to work abroad. Additionally, there remains a need to encourage younger GPs locally to undertake partnership roles in practices to ensure ‘future proofing’ of the profession, and stability of existing practices.

As noted above, there is a body of evidence which demonstrates that the mentoring of practitioners improves their retention and performance. In 2018/19, the HSCB commissioned NIMDTA to develop and pilot The Northern Ireland General Practitioner Mentoring Scheme. The three year Scheme is intended to help practising GPs who need some mentoring support in addressing the challenges they are facing. All of the mentors in the scheme are GPs who are GP trainers and/or appraisers with a broad range of relevant experience. Six mentors were recruited and trained in 2018/19 with a further 15 in 2019/20. At the time of writing, 17 GPs are undergoing mentoring. The Scheme continues to gather traction and it is anticipated that any additional demand can be met.

Additionally, the HSCB has sought to mitigate the GP workforce issue at an operational level by providing additional funding to general practices to increase staff capacity, such as funding additional sessions for nurses and counsellors, and the continuing roll out of practice based pharmacist posts.

Child Sexual Exploitation (CSE)

The HSCB continues, through the Trusts, to respond to concerns about CSE under the Protocol for Joint Investigation in conjunction with the Police Service of Northern Ireland (PSNI).

The HSCB continues to meet with the PSNI and Trusts at both local and regional levels to coordinate responses to CSE. The assessment/screening tool was updated and reissued to Trusts and PSNI in 2016. Additional investment from the HSCB has enabled the appointment on a permanent basis of a CSE Lead (Senior Practitioner) in each Trust. The CSE Leads are co-located in the PSNI Public Protection Units, on a part-time basis.

The HSCB has procured from a non-statutory provider an ongoing therapeutic support service to young people that are particularly vulnerable to CSE. Separate arrangements have procured training for Trust staff in relation to CSE.

The HSCB and the PSNI continue to monitor and refine the missing person's guidance and improve preventative strategies and responses. An action plan has been implemented and a number of key areas are being progressed to address the joint PSNI/HSC action plan on missing children. Data collection systems assist in promoting our understanding and identifying emerging trends and issues. Voice of Young People in Care (VOYPIC) also continues to engage young people directly to ensure that their views are considered and taken into account.

The DoH has stood down the response team which reviewed the Marshall Action Plan as the recommendations have been addressed and associated costings where available have been identified.

The Safeguarding Board for NI has conducted a follow up review to the Marshall Report and its findings are being considered by a range of agencies including the HSCB.

Domiciliary Care/Independent Home Care

Developing a sustainable service with the necessary capacity across the region in terms of workforce and service volumes remains challenging.

The Board is leading on work regionally to develop a New Model for domiciliary care, with Trusts and other stakeholders being actively engaged in this work. The New Model will seek to address current challenges including staff recruitment, retention and delivery of personalised service user outcomes.

Trusts have been provided Transformational Funding up to March 2020, to facilitate the change process locally, by testing different aspects of the new

model. The learning outcomes from the proofs will be shared regionally. A regional needs assessment and outline business case for 'live' (real time) call monitoring has been developed with the support of e-Health colleagues. This will improve the overall management of the domiciliary care service and improve use of available resources.

Trusts continue to report difficulty in achieving access to domiciliary care. Such difficulties can vary between and within individual Trust localities and may be most keenly experienced in terms of Winter Pressures, rurality and support for timely discharge from the acute sector to the community. Trusts continue to proactively seek to recruit Care workers and some Trusts have reviewed the bandings of their statutory home care workforce to underpin this.

Independent Providers continue to make representations to Trusts and the HSCB for enhancements to the hourly rate paid for care, with recruitment/retention difficulties and other inflationary pressures being noted. Using Transformational Fund monies, the HSCB has facilitated a dynamic systems modelling approach to better understand the relationship between payment rates, staffing, changes to the domiciliary/care and support at home model and any possible impacts upon the wider health and social care system. This work will help inform the wider decision making processes in relation to system reform.

The HSCB, via the Northern Ireland Social Care Council (NISCC), has used Transformational Fund monies to provide enhanced training to the social care workforce; this includes positive behaviour support, nutrition, continence and medicines management. Training approaches used have included more traditional group/face-to-face training as well as distance, Extension for Community Healthcare Outcomes (ECHO) and digital learning.

This project was one of five shortlisted for the European Social Network Collaborative Practice Award

Sector stability continues to be monitored via regular meetings with Trusts and the Independent Sector representatives. The issue remains on the HSCB Corporate Risk Register and is a standing agenda item at Delegated Statutory Function and related meetings with Trusts.

HSCB Business Continuity

The closure of the Health and Social Care Board was confirmed as a priority by the then Minister in October 2016 when launching 'Health and Wellbeing 2026 - Delivering Together' and there continues to be a risk to the ability of the HSCB to deliver its statutory, mandatory and business planning requirements. When the HSCB closes, the majority of its functions will move to DoH. HSCB staff continued to be involved in a number of Design Groups to plan for the transition and implementation of the future operating model, by the anticipated dissolution date of 31 March 2022.

The DoH has produced, in line with Orange Book guidance, a report of the 'Risk Assessment of the Transition Period to the Closure of the HSCB' which sets out

potential risks in a period of considerable change and transition. The report also includes recommended actions to effectively mitigate these risks which HSCB staff are starting to implement, working in partnership across the impacted organisations.

Currently, the HSCB has put in place the following controls:-

- Chief Executive is a member of the Oversight Board - participation in the Oversight Group established to provide strategic oversight and leadership to the closure of the HSCB.
- Director of Finance/Deputy Chief Executive is member of a Design Advisory Team which provides oversight, co-ordination and challenge to the work of the Design Groups.
- HSCB staff continued to participate in a number of Design Groups, which cover the key functional areas of the HSCB and are jointly chaired by HSCB and DoH colleagues. Corporate communication relating to the work of the design groups was shared with staff summer 2019.
- Director of Finance / Deputy Chief Executive and interim Director of Performance and Service Improvement participation in Closure of HSCB Staff Side Forum which is jointly chaired by Staff Side.
- Active and ongoing consideration of business priorities within SMT and with DoH colleagues as issues arise.
- Regular updates to staff when information is available.
- Regular review of key duties as staff leave the HSCB.
- A corporate approach to recruitment, retention and VES.

Other associated issues which were identified and will require careful management include the potential loss of the HSCB's corporate memory and knowledge during the period of transition. To ensure this risk is appropriately addressed, a number of actions have been identified and included in the Information Governance Action Plan.

Prescribing Efficiency Targets

Through successive years, significant attention has been paid to the costs of medicines supplied in primary care. In 2016/17 £23m of efficiencies were delivered and £17m delivered in 2017/18. In 2018/19, another substantial target of £32m was proposed by DoH. Efficiencies were delivered through a range of projects with the shortfall being made up via the reduction of prices and other actions which reduced volume. With the range of actions undertaken, the requirement for the pharmacy efficiency programme for 2018/19 was met on a recurrent basis and no recurrent deficit was carried forward into 2019/20.

In 2019/20 the overall pharmacy efficiency target for HSCB was £12.1m. A plan was developed encompassing 53 projects to deliver efficiencies in primary care drug costs. Other price efficiencies were delivered arising from Drug Tariff changes. A total of £15.1m was delivered in year (£2.9m and £12.2m

respectively); however, the over-delivery in efficiencies of £3.0m applies in year only.

The HSCB continues to work closely with the DoH, Trusts and other key stakeholders in order to make the most effective use of the available budget without impacting patient care. The general pharmaceutical spend for the year 2019/20 was within budget.

Supported Housing

The Northern Ireland Housing Executive (NIHE) budget pressures have resulted in the capping of revenue funding (Supporting People Funding), thereby limiting the capacity to jointly plan and develop new supported housing schemes with HSC organisations. NIHE removed all supported housing schemes for HSC client groups from their capital development plans from 2017/18 and beyond, unless they had already committed funding. This will limit the capacity of HSC organisations to develop appropriate housing options for vulnerable client groups. Separate arrangements are now in place between the HSCB and NIHE to facilitate the speedy development of supported living arrangements for people awaiting discharge from hospitals such as Muckamore Abbey Hospital.

Acute Service Continuity

There are currently challenges in maintaining services at some smaller acute hospital sites, primarily related to levels of hospital consultant, staff grade and junior doctor vacancies with a corresponding over-reliance on locum doctors. The HSCB will continue to work with Trusts and other key stakeholders to identify and, as far as possible, mitigate potential risks to service continuity.

One example of significant progress has been the implementation of the recommendations of the Daisyhill Pathfinder Group. The Direct Assessment Unit was one of the proposals agreed through the Pathfinder Project to help sustain and develop unscheduled care services for the Newry and Mourne population. The Unit opened at the beginning of February with a number of services moving in from other parts of the hospital – the Day Clinical Centre, Older People's Assessment Unit and the Clinical Decision Unit. Since it opened, the new Direct Assessment Unit at Daisy Hill Hospital (DHH) is having a real impact on patient care. Between February 2019 and July 2019, 1,323 people have been seen by the team for observation, diagnostics or treatment, freeing up space and time in the busy Emergency Departments (EDs) for other patients who need more immediate acute care.

The Pathfinder Project continues to progress other recommendations for appropriately staffed ED at DHH to be achieved through a five year workforce plan, strengthened High Dependency Care, the expansion of Acute Care at Home services across Newry and Mourne along with the introduction of rapid assessment clinics in DHH and a 'Discharge to Assess' model to improve the management of frail elderly patients.

Work continues to recruit the staff required as outlined in the original business case across all clinical disciplines. Looking further ahead, the HSCB continues to

believe that the essential requirement in order to sustain improved performance in the future is the progress and completion of the strategic reform of the system recommended in the Bengoa Report (2016) and Delivering Together. Work to progress the Pathfinder Project was temporarily suspended due to COVID-19.

Cyber Security

The eHealth programme has commissioned a programme of work through the Cyber security Programme Board focussed on a programme of work as outlined below.

A risk has been added and updated on the HSCB corporate risk register outlining the response to the threat of cyber-attacks on the HSC network leading to potential loss of access to systems for a sustained period and/or the potential loss of data. A review of existing business continuity plans is underway to ensure they reflect the nature of the potential threat. This includes the review of incident management processes, and the development of additional guidance to ensure clarity on the operation of existing business continuity arrangements in the event of a cyber-attack with potential or actual impact on the HSC. Internal Audit is continuing ICT audits based around the National Cyber Security Centre (NCSC) "10 Steps to Cyber Security". The recommendations and outcomes of the audits across HSC organisations are being incorporated into Cyber Security work programmes and plans.

The Chief Digital Information Officer (CDIO) is accountable for the delivery of the Digital Health Portfolio and for Cyber security. Through the Memorandum of Understanding (MoU) in place between DoH, HSCB and PHA the CDIO directs the staff in the eHealth Department (HSCB) and Centre for Connected Health (PHA) now rebranded as Digital Health & Care NI (DHCNI) to design, deliver and monitor this portfolio. Cyber Security is currently a Programme within the DHCNI portfolio and a Programme Manager is in place in the Business Services Organisation.

Instability in Independent Care Home Market

Nursing homes and most residential homes are owned and managed by independent providers. A small but significant number of the smaller businesses may close during any given period due to the planned retirement of the owner/manager, requiring Trusts to take steps to ensure service continuity.

Larger companies continue to seek cost efficiencies and the reduction of costs through consolidation of their estate and withdrawal from areas where profits are deemed to be low or reducing. Many homes levy Third Party 'top-up' charges to cover the cost of enhancements to core services (typically in relation to room quality or additional requested services).

Nursing homes continue to find it very difficult to recruit and retain appropriately qualified staff to deliver the required level of care and leadership within homes. The continued use of nursing agency staff to fill vacant posts has exacerbated cost pressures felt across the sector.

The HSCB continues to:

- Host regular meetings with HSC Trusts, DOH and RQIA to share information and assess the state of provision on a regional basis.
- Support HSC Trusts where local contingency plans have to be implemented on the occasion of the re-registration or closure of a home and make sure any regional learning is identified and shared. To date, such contingency plans when tested have been found to be robust.
- Develop a regional process to provide regular updates on bed availability. This includes the testing of a technology based solution - a web based 'portal' to improve real-time access to information about bed availability.
- Meet regularly with the independent sector to better understand the pressures affecting the market that could impact on market instability, including sector cost pressures, including workforce.
- Monitor any relevant Failure to Comply Notices issued by the regulator, to identify trends and manage risks and engage with the regulator as appropriate.
- Engage with DOH and take forward any relevant actions arising from the Commissioner for Older People's 'Home Truths' report.
- Develop and refine the regional 'Care Homes Business Continuity response plan' with DoH, Trusts and Providers and other stakeholders in the event of a serious or catastrophic failure within the care home sector.

In addition, the PHA has commenced a review of nursing levels within independent care homes and continues to work with care home staff to strengthen that workforce and enhance skills, and therefore, care.

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 future relationship between the EU and the UK will be determined by negotiations taking place during the transition period ending 31 December 2020. As uncertainty still exists regarding the Northern Ireland Protocol, this is under review in conjunction with key stakeholders. The Health & Social Care Board will continue to work collaboratively with colleagues during 2020/21 across the Department, HSC and wider to ensure we are appropriately prepared for the end of the transition period and the new dispensation.

Neurology Services Review

The HSCB and PHA continue to liaise with the Trusts and Independent Sector providers through the Regional Co-Ordination Group for the Neurology Recall to co-ordinate the work necessary to complete the recall process. Phase 1 of the recall process has been completed and a report on activity and outcomes was published in December 2019. Phase 2 of the recall commenced in November

2018 and a report covering the period to October 2019 will be published during 2020. A process is underway to identify any further cohorts of people to be included as part of the recall.

The Regional Co-ordination Group will ensure that a consistent approach is taken both during the review and reporting of outcomes to enable patients to be assessed and receive appropriate treatment and care where it is required.

The DoH has established an independent inquiry panel to examine how concerns about an individual clinician are communicated and responded to. The DoH has also directed RQIA to undertake an expert review of the records of deceased patients under the care of the clinician in question, whose deaths occurred over the past ten years.

Furthermore, the DoH has requested the RQIA to undertake a review of the governance of outpatient services in the Belfast Trust with a particular focus on neurology services and HSCB are participating in this review.

Delivery of Transformational Programmes including Multi-Disciplinary Teams

Primary Care continues to experience pressures and demands which impact on the ongoing delivery of services, a result of increases in population, long term chronic illnesses and greater clinical complexity, patient expectations and a shortage of GPs. Transformational funding has been provided for investment into primary care with the aim of addressing these increased demands to improve the way that services will be delivered in future.

Funding was allocated in the current financial year for a number of transformational programmes, with a key programme being the development of Multi-Disciplinary Teams (MDTs). Five areas are now progressing the MDT model and include Down, Derry, West Belfast, Causeway and Newry Federations who are recruiting physiotherapists, social workers, mental health practitioners and increased numbers of district nurses and health visitors. These programmes are being delivered by GP Federations and Trusts working together.

Programme Boards have been set up for all MDTs including representation from DoH, HSCB, Trust and GP Federations. These Programme Boards have responsibility for overseeing the implementation of MDTs and to ensure that appropriate governance arrangements are in place. Funding was allocated on a capitation basis and will be monitored on a regular basis. Monies have also been allocated for training, specialist support and evaluations.

In addition, as part of the Transformation Programme, funding has been allocated for other schemes, for example Advanced Nurse Practitioner schemes, development of paramedic support, further support for the Practice Based Pharmacist scheme, together with a number of Pharmacy and Dental developments. Pharmacy schemes include Pharmacy First, Living Well, Safer Community Pharmacies, Improving Medicines Safety and Connection to HSC Network. Dental schemes include Oral Health surgery, Fluoride Varnish programmes and training for General Dental Practitioners (GDPs).

The risks around taking forward these programmes include a potential lack of suitably qualified staff, insufficient interest in training programmes, together with the potential workforce impact on other parts of the service and the availability of suitable accommodation in GP Practices. The HSCB continues to work with all interested parties (DoH, PHA, Trusts, Northern Ireland General Practitioners Committee (NIGPC), and Universities, etc.) to take forward the various programmes.

The MDT programme now includes five Federation areas. The existing MDT areas of Down, Derry and West Belfast have now been joined by two new MDT areas in Causeway and Newry & District Federation. This increases the population coverage within these MDT areas to circa 640,000, delivered via a total of more than 100 GP practices, with the MDTs supported by in excess of 500 WTEs in staff across Physiotherapy, Mental Health Practitioners, Social Workers, District Nursing and Health Visiting professions. Planning is underway to develop the programme across all 17 Federations.

Confidence and Supply Funding – Business Case Approval Process

A condition of the Confidence and Supply funding provided to each HSC organisation was approval of each business case by the organisation's Senior Management Team/Directors and the HSCB. BSO Internal Audit carried out a review in 2019/20 to consider the HSCB processes around the allocation of Transformation monies with a focus on the approval of Investment Proposal Templates (IPTs) within the HSCB (after approval within individual Trusts). The review was based on the risk that IPTs were not appropriately approved by the HSCB in line with agreed procedure and that accurate allocations were not being made.

Through the review, Internal Audit identified that the allocations made by the HSCB were appropriately made, for the sample tested, in line with agreed IPTs. Internal Audit did however note that for a number of IPTs, HSCB SMT approval had not been obtained as required and a number of business cases were approved by the HSCB that had not been fully populated as required. There were also instances where there was a lack of evidence to support scrutiny and challenge by the approving HSCB Directors. It is recognised that transformation proposals were developed through the Transformation Implementation Group and that a large number of the IPTs were required to be approved by Trust Chief Executives before submission to HSCB.

Insufficient Placements

Foster Care: Trusts are struggling to meet the demand for foster care. A number of initiatives have been addressed and in particular marketing and recruitment strategies but these are unlikely to resolve the increased demand for placements in the immediate future. The Board has submitted an inescapable pressure in relation to additional social work capacity to undertake fostering assessments to address capacity issues.

Children with a Disability: All Trusts continue to report significant pressures in regard to availability of placements for children with disability including complex

health care needs who require longer term care arrangements. The HSCB convened a workshop to review the issues, however, the trend continues on an upward trajectory, not only in terms of prevalence of need but also in terms of impact on the outcomes for the young people involved but also in terms of significant financial pressures for Trusts with numbers of placements having to be outsourced to private providers or out of the jurisdiction placements. The Children's Services Improvement Board have prioritised children with disabilities as a key area of work in 2020/21 and a regional working group comprising of Assistant Directors has been established by the HSCB to progress a range of work streams including a draft framework for disability services

Residential Children's Homes: The availability of residential care placements has significantly reduced in line with the strategy direction i.e. Transforming Your Care, which emphasis a reduced reliance on residential children's home placements. Reduction over the last number of years has been from 12% to 5.5%. As a consequence there is greater demand for and reliance on other placement types. The out workings of the regional review of facilities continues to be progressed as a key priority.

Workforce Pressures

All Trusts report increased pressures in securing sufficient staffing levels in some areas of children's services which has been compounded by the additional posts identified within the transformation process, sick leave and other related Human Resources issues.

The DoH are leading on a Social Work Workforce Review, with all relevant stakeholders, including the HSCB. The outcome of which, it is hoped with set the strategic direction for workforce planning in the future.

Muckamore Abbey Hospital

A number of serious adverse incident (SAI) reports raising concerns about the care and treatment of adult in-patients with a learning disability led to a Level 3 Independent Review of the care and treatment at the hospital under SAI procedures. Adult Safeguarding investigations were also commenced, and police investigation is ongoing. A number of staff have been suspended pending disciplinary and criminal proceedings. Relevant referrals have been made to relevant professional/registering bodies.

Belfast Trust has developed and commenced work on actions to ensure the safety and wellbeing of patients. Health and Social Care Trusts, with patients in the hospital whose discharge is delayed, are accelerating work to identify and develop suitable community placements to enable discharge/resettlement. The HSCB has established and will chair a Directors' forum to oversee this work. HSCB has also recently set up a Regional Learning Disability Operational Delivery Group with a focus on resettlement as well as addressing regional issues with respect to discharge and providing services to maintain people in their communities of origin.

The HSCB is leading on work to review and modernise services for people with a learning disability. Assessment and Treatment for people with a learning disability experiencing mental health difficulties (currently treated in Learning Disability Hospitals) has been identified as an accelerated work stream of the review. The Review report review was received. A regional workshop was held in December 2019 with clinical and social care colleagues across the region to begin to address the recommendations from the review report. A series of further regional workshops is planned to progress the development of Assessment and Treatment Services across the region culminating with a pathway and service specification by September 2020.

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

Novel Coronavirus – 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 and its ALBs immediately enacted emergency response plans across the NI Health sector. There is 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 were 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. This has required a number of measures to urgently repurpose and temporarily reconfigure the provision of services, and to identify additional capacity including the need to ensure availability of appropriate Personal Protective Equipment. Financial measures have been put in place by the NI Executive to enable NI to tackle the response to COVID-19 and Health has obtained essential financial support from this package of measures to assist in the ongoing fight against COVID-19.

Contingency arrangements have been in operation including the establishment of an Emergency Operations Centre within the Department to support HSC colleagues' frontline response to the pandemic. Given the wide ranging impact and the need to react immediately to changing healthcare needs, this has had an effect on the ability to conduct routine health business with a need to curtail non-urgent healthcare activity in order to re-direct resources to deal with the pandemic. There have been substantial resourcing impacts across the Department and ALBs to scale up the response 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.

Social distancing measures were implemented in line with The Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 and the health sector played an important part in ensuring the NI population were aware of the need to adhere to the measures to reduce risk of transmission. The actions of the health sector throughout the continued response to the pandemic are based on the ongoing assessment of three key criteria: the most up-to-date scientific evidence; the ability of the health service to cope; and the wider impacts on our health, society and the economy. Across healthcare, leading on the testing of COVID-19 in NI has and continues to be a key priority with testing centres being set up across the country including mobile testing. The Department's Expert Advisory Group has overseen the strategic approach to testing in NI. The Minister of Health is a member of the Ministerial Testing Taskforce, chaired by the Secretary of State for Health, and so NI is fully engaged with the strategy for testing at a national level. NI testing capacity has also been increased through Health's facilitation of the UK Coronavirus National Testing Programme. Northern Ireland Contact Tracing Service began contact tracing all confirmed cases of COVID-19 on 18 May 2020. Volunteers have been recruited and redeployed across the health sector and the team is being scaled up to strive to ensure that every conceivable effort is made to continue to limit transmission as lockdown measures across the region are eased. The Department has prepared a COVID-19 Test, Trace and Protect Strategy which sets out the public health approach to minimising COVID-19 transmission in the community in Northern Ireland. The Chief Medical Officer has established a Strategic Oversight Board for the NI COVID-19 strategy which will bring all of the key elements together – namely testing, contact tracing, information and advice, and support - working together with colleagues across the HSC to endeavour to maintain community transmission at a low level and respond to clusters of infection localised in NI. The early outcome is more favourable than the modelling of the reasonable worst case scenario and the Department and HSC are no longer in emergency response mode, some areas have been able to be stood down in recent times although there is a need to continue to remain vigilant and in a state of operational readiness to react should a resurgence occur.

Alongside the ongoing and changing needs of response to COVID-19 there is an urgent need to seek to rebuild wider healthcare services and confidence in the community. Officials have over recent weeks carried out an urgent project to assess the impact of COVID-19 on HSC services delivery. On 9 June 2020 a new Strategic Framework was launched aimed at rebuilding health and social care services. The key aim will be to incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions. A new Management Board for Rebuilding HSC Services has also been created. This will broadly consist of senior Department of Health officials, Trust Chief Executives and other HSC leaders. COVID-19 has had a profound impact on the delivery of health and social care services and across the HSC plans are incrementally being enacted to begin recovery whilst planning for a potential second wave. The Department is continuing to work closely across the HSC to support and define the requirements and opportunities to meet continuing and rapidly changing pressures in these unprecedented and challenging times.

Board Succession Planning

In April 2019, the Department of Health extended the Terms of Office for Non-Executive Directors for a further year, to 31 March 2020 and advised that a recruitment exercise would be undertaken to replace all who had served in excess of ten years. The post of Chair was advertised in September 2019 and a new Chair has been appointed from 1 April 2020 until 31 March 2022, which is in line with the current planned date for closure of the HSCB. The Non-Executive Directors posts were advertised in December 2019, with interviews held in March 2020. The Department of Health extended the Terms of Office for 3 Non-Executive Directors for a maximum period of up to 6 months from 1 April 2020, and advised that it may give notice to terminate the appointment at any time.

The following extract from the NIAO – HSCB 2019-20 Audit Strategy (January 2020) referred to the retirement of the Chief Executive, as Accounting Officer at the end of March 2020 as well as a number of known changes to the make-up of the Senior Management Team at, or closely after, the year end: *"We consider that these gaps could create a governance risk with significant loss of corporate memory, which impacts on the Board as it transitions to the planned future arrangements. We will consider the impact of the change in Accounting Officer and Senior staff during the year including any associated impact on financial controls and who will sign off the Annual Report and Accounts."* At the request of the Permanent Secretary, the Chief Executive will remain in post for a period of time post 31 March 2020. The appointment of new Non-Executive Directors and clarification on management structure will be key to the governance of the organisation in the 2020/21 year.

11. Conclusion

The HSCB 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 Body and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the HSCB has operated a sound system of internal governance during the year 2019/20.

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 Health and Social Care Board.

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, 2017/18, 2018/19 and 2019/20 Senior Executive pay awards had not been received by 31 March 2020. Any related payments, therefore have not been made to Executive Directors.

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

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the HSCB received any other bonus or performance related pay in 2019/20. 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 initially with a possibility of extension.

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 2019/20.

Membership of the Remuneration and Terms of Service Committee:

Dr Ian Clements - Chair
Dr Melissa McCullough – Non-Executive Director
Stephen Leach – Non-Executive Director

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

Senior Employees' Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows (it should be noted that there were no bonuses paid to any Director during 2019/20 or 2018/19):

Non Executive Members (Table Audited)

	2019/20				2018/19			
Name	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**
Dr Ian Clements (*Chair*)	35-40	100	-	35-40	35-40	-	-	35-40
Mr Stephen Leach	5-10	100	-	5-10	10-15	-	-	10-15
Dr Melissa McCullough	5-10	-	-	5-10	10-15	-	-	10-15
Mr Robert Gilmore	5-10	100	-	5-10	10-15	100	-	10-15
Mr Brendan McKeever	5-10	100	-	5-10	10-15	-	-	10-15
Mr John Mone	5-10	100	-	5-10	10-15	-	-	10-15
Mrs Stephanie Lowry	5-10	-	-	5-10	10-15	-	-	10-15

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.

Circular HSC(F) 17-2019 entitled The Payment of Remuneration of Chairs and Non-Executive Members Determination (Northern Ireland) 2019 No. 2 was issued in May 2019 which resulted in back dated remuneration to non-executive members.

Executive Members (Table Audited)

	2019/20				2018/19			
Name	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**
Mrs Valerie Watts *Chief Executive*	155-160	200	-	155-160	155-160	200	32,000	185-190
Mrs Fionnuala McAndrew *Director of Social Care and Children* (Leaver 30th Apr 2018)	-	-	-	-	5-10 (90-95 FYE)	-	-	5-10
Mr Cecil Worthington *Acting Director of Social Care and Children* (Leaver 31st Jul 2018)	-	-	-	-	30-35 (90-95 FYE	-	-	30-35
Ms Marie Roulston *Director of Social Care and Children*	80-85	300	22,000	105-110	55-60 (80-85 FYE)	100	-	55-60
Mr Paul Cummings *Director of Finance / Deputy Chief Executive*	120-125	6,700	(9,000)	115-120	120-125	5,600	107,000	230-235
Dr Sloan Harper *Director of Integrated Care*	130-135	2,700	-	130-135	125-130	5,000	(14,000)	115-120
Dr Miriam McCarthy *Director of Commissioning*	115-120	100	14,000	130-135	115-120	100	213,000	325-330
Mrs Lisa McWilliams *Interim Director of Performance Management & Service Improvement*	85-90	200	17,000	100-105	80-85	100	15,000	95-100
Mr Sean Donaghy *Director of eHealth and External Collaboration* (Leaver 14th Dec 2018)	-	-	-	-	85-90 (125-130 FYE)	-	-	85-90
Ms Louise McMahon *Director*	105-110	500	24,000	130-135	105-110	-	21,000	130-135

Notes

Between October 2016 and March 2020 Mrs Valerie Watts was also the Interim Chief Executive of the Public Health Agency (PHA) and had dual responsibility for the HSCB and the PHA. All remuneration and pension information has been reported under the substantive post in the HSCB and referenced as such in the PHA report.

FYE – Full Year Equivalent

Pensions of Senior Management – Executive Members (Table Audited)

Name	2019/20				
	Real increase in pension and related lump sum at age 60	Total accrued pension at age 60 and related lump sum	CETV at 31/03/19	CETV at 31/03/20	Real increase in CETV
	£000s	£000s	£000s	£000s	£000s
Mr Paul Cummings *Director of Finance / Deputy Chief Executive*	0-2.5 pension 0-2.5 lump sum	50-55 pension 160-165 lump sum	1,217	1,282	7
Dr Miriam McCarthy *Director of Commissioning*	0-2.5 pension	15-20 pension	271	313	29
Mrs Lisa McWilliams *Interim Director of Performance Management & Service Improvement*	0-2.5 pension	15-20 pension 35-40 lump sum	266	289	15
Mrs Marie Roulston *Director of Social Care and Children*	0-2.5 pension 2.5-5 lump sum	35-40 pension 110-115 lump sum	851	888	38
Ms Louise McMahon *Director*	0-2.5 pension	15-20 pension	251	287	27

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 in any contingent spouse's pension payable from the scheme.

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

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

The CETV figures 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 takes account of the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses 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. There has been no significant change to the ratio when compared to 2018/19.

	2020	2019
Band of Highest Paid Director's Remuneration (band in £000s)	155-160	155-160
Median Total Remuneration (£)	37,570	34,062
Ratio	4.13	4.55

No employee received remuneration in excess of the highest paid director, and remuneration ranged from £3,744 to £155,000 in both years. The lowest salary relates to Local Commissioning Group (LCG) members.

Staff Report

Staff Costs Comprise (Table Audited):

	2020			2019
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	22,591	1,058	23,649	21,167
Social security costs	2,362	110	2,472	2,277
Other pension costs	4,315	203	4,518	3,184
Total staff costs reported in Statement of Comprehensive Expenditure	**29,268**	**1,371**	**30,639**	**26,628**
Less recoveries in respect of outward secondments			(562)	(527)
Total net costs			**30,077**	**26,101**

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension Scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in the 2019/20 accounts.

Average Number of Persons Employed (Table Audited)

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

	2020			2019
	Permanently employed staff	Others	Total	Total
Commissioning of Health and Social Care	465	34	**499**	**478**
Less average staff number relating to capitalised staff costs	-	-	**-**	**-**
Less average staff number in respect of outward secondments	(8)	-	**(8)**	**(7)**
Total net average number of persons employed	**457**	**34**	**491**	**471**

Reporting of early retirement and other compensation scheme – 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	
	2020	2019	2020	2019	2020	2019
<£10,000	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	3	-	3
£50,001 - £100,000	-	-	-	1	-	1
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
£200,001 - £250,000	-	-	-	-	-	-
Total number of exit packages by type	**0**	**0**	**0**	**4**	**0**	**4**
Total resource cost £000s	**£0**	**£0**	**£0**	**£154**	**£0**	**£154**

The table above shows the total cost of exit packages agreed and accounted for in 2019/20 and 2018/19. £61k exit costs were paid in 2019/20, the year of departure (2018/19 £256k).

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 HSCB 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 HSCB had no staff benefits in 2019/20 or 2018/19.

HSCB Management Costs

	2020 £000s	2019 £000s
HSCB management costs	34,443	31,267
Income:		
RRL	5,552,620	5,074,709
Less non cash RRL excluding element to cover clinical negligence provision	(6,611)	3,553
Income per Note 4	56,853	56,405
Less interest receivable	(14)	(15)
Total Income	**5,602,848**	**5,134,652**
% of total income	**0.61%**	**0.61%**

The management costs have been prepared on consistent basis from previous years and have been based on the appropriate HSCB elements contained in the circular HSS (THR) 2/99.

Retirements due to ill-health

During 2019/20 there were no early retirements from the HSCB agreed on the grounds of ill-health.

Staff Composition

At 31 March 2020 the HSCB's headcount is 500 employees which equates to 453.2 WTE. Of this figure, 434 are permanent staff members with 66 temporary staff. The ratio of female to male employees is 360 women to 140 men.

There were 75 senior staff who earn over £67k or would earn over £67k if they were 1.00 WTE, of these 37 are women and 38 men.

Sickness Absence Data

The corporate cumulative annual absence level for the HSCB for the period from 1 April 2019 – 31 March 2020 is 3.17% (2018/19 4.27%).

There were 28,033 hours lost due to sickness absence (2018/19 36,794 hours), or the equivalent of 56 hours (2018/19 75 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 7.5 days (2018/19 10 days) per employee.

Staff Policies Applied During the Financial Year

The Board is committed to promoting equality of opportunity and good relations for all groups under Section 75 of the Northern Ireland Act and Equality of Opportunity Policy. In respect of recruitment, the introduction of Shared Services enabling online recruitment continues to be embedded and processes updated as required within the HSCB and other HSC organisations. A number of HR policies are available on the HSCB website including Attendance Management, Special Leave and Family Pack and all staff have access to a range of organisational policies and procedures in respect of flexible working arrangements which have been equality screened.

The Board along with several other organisations continues to participate in the Disability Placement scheme which provides a 6 month employment placement for individuals with a disability. After 4 months of placement, these individuals can apply for internal posts within organisations participating in the scheme.

The Occupational Health Service provided to the organisation under a SLA continues to support managers and staff as required. Any recommendations in respect of reasonable adjustments where necessary, are implemented in order to facilitate and maintain the staff member within the working environment. This may include relocation of an individual to another post and all appropriate training required will be facilitated. Human Resource colleagues work closely with all parties involved. The Disability legislation is part of the Selection and Recruitment training for Board staff. All staff including those with a disability have the same opportunity and access to training, development and promotion in respect of career development. This is assisted by the participation of all staff in the Performance Appraisal process which affords discussion on career development and progression.

Expenditure on Consultancy

The HSCB had no expenditure on external consultancy projects during 2019/20 (nil in 2018/19).

Off-Payroll Engagements

The HSCB is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed with a total cost of over £58,200 during the financial year, which were not paid through the HSCB Payroll. In 2019/20 there were no such ‘off-payroll’ engagements (2018/19 – none).

ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure

The HSCB 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 Departmental guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit, and during 2019/20 there has been no evidence of irregular expenditure.

Losses and Special Payments (Table Audited)

Type of loss and special payment		2019/20		2018/19
		Number of Cases	£	£
Administrative write-offs				
	Bad Debts	1	9,142	-
Cash losses				
	Cash Losses – Overpayments of salaries, wages and allowances	2	144	-
Special Payments				
	Compensation payments:			
	- Clinical Negligence	4	360,000	3,077,262
	- Employers Liability	4	47,167	197,994
TOTAL		**11**	**416,453**	**3,275,256**

Special Payments

There were no other special payments or gifts made during the year (2018/19 – none).

Other Payments and Estimates

There were no other payments made during the year (2018/19 – none).

Estimate of Patient Exemption Error/Potential Fraud

The calculation was carried out by the Business Services Organisation (BSO) Information and Registration Unit on the following basis:

1. The BSO, on behalf of HSCB handles payments to contractors providing family practitioner services. Probity Services which are part of the Counter Fraud and Probity Service within the BSO are responsible for checking patient exemption entitlement and for taking follow-up action where a patient's claim to exemption from statutory charges has not been confirmed.

2. Given the volume of Dental and Ophthalmic claims each year, sampling is used to establish an estimate of the total annual potential loss due to error/potential fraud. Patients aged 80 and over are excluded from the population from which the sample is drawn. The sample data is passed to the Department for Works and Pensions and the NHS Business Services Authority to provide independent verification of entitlement across a number of exemption categories. Following these checks, the sample data is returned and uploaded to the Electronic Prescribing and Eligibility System (EPES) case management system. All cases where verification of entitlement has not been confirmed are referred within EPES for further follow-up checks.

3. To estimate the total annual loss due to patient exemption error/potential fraud in the population, the BSO applies the estimated rate of loss for each exemption category in the sample to the volumetric and average liability for that category in the population.

4. Those cases which are discontinued and not followed up (for example where the patient is terminally ill or in a nursing home) are now excluded from the calculation.

5. With regard to this year's sample, it was necessary to exclude 21 cases from the overall sample - 11 cases for dental and 10 cases for ophthalmic service areas respectively which, due to a technical issue, had insufficient time for an investigation to be undertaken. However, inspection of the data suggests these are a random selection of cases and their exclusion should not, therefore, impact on the central estimate nor distort the comparison with last year's results.

The best estimate available for patient exemption fraud for 2019/20 is £3.9m (£2.9m Dental, £1.0m Ophthalmic). The combined estimate for 2018/19 was £4.0m. If the 2018/19 figures were uplifted to 2019/20 activity levels, the estimated combined figure would have been £3.7m.

Losses and Special Payments over £250,000 (Table Audited)

Losses and Special Payments over £250,000		Number of Cases	2019/20 £	2018/19 £
Special Payments				
	Compensation payments:			
	- Clinical Negligence	-	-	2,914,345
TOTAL		**-**	**-**	**2,914,345**

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 20 of the financial statements, the HSCB also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is considered too remote to meet the definition of contingent liability. As at 31 March 2020, the HSCB is not aware of any remote contingent liabilities.

Mrs Valerie Watts

Chief Executive

Date 7th July 2020

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 the Health and Social Care Board for the year ended 31 March 2020 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. 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 Health and Social Care Board's affairs as at 31 March 2020 and of the Health and Social Care Board'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 of opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs) 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 the Health and Social Care Board in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2016, 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

I have nothing to report in respect of the following matters in relation to which the ISAs(UK) require me to report to you where:

- the Health and Social Care Board's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Health and Social Care Board have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Health and Social Care Board's ability to continue to adopt the going concern basis.

Other Information

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

In connection with my audit of the financial statements, 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, 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:

- 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.

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 and for being satisfied that they give a true and fair view.

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 evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. 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.

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.

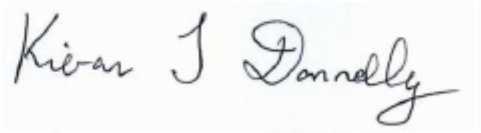
Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

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

Report

I have no observations to make on these financial statements.



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

10 July 2020

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2020

FOREWORD

These accounts for the year ended 31 March 2020 have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Health and Social Care Board

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2020

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.

		2020	2019
Income	**NOTE**	**£000**	**£000**
Revenue from contracts with customers	4.1	54,978	54,739
Other operating income (excluding interest)	4.2	1,861	1,651
Total operating income		56,839	56,390
Expenditure			
Staff costs	3	(30,639)	(26,628)
Purchase of goods and services	3	(1,064,367)	(1,031,683)
Depreciation, amortisation and impairment charges	3	(2,939)	(2,530)
Provision expense	3	(3,599)	6,142
Other operating expenditure	3	(21,211)	(20,896)
Total operating expenditure		(1,122,755)	(1,075,595)
Net operating Expenditure		**(1,065,916)**	**(1,019,205)**
Finance income	4.1	14	15
Finance expense	3	0	0
Net expenditure for the year		(1,065,902)	1,019,190
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(1,482,817)	(1,347,842)
South Eastern Health & Social Care Trust		(701,086)	(627,148)
Southern Health & Social Care Trust		(714,732)	(645,346)
Northern Health & Social Care Trust		(788,843)	(704,072)
Western Health & Social Care Trust		(687,506)	(626,307)
NIAS Health & Social Care Trust		(87,578)	(76,448)
NI Medical & Dental Training Agency		(1,866)	(1,826)
PCC		(5)	(5)
Total RRL issued		(4,464,433)	(4,028,994)
Total Commissioner resources utilised		(5,530,335)	(5,048,184)
Revenue Resource Limit (RRL) received from DoH	23.1	5,552,620	5,074,709
Surplus / (Deficit) against RRL		**22,285**	**26,525**

OTHER COMPREHENSIVE EXPENDITURE	**NOTE**	**2020 £000**	**2019 £000**
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/5.2/8	3,607	201
Net gain/(loss) on revaluation of intangibles	6.1//6.2/8	0	2
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(1,062,295)**	**(1,018,987)**

The notes on pages 98 to 126 form part of these accounts.

The surplus held by HSCB offsets the £21.7m control total for the Western Health and Social Care Trust, which has been authorised by the Department of Health in 2019/20. This has ensured that the HSC achieved a breakeven position across all organisations. Further details are provided within the Governance Statement.

STATEMENT of FINANCIAL POSITION as at 31 March 2020

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

	NOTE	2020 £000	£000	2019 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	20,441		16,385	
Intangible assets	6.1/6.2	2,354		2,160	
Financial assets	7	644		703	
Total Non Current Assets			23,439		19,248
Current Assets					
Trade and other receivables	12	4,207		4,958	
Other current assets	12	19		26	
Financial assets	7	117		113	
Cash and cash equivalents	11	1,243		749	
Total Current Assets			5,586		5,846
Total Assets			**29,025**		**25,094**
Current Liabilities					
Trade and other payables	13	(173,397)		(167,345)	
Provisions	14	(2,714)		(2,075)	
Total Current Liabilities			(176,111)		(169,420)
Total assets less current liabilities			**(147,086)**		**(144,326)**
Non Current Liabilities					
Provisions	14	(31,000)		(30,487)	
Total Non Current Liabilities			(31,000)		(30,487)
Total assets less total liabilities			**(178,086)**		**(174,813)**
Taxpayers' Equity and other reserves					
Revaluation reserve		12,416		8,809	
SoCNE reserve		(190,502)		(183,622)	
Total equity			**(178,086)**		**(174,813)**

The financial statements on pages 94 to 126 were approved by the Board on 7th July 2020 and were signed on its behalf by:

Signed  (Chairman) Date 7th July 2020

Signed  (Chief Executive) Date 7th July 2020

The notes on pages 98 to 126 form part of these accounts.

Health and Social Care Board

STATEMENT of CASH FLOWS for the year ended 31 March 2020

The Statement of Cash Flows shows the changes in cash and cash equivalents of the HSCB during the reporting period. The statement shows how the HSCB 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 HSCB. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the HSCB's future public service delivery.

	NOTE	2020 £000	2019 £000
Cash flows from operating activities			
Net surplus after interest/Net operating cost	SoCNE	(1,065,902)	(1,019,190)
Adjustments for non cash costs	3	6,611	(3,553)
(Increase)/decrease in trade and other receivables	12	758	58
Increase/(decrease) in trade payables	13	6,051	11,218
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	702	(64)
Movements in payables relating to the purchase of intangibles	13	48	(592)
Use of provisions	14	(2,447)	(4,741)
Net cash outflow from operating activities		(1,054,179)	(1,016,864)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(3,629)	(3,135)
(Purchase of intangible assets)	6	(742)	(143)
(FTC loans issued to GPs)	7	(43)	0
FTC loans returned by GPs	7	118	115
Net cash outflow from investing activities		(4,296)	(3,163)
Cash flows from financing activities			
Grant in aid		1,058,969	1,015,298
Cap element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net financing		1,058,969	1,015,298
Net increase (decrease) in cash & cash equivalents in the period		494	(4,730)
Cash & cash equivalents at the beginning of the period	11	749	5,479
Cash & cash equivalents at the end of the period	11	**1,243**	**749**

The notes on pages 98 to 126 form part of these accounts.

Health and Social Care Board

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2020

This statement shows the movement in the year on the different reserves held by HSCB, analysed into the SoCNE Reserve (i.e. that reserve that reflects a contribution from the Department of Health). The Revaluation Reserve 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 HSCB 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 2018		**(179,782)**	**8,606**	**(171,176)**
Changes in Taxpayers' Equity 2018/19				
Grant from DoH		1,015,298	0	1,015,298
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(1,019,190)	203	(1,018,987)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	52	0	52
Balance at 31 March 2019		**(183,622)**	**8,809**	**(174,813)**
Changes in Taxpayers' Equity 2019/20				
Grant from DoH		1,058,969	0	1,058,969
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(1,065,902)	3,607	(1,062,295)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	53	0	53
Balance at 31 March 2020		**(190,502)**	**12,416**	**(178,086)**

The notes on pages 98 to 126 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 Health and Social Care Board (HSCB) for the purpose of giving a true and fair view has been selected. The particular policies adopted by the HSCB 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 HSCB is funded, the Statement of Financial Position will show a negative position. In line with the FReM, sponsored entities such as the HSCB 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 Land, 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 HSCB;
- 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

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors Global Standards & UK National Supplement in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2020 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the HSCB are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- Land and non-specialised buildings – open market value for existing use;
- Specialised buildings – depreciated replacement cost; and
- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets.

Modern Equivalent Asset

DoF has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. Land and Property Services (LPS) have included this requirement within the latest valuation.

Assets under Construction (AUC)

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

Short Life Assets

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

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

Revaluation Reserve

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

1.4 Depreciation

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

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the HSCB 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 HSCB'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 HSCB'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 HSCB 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 HSCB had no non-current assets held for sale in either 2019/20 or 2018/19.

1.9 Inventories

The HSCB had no inventories as at 31 March 2020 or 31 March 2019.

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 5 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 HSCB 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.

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 HSCB did not hold any investments in either 2019/20 or 2018/19.

1.12 Research and Development expenditure

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 HSCB as lessee

The HSCB held no finance leases during 2019/20 or 2018/19.

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 HSCB as lessor

The HSCB did not have any lessor agreements in either 2019/20 or 2018/19.

1.16 Private Finance Initiative (PFI) transactions

The HSCB had no PFI transactions during 2019/20 or 2018/19.

1.17 Financial instruments

- Financial assets

Financial assets are recognised on the Statement of Financial Position (SoFP) when the HSCB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

During 2015/16 the HSCB introduced one type of financial instrument, the GP Infrastructure Loans Scheme. These assets have been initially recognised at fair value in the SoFP.

IFRS 9 introduces the requirement to consider the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the HSCB'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.

- Financial liabilities

The HSCB had no financial liabilities in 2019/20 or 2018/19.

- 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 HSCB is not exposed to the degree of financial risk faced by business entities.

The HSCB 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 HSCB in undertaking activities. Therefore the HSCB is exposed to little credit, liquidity or market risk.

- Currency risk

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

- Interest rate risk

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

- Credit and liquidity risk

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

The credit risk associated with the financial instruments (GP Loan Scheme) has been assessed as minimal during the application process and will be reviewed on an annual basis.

1.18 Provisions

In accordance with IAS 37, provisions are recognised when the HSCB has a present legal or constructive obligation as a result of a past event, it is probable that the HSCB 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 2020, using the discount rates issued by the Department of Finance (DoF) below.

Rate	Time period	Real rate
Nominal	Short term (0 – 5 years)	0.51%
	Medium term (5 – 10 years)	0.55%
	Long term (10 - 40 years)	1.99%
	Very long term (40+ years)	1.99%
Inflationary	Year 1	1.9%
	Year 2	2.0%
	Into perpetuity	2.0%

Note that Public Expenditure System 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) 37-2019.

The discount rate to be applied for employee early departure obligations is -0.5% with effect from 31 March 2020.

The HSCB 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 HSCB 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 HSCB 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 HSCB.

1.19 Contingent liabilities/assets

In addition to contingent liabilities disclosed in accordance with IAS 37, the HSCB 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 HSCB 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 HSCB, 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 HSCB. A contingent asset is disclosed where an inflow of economic benefits is probable.

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 2020. Untaken flexi leave is estimated to be immaterial to the HSCB 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 HSCB and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The HSCB 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 HSCB and charged to the Statement of Comprehensive Net Expenditure at the time the HSCB commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension Scheme updated to reflect current financial conditions (and a change in financial assumption methodology) will be used in 2019/20 HSC Pension Scheme 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 HSCB had no third party assets in 2019/20 or 2018/19.

1.24 Government Grants

The HSCB had no government grants in 2019/20 or 2018/19.

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 HSCB 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 not yet adopted.

IFRS 16 *Leases* replaces IAS 17 *Leases* and is effective with EU adoption from 1 January 2019. In line with the latest advice from HM Treasury and the Financial Reporting Advisory Board, IFRS 16 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2021.

Management consideration of the impact on introduction of IFRS 16 on initial application remains under consideration and will be fully determined in 2020/21.

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 2020. 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 HSCB has identified 3 segments: Commissioning, Family Health Services (FHS) and Administration, including the Dementia Project. Net expenditure is reported by segment as detailed below:

Summary	NOTE	2020 £000	2019 £000
Commissioning	2.1	4,547,145	4,101,578
FHS	2.2	926,494	904,159
Board Administration	2.3	56,696	42,447
Total Commissioner Resources utilised		**5,530,335**	**5,048,184**

2.1 Commissioning

Expenditure	NOTE	2020 £000	2019 £000
Belfast Health & Social Care Trust	SoCNE	1,482,817	1,347,842
South Eastern Health & Social Care Trust	SoCNE	701,086	627,148
Southern Health & Social Care Trust	SoCNE	714,732	645,346
Northern Health & Social Care Trust	SoCNE	788,843	704,072
Western Health & Social Care Trust	SoCNE	687,506	626,307
NIAS Health & Social Care Trust	SoCNE	87,578	76,448
NI Medical & Dental Training Agency	SoCNE	1,866	1,826
Patient and Client Council	SoCNE	5	5
Other Providers	3.1	109,262	98,939
		4,573,695	4,127,933
Income			
Income from activities	4.1	26,550	26,355
Commissioning Net Expenditure		**4,547,145**	**4,101,578**

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

Expenditure	NOTE	2020 £000	2019 £000
General Medical Services	3.1	307,600	284,813
General Dental Services	3.1	131,598	132,103
General Pharmaceutical Services	3.1	492,866	491,236
General Ophthalmic Services	3.1	22,844	24,375
		954,908	932,527
Income			
Revenue from contracts with customers FHS	4.1	28,414	28,368
FHS Net Expenditure		**926,494**	**904,159**

2.3 Board Administration

Expenditure	NOTE	2020 £000	2019 £000
Salaries and wages	3.2	30,639	26,628
Operating expenditure	3.2	21,335	21,052
Non-cash costs	3.3	3,652	(6,116)
Depreciation	3.3	2,959	2,563
		58,585	44,127
Revenue from contracts with customers			
FTC interest	4.1	14	15
Other Operating Income			
Staff secondment recoveries	4.2	563	527
Canteen	4.2	161	164
Other income	4.2	1,151	974
		1,875	1,665
Board Administration Net Expenditure		**56,696**	**42,447**

NOTE 3 - EXPENDITURE

3.1 Commissioning:	2020 £000	2019 £000
General Medical Services	307,600	284,813
General Dental Services	131,598	132,103
General Pharmaceutical Services	492,866	491,236
General Ophthalmic Services	22,844	24,375
NHS Trusts	46,569	40,061
Other providers of healthcare and personal social services	62,693	58,878
Total Commissioning	1,064,170	1,031,466

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	23,649	21,167
Social security costs	2,472	2,277
Other pension costs	4,518	3,184
Supplies and services - general	197	217
Establishment	19,698	18,922
Transport	12	15
Premises	1,318	1,302
Bad debts	9	0
Rentals under operating leases	101	101
Costs of exit packages provided for	0	495
Total Operating Expenses	51,974	47,680

3.3 Non cash items:		
Depreciation	2,308	2,007
Amortisation	651	556
Impairments relating to FTC	(19)	(33)
Loss on disposal of property, plant & equipment (including land)	19	7
Increase / Decrease in provisions (provision provided for in year less any release)	3,842	(5,346)
Cost of borrowing of provisions (unwinding of discount on provisions)	(243)	(796)
Auditors remuneration	53	52
Total non cash items	6,611	(3,553)
Total	**1,122,755**	**1,075,593**

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

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers	2020 £000	2019 £000
Income from Department of Education	25,598	25,445
CAWT	349	307
Family Health Services Receipts	26,053	26,051
Family Health Services Receipts (PHA GMS)	2,361	2,318
FTC interest receivable	14	15
Accommodation	603	603
Total	**54,978**	**54,739**

4.2 Other Operating Income	2020 £000	2019 £000
Canteen	161	164
Seconded Staff	563	527
Other income - Home Office	980	630
Other income - MacMillan	132	251
Other income - Other	39	94
Total	**1,875**	**1,666**

TOTAL INCOME	**56,853**	**56,405**

NOTE 5.1 - PROPERTY, PLANT & EQUIPMENT (Year ended 31 March 2020)

	Land £000	Buildings (excluding dwellings) £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2019	3,584	7,793	6	18,573	164	30,120
Indexation	0	0	0	2	0	2
Additions	0	119	0	2,806	0	2,925
Transfers	0	0	0	(150)	0	(150)
Revaluation	466	1,626	0	0	0	2,092
Disposals	0	(1)	0	(1,629)	0	(1,630)
At 31 March 2020	**4,050**	**9,537**	**6**	**19,602**	**164**	**33,359**
Depreciation						
At 1 April 2019	0	1,271	6	12,294	164	13,735
Indexation	0	0	0	1	0	1
Revaluation		(1,513)	0	0	0	(1,513)
Disposals	0	(1)	0	(1,610)	0	(1,611)
Provided during the year	0	316	0	1,991	0	2,307
At 31 March 2020	**0**	**73**	**6**	**12,676**	**164**	**12,919**
Carrying Amount						
At 31 March 2020	**4,050**	**9,464**	**0**	**6,926**	**0**	**20,440**
At 31 March 2019	**3,584**	**6,522**	**0**	**6,279**	**0**	**16,385**
Asset financing						
Owned	4,050	9,464	0	6,926	0	20,440
Carrying Amount						
At 31 March 2020	**4,050**	**9,464**	**0**	**6,926**	**0**	**20,440**

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 (2019 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2019 - £nil).

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors Global Standards & UK National Supplement in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2020 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

As a result of the recent and ongoing COVID-19 pandemic events, and in line with current RICS guidance, LPS have advised that market evidence gathered as part of the recent 5-yearly valuation has attached to it, due to the worldwide impact of the pandemic, an increased level of uncertainty in terms of informing opinions of value. Whilst at this stage there is no evidence of impairment as at year-end, the future impact of COVID-19 on land and building values cannot yet be accurately assessed therefore the need for further future valuations will remain under consideration, subject to resources.

NOTE 5.2 - PROPERTY, PLANT & EQUIPMENT (Year ended 31 March 2019)

	Land £000	Buildings (excluding dwellings) £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2018	3,413	7,492	6	17,181	164	28,256
Indexation	171	35	0	7	0	213
Additions	0	236	0	2,964	0	3,200
Transfers	0	30	0	(14)	0	16
Disposals	0	0	0	(1,565)	0	(1,565)
At 31 March 2019	**3,584**	**7,793**	**6**	**18,573**	**164**	**30,120**
Depreciation						
At 1 April 2018	0	954	6	12,134	164	13,258
Indexation	0	9	0	3	0	12
Transfers	0	5	0	11	0	16
Disposals	0	0	0	(1,558)	0	(1,558)
Provided during the year	0	303	0	1,704	0	2,007
At 31 March 2019	**0**	**1,271**	**6**	**12,294**	**164**	**13,735**
Carrying Amount						
At 31 March 2019	**3,584**	**6,522**	**0**	**6,279**	**0**	**16,385**
At 1 April 2018	**3,413**	**6,538**	**0**	**5,047**	**0**	**14,998**
Asset financing						
Owned	3,584	6,522	0	6,279	0	16,385
Carrying Amount						
At 31 March 2019	**3,584**	**6,522**	**0**	**6,279**	**0**	**16,385**
Asset financing						
Owned	3,413	6,538	0	5,047	0	14,998
Carrying Amount						
At 1 April 2018	**3,413**	**6,538**	**0**	**5,047**	**0**	**14,998**

NOTE 6.1 - INTANGIBLE ASSETS (Year ended 31 March 2020)

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under Construction £000	Total £000
Cost or Valuation				
At 1 April 2019	2,300	5,500	49	7,849
Indexation	0	1	0	1
Additions	218	61	415	694
Transfers	0	0	150	150
Disposals	(1)	(32)	0	(33)
At 31 March 2020	**2,517**	**5,530**	**614**	**8,661**
Amortisation				
At 1 April 2019	1,334	4,355	0	5,689
Indexation	0	0	0	0
Transfers	0	0	0	0
Disposals	(1)	(32)	0	(33)
Provided during the year	264	387	0	651
At 31 March 2020	**1,597**	**4,710**	**0**	**6,307**
Carrying Amount				
At 31 March 2020	**920**	**820**	**614**	**2,354**
At 31 March 2019	**966**	**1,145**	**49**	**2,160**
Asset financing				
Owned	920	820	614	2,354
Carrying Amount				
At 31 March 2020	**920**	**820**	**614**	**2,354**

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 (2019 - £nil).

NOTE 6.2 - INTANGIBLE ASSETS (Year ended 31 March 2019)

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under £000	Total £000
Cost or Valuation				
At 1 April 2018	2,226	5,322	0	7,548
Indexation	0	3	0	3
Additions	377	309	49	735
Transfers	0	(16)	0	(16)
Disposals	(303)	(118)	0	(421)
At 31 March 2019	**2,300**	**5,500**	**49**	**7,849**
Amortisation				
At 1 April 2018	1,427	4,142		5,569
Indexation	0	1		1
Transfers	0	(16)		(16)
Disposals	(303)	(118)		(421)
Provided during the year	210	346		556
At 31 March 2019	**1,334**	**4,355**	**0**	**5,689**
Carrying Amount				
At 31 March 2019	**966**	**1,145**	**49**	**2,160**
At 1 April 2018	**799**	**1,180**	**0**	**1,979**
Asset financing				
Owned	966	1,145	49	2,160
Carrying Amount				
At 31 March 2019	**966**	**1,145**	**49**	**2,160**
Asset financing				
Owned	799	1,180	0	1,979
Carrying Amount				
At 1 April 2018	**799**	**1,180**	**0**	**1,979**

NOTE 7 - FINANCIAL INSTRUMENTS

As the cash requirements of HSCB 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 HSCB's expected purchase and usage requirements and the HSCB is therefore exposed to little credit, liquidity or market risk.

During 2015/16 the HSCB introduced one type of financial instrument, the GP Infrastructure Loans Scheme. This scheme utilises Financial Transactions Capital (FTC) in the form of loans to GPs to enable them to undertake premises developments and improvements for health and social care purposes. The first two loans were issued in 2015/16, with a 3rd loan issued in 2016/17. One GP practice increased their loan in 2019/20 by an additional amount of £43k.

These assets have been initially recognised at fair value in the Statement of Financial Position.

	2020 Assets £000	2019 Assets £000
Balance at 1 April	816	898
Additions	43	0
Settlement	(118)	(115)
Impairments	(128)	(148)
Reversal of impairments	148	181
Balance at 31 March	**761**	**816**

Analysis of expected timing of discounted flows

	2020 Assets £000	2019 Assets £000
Not later than one year	117	113
Later than one year and not later than five years	335	324
Later than five years	309	379
	761	**816**

NOTE 8 - IMPAIRMENTS

	2020 Financial Assets £000	2019 Financial Assets £000
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	(19)	(33)
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0
Total value of impairments for the period	**(19)**	**(33)**

The HSCB had no other impairments in 2019/20 in relation to Property, Plant & Equipment or intangible assets.

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 HSCB did not hold any assets classified as held for sale in 2019/20 or 2018/19.

NOTE 10 - INVENTORIES

The HSCB did not hold any inventories as at 31 March 2020 or 31 March 2019.

NOTE 11 - CASH AND CASH EQUIVALENTS

	2020 £000	2019 £000
Balance at 1st April	749	5,479
Net change in cash and cash equivalents	494	(4,730)
Balance at 31st March	**1,243**	**749**

The following balances at 31 March were held at	2020 £000	2019 £000
Commercial banks and cash in hand	1,243	749
Balance at 31st March	**1,243**	**749**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2020 £000	2019 £000
Amounts falling due within one year		
Trade receivables	2,965	3,315
VAT receivable	468	1,173
Other receivables - not relating to fixed assets	171	469
Other receivables - relating to property plant and equipment	603	0
Other receivables - relating to intangibles	0	0
Trade and other receivables	**4,207**	**4,958**
Prepayments and accrued income	19	26
Other current assets	**19**	**26**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
Prepayments and accrued income		
Other current assets falling due after more than one year	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**4,207**	**4,958**
TOTAL OTHER CURRENT ASSETS	**19**	**26**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**4,226**	**4,984**

The balances are net of a provision for bad debts of £nil (2019 £nil).

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2020 £000	2019 £000
Amounts falling due within one year		
Other taxation and social security	852	591
Trade capital payables - property, plant and equipment	32	735
Trade capital payables - intangibles	562	610
Trade revenue payables	61,069	46,269
Payroll payables	2,215	1,773
Clinical negligence payables	463	67
VER payables	0	96
BSO payables	6,494	4,532
Other payables	2,656	5,881
Accruals	99,028	106,763
Deferred income	26	28
Trade and other payables	**173,397**	**167,345**
Total payables falling due within one year	**173,397**	**167,345**
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**173,397**	**167,345**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2020

	Clinical negligence £000	Other £000	2020 £000
Balance at 1 April 2019	21,986	10,576	32,562
Provided in year	2,119	2,188	4,307
(Provisions not required written back)	(272)	(194)	(466)
(Provisions utilised in the year)	(1,852)	(595)	(2,447)
Cost of borrowing (unwinding of discount)	(270)	28	(242)
At 31 March 2020	**21,711**	**12,003**	**33,714**

Comprehensive Net Expenditure Account charges	**2020 £000**	**2019 £000**
Arising during the year	4,307	2,484
Reversed unused	(466)	(7,830)
Cost of borrowing (unwinding of discount)	(242)	(796)
Total charge within Operating expenses	**3,599**	**(6,142)**

Analysis of expected timing of discounted flows

	Clinical negligence £000	Other £000	2020 £000
Not later than one year	2,037	677	2,714
Later than one year and not later than five years	3,179	2,136	5,315
Later than five years	16,495	9,190	25,685
At 31 March 2020	**21,711**	**12,003**	**33,714**

Provisions have been made for 3 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, and Injury Benefit. The provision for Injury Benefit relates to the future liabilities for the HSCB based on information provided by HSC Pensions. For Clinical Negligence, Employer's and Occupier's claims the HSCB has estimated an appropriate level of provision based on professional legal advice.

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2019

	Clinical negligence £000s	Other £000s	2019 £000s
Balance at 1 April 2018	32,757	10,688	43,445
Provided in year	1,520	964	2,484
(Provisions not required written back)	(7,509)	(321)	(7,830)
(Provisions utilised in the year)	(3,989)	(752)	(4,741)
Cost of borrowing (unwinding of discount)	(793)	(3)	(796)
At 31 March 2019	**21,986**	**10,576**	**32,562**

Analysis of expected timing of discounted flows

	Clinical negligence £000s	Other £000s	2019 £000s
Not later than one year	1,453	621	2,075
Later than one year and not later than five years	4,101	1,924	6,025
Later than five years	16,432	8,031	24,462
At 31 March 2019	**21,986**	**10,576**	**32,562**

NOTE 15 - CAPITAL COMMITMENTS

The HSCB did not have any capital commitments as at 31 March 2020 or 31 March 2019.

NOTE 16 - COMMITMENTS UNDER LEASES

16.1 Finance Leases

The HSCB had no finance leases in 2019/20 or 2018/19.

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	2020 £000	2019 £000
Buildings		
Not later than 1 year	51	101
Later than 1 year and not later than 5 years	0	51
Later than 5 years	0	0
	51	**152**

16.3 Commitments under Lessor Agreements

The HSCB had no lessor obligations in either 2019/20 or 2018/19.

NOTE 17 - COMMITMENTS UNDER PFI CONTRACTS AND OTHER SERVICE CONCESSION ARRANGEMENTS

The HSCB had no commitments under PFI or service concession arrangements in either 2019/20 or 2018/19.

NOTE 18 - OTHER FINANCIAL COMMITMENTS

The HSCB did not have any other financial commitments at either 31 March 2020 or 31 March 2019.

NOTE 19 - FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which the HSCB is funded, financial instruments play a more limited role within the HSCB in creating risk than would apply to a non public sector body of a similar size, therefore the HSCB is not exposed to the degree of financial risk faced by business entities. The HSCB 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 HSCB in undertaking activities. Therefore the HSCB is exposed to little credit, liquidity or market risk.

For disclosures relating to HSCB financial instruments in existence at 31 March 2020, please refer to Note 7.

NOTE 20 - CONTINGENT LIABILITIES

Clinical negligence

The HSCB has contingent liabilities of £246k.

	2020 £000	2019 £000
Total estimate of contingent clinical negligence liabilities	222	180
Amount recoverable through non cash RRL	(222)	(180)
Net Contingent Liability	**0**	**0**

In addition to the above contingent liability, provision for clinical negligence is given in Note 14. Other clinical 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.

Contingencies not relating to clinical negligence are as follows:

	2020 £000	2019 £000
Employers' liability	24	23
Amount recoverable through non cash RRL	(24)	(23)
Total	**0**	**0**

The Department of Justice has power to set the personal injury discount rate for Northern Ireland in consultation with the Government Actuary and the Department of Finance. The rate is currently 2.5% however, the Department has consulted the statutory consultees on a proposed change to the rate to -1.75%. Once their responses are received, the Minister will consider these and make a final decision. As a final decision on this consultation remains outstanding at this time significant uncertainty remains around the timing and the financial effect therefore it is not currently possible to quantify the potential impact on the Health & Social Care Board of any change in discount rate.

In Northern Ireland the discount rate currently has to be set in accordance with legal principles set out by the House of Lords in Wells v Wells. However, the Department also proposes to take forward a consultation on changing how the rate is set. Both England and Wales and Scotland have already made primary legislation which changed how their discount rates are set and have reviewed their rates under these new legislative frameworks.

NOTE 21 - RELATED PARTY TRANSACTIONS

The HSCB is an arms length body of the Department of Health and as such the Department is a related party with which the HSCB has had various material transactions during the year. In addition, the HSCB has material transactions with the Business Services Organisation for which the DoH is regarded as the parent, and also with HSC Trusts.

Mr Danny Power (Interim Chair of Belfast Local Commissioning Group) is a member of the Board of Directors of Clan Mor Surestart and the West Belfast Partnership Board, both of which are organisations that do business with the HSCB.

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 HSCB.

NOTE 22 - THIRD PARTY ASSETS

The HSCB had no third party assets in 2019/20 or 2018/19.

NOTE 23 - FINANCIAL PERFORMANCE TARGETS

23.1 Revenue Resource Limit

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

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

	2020 Total £000	2019 Total £000
DoH (excludes non cash)	5,541,776	5,076,405
Non cash RRL (from DoH)	6,611	(3,553)
Adjustment for CRL grants received	4,233	1,857
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**5,552,620**	**5,074,709**

23.2 Capital Resource Limit

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

	2020 Total £000	2019 Total £000
Gross capital expenditure by HSCB	3,620	3,935
FTC issued to third parties	43	0
(FTC received from third parties)	(118)	(115)
Net capital expenditure	3,545	3,820
Capital Resource Limit	8,148	5,719
Adjustment for CRL grants received	(4,233)	(1,857)
Net CRL	3,915	3,862
Overspend/(Underspend) against CRL	**(370)**	**(42)**

23.3 Financial Performance Targets

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

	2019/20 £000	2018/19 £000
Net Expenditure	(5,530,335)	(5,048,184)
RRL	5,552,620	5,074,709
Surplus / (Deficit) against RRL	22,285	26,525
Break Even cumulative position(opening)	35,400	8,875
Break Even cumulative position (closing)	**57,685**	**35,400**

Materiality Test:	2019/20 %	2018/19 %
Break Even in year position as % of RRL	0.40%	0.52%
Break Even cumulative position as % of RRL	1.04%	0.70%

The surplus held by HSCB offsets the £21.7m control total for the Western Health and Social Care Trust, which has been authorised by the Department of Health in 2019/20. This has ensured that the HSC achieved a breakeven position across all organisations.

NOTE 24 - EVENTS AFTER THE REPORTING PERIOD

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

DATE OF AUTHORISATION FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 10th July 2020.