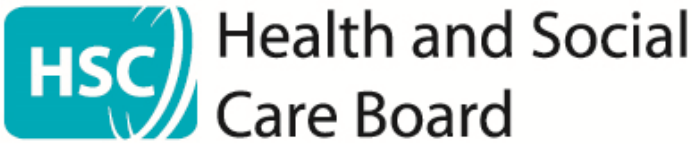

ANNUAL REPORT & ACCOUNTS
2020/21

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PERFORMANCE REPORT

Performance Overview

Welcome to the Health and Social Care Board's Annual Report covering the financial year 2020/21.

Purpose

The purpose of this Performance Report is to define the role of the Health and Social Care Board, how it has performed during the year and the key issues and risks affecting the achievement of its objectives.

About the Health and Social Care Board

The Health and Social Care Board (HSCB) is a statutory body responsible for the commissioning of health and social care services for the population of Northern Ireland (NI). 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 Care services for the 1.8 million people who live in NI.

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 NI Executive – currently around £6.4 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) 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; 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. Its expenditure amounts to around £17 million on every single day of the year.

The HSCB publishes a Commissioning Plan, in partnership with the Public Health Agency (PHA), in response to the direction set by the Department of Health. The Commissioning Plan sets out the range of services to be commissioned and the associated costs of delivering these. From June 2020, the Health Minister directed the HSCB, PHA, Trusts and the Business Services Organisation to prioritise service planning, delivery and deployment of resources, for a two year period, to stabilise and restore service delivery as quickly as possible by achieving the right balance between delivering Covid-19 and non-Covid-19 activity.

In pursuance of this priority, the Commissioning Plan Direction (CPD), Commissioning Plan and associated Service and Budget Agreements (SBAs), for the 2019/20 financial year were rolled forward into the years 2020/21 and 2021/22 and updated to reflect Departmental budget allocations in each of these years.

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 NI 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, Allied Health Professionals, 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 in line with Co-Production Guide for Northern Ireland - Connecting and Realising Value through People' (DoH, 2018) (available at www.health-ni.gov.uk). This strategy aims to ensure that service users, carers and the public influence are at the heart of planning, commissioning and delivery of health and social care services.

The participation of the HSCB in Community Planning is a statutory duty as set out in the requirements of the Local Government Act (NI) 2014. Through its collaboration with 11 Community Planning Partnerships, the HSCB contributes to the implementation of shared plans for promoting wellbeing, enhancing quality of life and improving community cohesion.

Chair's Report

This has been an exceptionally tough year for all – both professionally and personally. We have had to adapt our working practices, and I know that staff both in the Health and Social Care Board (HSCB) and across the Health and Social Care (HSC), have risen tremendously to the challenge.

There have been many challenges facing the HSC over the years, but I think that facing the Covid-19 pandemic – the first one in our lifetime – has been the greatest and has led us to having to work together at a pace never encountered before. I have been genuinely impressed and encouraged by the enthusiasm, professionalism and commitment of staff during these testing times.

During 2020/21, the HSCB has continued to lead on the delivery of improved outcomes for patients and service users in line with key system wide priorities and direction. However, similar to all other sectors, this year's efforts were concentrated on responding to, and minimising service disruption generated by the pandemic, with the HSCB playing a key role in supporting Trusts and the wider system.

The Covid-19 pandemic has highlighted serious long established fragilities in our health and social care system. In particular it has had significant impact on our already unacceptable waiting lists with too many people waiting too long for treatment, which we know only too well, can cause much distress and anxiety for patients and their families.

We know that people in Northern Ireland are looking for urgent action on this burning issue, and it must be put right as a priority. We now restart the journey of rebuilding and transforming our services. However, this will require significant and recurrent funding. Further details of key work underway to address the challenges are highlighted in the Chief Executive's report and included in the Performance Analysis and Governance Statement.

Throughout the year there are many examples of how HSCB staff have been at the heart of the Covid response, while maintaining core services as far as possible. These include:

- The establishment of 10 GP Covid Centres to help manage the increase of coronavirus cases in the community by separating patients with symptoms of the virus from those with non Covid-19 related conditions. This has ensured that vital GP services could be maintained with minimal disruption.

- Working closely with the DoH, PHA, Trusts and care home providers, the HSCB led on the development of a Regional Surge Plan for the Care Home sector in NI to help protect residents and staff and slow the spread of the virus.

- The establishment of a co-ordinated regional approach to utilise available theatre capacity for red flag cancer and urgent patients. In addition, the HSCB worked with Trusts to expand critical care capacity across NI and monitor Intensive Care Unit beds on a daily basis.

- A remote sign language interpreting service, funded by DoH and the Department for Communities and managed by the HSCB, enabled equitable access to HSC services for people who are deaf, deafblind and hard of hearing.

- Assisting people who were shielding, including working with the Community Development Health Network to set up a volunteer medicines delivery service; and raising awareness of community support hubs to GPs and community pharmacists through innovative work undertaken by Integrated Care Partnerships.

- Supporting mental health and emotional wellbeing initiatives for staff and the public.

- Playing a major role, alongside partners, in planning, supporting and monitoring the roll out of the Covid Vaccination Programme in GP practices which has been very successful to date.

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.

During the reporting year, there have been significant changes to the HSCB Board at Executive and Non-Executive level, with a number of members either retiring or reaching the end of their terms. I would like to personally thank them for their professionalism, commitment and dedication to duty. I would also like to pay tribute to the new Board members who are playing a vital role in providing strong leadership and direction as we enter the final stages of the plans to migrate HSCB staff to the Business Services Organisation and functions to the Department of Health.

I am confident that exciting opportunities lie ahead as we continue to make a real difference to health and social care services in NI.

Les Drew
Chair

Chief Executive's Overview

The opportunity to reflect on the past year enables us to take stock and give account of our collective efforts in addressing the Covid-19 pandemic, and to highlight how the HSCB, working with the wider HSC and all of our partners, continued to make a positive impact on the care, health and wellbeing of the population of NI over the past year.

Throughout 2020/21 the Covid-19 pandemic has had a profound impact locally, nationally and globally. It has compelled us to redesign and improve our services, and to remodel the delivery of care and treatment to meet the emerging needs of people and communities, all in the face of the many challenges created by public health regulations and competing service demands.

The professionalism and commitment of the people who work across the HSC have long been the strength of the system. Since March 2020 this has never been more evident. It has been inspiring to view how our HSCB staff, in collaboration with other HSC staff and key partners, adapted and reconfigured services to ensure the people of NI continued to access safe, appropriate treatment and care. This is evident throughout this report and demonstrates the scale of the work undertaken in responding to the pandemic.

Without question the pandemic has shone a spotlight on an already very fragile HSC system. The HSC continues to bear unprecedented strain, particularly in relation to waiting times for emergency and unplanned care. Likewise, waiting times for outpatient assessment, diagnostics, inpatient and day case treatment remain extremely challenging across NI. Ministerial targets have not been met, leaving thousands of people waiting in avoidable pain. All of this very strongly and very starkly reinforces the need for transformation in line with the direction set out for us in 'Health and Wellbeing 2026: Delivering Together' (DoH, 2016) (available at www.health-ni.gov.uk). However, without a long-term recurrent funding commitment, we will be severely restricted in our ability to deliver.

It is clear that we must learn the lessons of the pandemic in terms of capacity, resilience and investment. Transformation is required over a number of years to ensure we reduce reliance on hospitals, reconfigure some services on a smaller number of sites and increase focus on the prevention of ill health. This will inevitably mean changes in how people access some services, however, this is vital to ensure we address the systemic challenges in a sustainable way; and can provide greater equality of access across NI to safe, high quality and timely care. Strong engagement and partnership with service users and a wider public conversation will be a critical part of making the changes.

As we emerge from the pandemic, the focus of the HSC in 2021/22 will be on resetting all elective services in an environment that is safe for both staff and patients. This is likely to be a gradual process with a direct link to the scale and speed of de-escalation of ICU and the managed return of theatre and surgical staff.

A number of key developments to rebuild and transform service are underway. A few examples, not exhaustive, include:

- An Elective Care Framework to be published shortly setting out both the immediate and longer term actions and funding requirements needed to tackle waiting lists.

- Trust Rebuild Plans which set out how routine activity will be restarted in the wake of the latest surge. These focus on developing green pathways and green sites to separate planned/routine services and emergency services and maximise theatre capacity. The Health Minister's Oral Statement to the NI Assembly on 13 April 2021 (available at www.health-ni.gov.uk) provides further information on rebuild plans.

- NI-wide regional approaches to the prioritisation of surgery and to orthopaedic surgery.

- The development and implementation of Covid-19 Urgent and Emergency Care Plan, 'No More Silos' (October 2020) (available at www.health-ni.gov.uk) which sets out 10 key actions to ensure that Urgent and Emergency Care Services across primary and secondary care are maintained and improved in an environment that is safe for patients and for staff.

I am pleased to report that despite this year's additional challenges and demands the HSCB was successful in meeting its breakeven duty. With careful financial management, at the end of 2020/21, the wider HSC showed a breakeven position.

Over the past five years the HSCB has been going through a major period of transition as it works towards closure. Subject to the legislative changes, from 1 April 2022 responsibility for existing Health and Social Care Board functions will move to the Department of Health (DoH). The functions will be undertaken by a new group to be established within DoH. Staff contracts will then transfer to the Business Services Organisation in a hosting arrangement, enabling HSCB staff to retain HSC terms and conditions.

Robust project management structures are in place to manage the migration process and to support staff through the change process. A number of design groups, jointly chaired by DoH and HSCB leads, have been established to help shape the new structures.

A new 'People Strategy' has now been introduced which aims to support our staff, enhance leadership at all levels, effect a smooth migration and ensure that we all make an impact for patients and service users in everything we do both now and into the future.

In addition the Minister recently approved the commencement of a programme of work to develop a new way of planning services based on an integrated approach underpinned by local need.

I am confident that all of these changes will play a key role in strengthening accountability and authority within the system, streamlining structures, transforming how we plan, deliver and manage services, and in responding to the significant challenges ahead.

We now have a unique and exciting opportunity to shape and build a new and exciting model for the commissioning and oversight of Health services in NI.

I especially wish to commend all HSCB staff and Board members for their continued professionalism, commitment and resilience during this last year.

The following report aims to provide an insight into some of this work.

Sharon Gallagher

Chief Executive

Non-Executive Directors' Report

The primary role of the HSCB Board Non-Executive Directors is to maintain oversight across the HSCB's performance in meeting its corporate goals and objectives, by bringing an independent voice and challenge to decision-making within the organisation.

The year 2020/21 saw considerable movement in the membership of the HSCB Board Executive and Non-Executive Teams. The commitment of the former Chair and Non-Executive Directors, during their terms on the Board, was acknowledged at all levels in the organisation. The Board met on 11 occasions and because of the pandemic, the April and May 2020 meetings were held without members of the public present. In order to maintain corporate governance arrangements, public access to Board Meetings recommenced from June 2020 to enable public participation or observation at virtual Board Meetings. Non-Executive Directors participated in the HSCB's governance infrastructure through the system of corporate governance described in the Governance Statement.

2020/21 presented significant challenges for the HSCB and wider HSC, in managing the serious impact of the coronavirus pandemic and its unprecedented impact on services.

We fully recognise the seriousness of the situation in relation to waiting times which was reflected in the Minister's Assembly statement in April 2021. Too many people are waiting in avoidable pain and we support the Minister's call for urgent action, wider transformation, supported by sustainable funding. As Non-Executive members we fully recognise that health is a human right and are firmly committed to seeing it is enjoyed by all on an equitable basis.

Throughout 2020/21, the Non-Executive Board members have fully engaged with Executive colleagues, supporting and challenging decisions regarding emergency response, service design and delivery, governance and assurance, transformation, and policy/strategy development. The HSCB Board has developed, delivered and monitored a range of statutory responsibilities including:

- HSCB finances, ensuring financial stewardship in line with the organisation's breakeven duty, recognising the challenges involved in balancing a wide range of pressures, both Covid and non-Covid.
- HSCB performance, understanding the impact on the wider community when performance and waiting lists are at unacceptable levels.
- Transformation and reform of HSC services in line with the direction set out in 'Health and Wellbeing 2026: Delivering Together' (DoH, 2016) (available at www.health-ni.gov.uk).
- The restructuring process and the HSCB Migration Project which facilitates the transfer of the responsibility for HSCB functions to the DoH and the transfer of HSCB staff to the BSO. The migration, supported by the longer term development of a population health model, will continue to be a key priority and play a major role in

ensuring the HSC meets the needs of all in NI and in addressing the inequalities in health outcomes.

Non-Executive Directors recognise how difficult 2020/21 has been for everyone, with pressures faced at all levels of the organisation and wish to thank the Senior Management Team and staff for their dedication and commitment in what has been a most challenging year.

Organisational Structure

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/Deputy Secretary (Designate). The Chief Executive/Deputy Secretary (Designate) 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.

Corporate Objectives for 2020/21

In order to maintain the organisation's focus on the pandemic response the 2019/20 Corporate Plan was rolled over (see the Governance Statement). Grouped under six key themes, it reflects how the organisation:

- Conducts its business
- Manages 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 NI 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

Financial Management

The HSCB received an allocation for 2020/21 of £6.4bn from the DoH to commission health and social care services for the population of NI. During the year this funding was supplemented by income from other sources of £40m.

At the end of 2020/21 the HSCB achieved a financial position of £12.7m surplus, which includes a control total of £12m held to manage pressures in the Western HSC Trust. 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.

Developing Services

The HSCB continues to work with the Public Health Agency, Trusts and other key partners in developing a range of new and innovative health and social care services aimed at keeping people well; providing care closer to communities; 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 of this report provides details of service improvements and developments implemented during 2020/21.

Key Issues and Risks

During 2020/21, the HSCB continued to lead on the delivery of improved outcomes for patients and service users in line with Departmental direction. Whilst a modern patient-centred Health and Social Care system remains the HSCB's primary aim, this year's efforts concentrated on responding to, and minimising service disruption generated by, the coronavirus pandemic. Hospital, social, community and primary care services were scaled back to ensure sufficient staff and resources were available, and capacity created, to cope with anticipated Covid-19 surges. The HSCB worked alongside the DoH and wider system and implemented emergency response and business continuity plans. Available resources were diverted to meet the ongoing demands of the pandemic response and to ensure that critical and statutory functions were delivered during these challenging times. A number of risks have been summarised in the Chair, Chief Executive and Non Executive's Report; see also the Performance Report and also Section 11B of the Governance Statement for comprehensive detail of these and other key issues, risks and the actions that are being taken forward in response.

PERFORMANCE ANALYSIS

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 for the performance management of services delivered through hospital-based care, and 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 at www.hscboard.hscni.net.

As covered in the Chief Executive's overview and Chair's report, the Covid-19 pandemic has had a seriously detrimental impact on services, requiring a significant effort right across the HSC and beyond to reprioritise and refocus resources to ensure the most urgent and time critical patients (both Covid and non-Covid) could receive the care and treatment they needed.

A number of the key challenges and also some examples of the key achievements in terms of making a positive impact on the care, health and wellbeing of service users are highlighted below. The HSCB/PHA Annual Quality Report 2019/20 (available at www.hscboard.hscni.net) also provides a comprehensive overview of the HSCB and PHA's commitment to ensuring safe, high quality services and putting patients, clients and their carers at the centre of everything we do.

1.1 Unscheduled Care

Prior to Covid-19, there was clear evidence that urgent and emergency care services in NI were under increasing pressure. The impact of Covid-19 and the focus on infection prevention and social distancing has further highlighted the critical need for change.

The current DoH targets on emergency care waiting times in NI for 2020/21 state that:

- 95% of patients attending any Type 1, 2 or 3 emergency care department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency care department should wait longer than twelve hours.' These targets were not met.

- By March 2021 at least 80% of patients to have commenced treatment following triage within 2 hours.

During 2020/21:

- 38,482 patients waited longer than 12 hours in an Emergency Department (ED) compared to 45,442 during the same period in 2019/20.

- 65% of patients were either treated and discharged home, or admitted, within four hours of their arrival (target: 95%) which is unchanged from 2019/20.

- 86% of patients commenced treatment, following triage, within 2 hours. This compares to 77% during 2019/20.

- While performance against the Ministerial targets has slightly improved compared to last year, this needs to be viewed in the context of a 26.6% reduction in ED attendances likely due, in the main, to pandemic related concerns.
-
- Further information on waiting time statistics is published on the DoH website at Emergency care statistics | Department of Health (available at www.health-ni.gov.uk).

Moving forward, working beyond traditional boundaries is essential in the delivery of safe, sustainable, high quality care during these unprecedented times and beyond. In October 2020 the Minister of Health published the Covid-19 Urgent and Emergency Care Plan, 'No More Silos' (available at www.health-ni.gov.uk) setting out 10 key actions to ensure that Urgent and Emergency Care Services across primary and secondary care can be maintained and improved in an environment that is safe for patients and for staff.

The actions relate to two main areas: how the general public access urgent or emergency care or treatment when they need it; and how older people and others who need support will be offered treatment and care in the community to avoid admission or long delays in hospital.

Two examples of progress include:

- Phone First - a new clinical telephone triage service 'Phone First' was rolled out across the Northern Trust area in December 2020, with a phased implementation taking place in the Southern and Western Trust areas. 'Phone First' provides clinical advice and signposting to anyone considering travelling to an Emergency Department (ED) with an urgent but not life threatening condition.
    - In the Northern Trust area, from 1 December 2020 to 23 April 2021, the service received 15,074 calls. Approximately 58% of people were given an appointment slot to attend an ED or an Emergency Nurse Practitioner; with over 20% discharged with advice or back to the care of their GP.
    - This helped patients get access to the right care quickly and safely, and it also helped to minimise the risk of the spread of Covid-19.
    - There are proposals to roll-out the service across the region in coming months in line with the Ministerial action plan.

- The Belfast Trust's Urgent Care Centre (UCC), established on the Royal Victoria Hospital site, provides an effective alternative service to attending an ED, operating 7 days per week, from 8am-10pm.
    - From 1 December 2020 to 23 April 2021, 18,140 patients attended the UCC.
    - There are proposals to roll-out Urgent Care Centres more widely across the region in coming months in line with the Ministerial action plan.

In terms of the longer term approach, the publication of the report outlining the findings and recommendations of the review of Urgent and Emergency Care was significantly delayed by the pandemic, however, it is anticipated that this will be published shortly. Once published, the DoH will conduct a full public consultation.

1.2 Elective Care

Due to the need to respond to the Covid-19 situation, the Ministerial priorities set out in the 2019/20 Commissioning Plan Direction (CPD) were rolled forward to 2020/21, including the following targets for elective care:

- 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.

- 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment and no patient waits longer than 52 weeks.

There is no doubt that the pandemic has had a devastating impact on our hospital services, particularly elective care. Waiting times were unacceptable before Covid-19 and regrettably will be even worse after the pandemic. Many more people are waiting far in excess of the Ministerial target waiting times and are suffering in pain and discomfort while they wait to be seen/treated.

At 31 March 2021:

- 16% of patients were waiting less than nine weeks for a first outpatient appointment, compared to 21% at the end of March 2020; 287,900 patients were waiting longer than nine weeks compared to 242,864 at the end of March 2020; and, 191,992 were waiting more than 52 weeks, up from 117,066. In addition, at the end of March 2021, 10,735 patients were waiting longer than nine weeks for a first outpatient at a cataract Day Procedure Centre and, of these, 6,970 were waiting longer than 52 weeks.

- 48% of patients were waiting less than nine weeks for a diagnostic test compared to 46% at the end of March 2020; 53,861 patients were waiting longer

than nine weeks compared to 58,639 at the end of March 2020; and, 32,485 were waiting more than 26 weeks, up from 28,130. While regionally the number of people waiting more than 26 weeks has increased compared with last year, the waiting time position has improved in-year for 9/26 weeks from a high of 93,939 (9 weeks) and 53,943 (26 weeks) in May and September 2020 respectively.

- 17% of patients were waiting less than 13 weeks for inpatient or day case treatment compared to 29% at the end of March 2020; 92,726 patients were waiting longer than 13 weeks compared to 66,872 at the end of March 2020; and, 68,344 were waiting more than 52 weeks, up from 30,696. In addition, 3,308 were waiting longer than 13 weeks for a cataract (2,439) or varicose vein (869) procedure at a DPC at the end of March 2021 and, of these, 2,228 (1,506 (cataract) and 722 (varicose veins)) were waiting longer than a year.

- Further information on waiting time statistics is published on the DoH website at Hospital waiting times statistics | Department of Health (available at www.health-ni.gov.uk)

Some of the efforts made to address the many challenges are detailed below:

- In January 2021, the Minister for Health established a Regional Prioritisation Oversight Group to ensure that all available capacity (both within the HSC and Independent Sector) is prioritised for cancer and time critical cases across specialties and Trust boundaries on an equitable basis. This Group continues to meet on a weekly basis.

- The HSCB secured theatre capacity during 2020/21 from the three local Independent Sector (IS) hospitals to treat the most urgent and time critical patients (i.e. those with confirmed or suspected cancer). These arrangements allowed many thousands of patients to be treated by HSC consultants in the private healthcare facilities. During the period from 1 April 2020 to 28 March 2021, approximately 5,060 patients had their procedures undertaken.

- In addition, the HSC secured capacity from a number of other IS healthcare providers both within NI and in the Republic of Ireland. Furthermore, a number of private healthcare providers provided in-sourcing services whereby privately recruited teams of clinicians treated HSC patients using available HSC infrastructure.

- The Modernising Radiology Clinical Network (MRCN) worked collaboratively to develop a Regional Imaging Rebuilding plan to address imaging backlogs during the pandemic and improve access to investigations across the region. This has led to reductions in waiting times and in variation across Trust areas for red flag, urgent, planned and routine patients across the region.

- Reductions in stroke admissions (20.3%) and thrombolysis (33%) recorded in the first Covid surge were addressed by a number of FAST public awareness campaigns. The number of life-saving/life-changing thrombectomy procedures increased by 21% during the first surge against a 12.7% decrease in over 187 stroke centres worldwide.

As we emerge from the latest surge of the pandemic, the focus of the HSC is on resetting all elective services in an environment that is safe for both staff and patients. This is likely to be a gradual process with a direct link to the scale and speed of de-escalation of ICU and the managed return of theatre and surgical staff.

In line with the approach in the Department's Rebuilding Health and Social Care Services: Strategic Framework (June, 2020) (available at www.health-ni.gov.uk), HSC Trusts have developed a series of Rebuild plans setting out how routine activity would be restarted in the wake of each surge of the pandemic.

- By way of example of the efforts of staff, from 1 October to 31 December 2020, Trusts had committed to delivering 228,500 outpatient consultations; 114,100 diagnostic tests; and, 13,800 inpatient or day case treatments. In fact, they delivered 264,600 assessments; 142,600 diagnostics; and 17,300 treatments.

- Trust Rebuild Plans for the period April 2021 to June 2021 set out how routine activity will be restarted in the wake of the most recent surge and outline their plans for green pathways and green sites to separate planned, routine and emergency services and maximise theatre capacity.

The Minister announced in the Assembly in April 2021 that he intends to publish an Elective Care Framework to set out both the immediate and longer term actions and recurrent funding requirements needed to tackle our waiting lists.

1.3 Cancer Care

The Covid-19 pandemic has undoubtedly had a devastating impact on cancer services with the long waiting times causing worry and concern for many patients and families.

The latest surge, which saw unprecedented levels of Covid-19 admissions and ICU beds significantly impacted, and a reduction in diagnostic and operating capacity across all Trusts, leading to an inevitable impact on cancer services and a worsening of waiting times.

- Regionally, during 2020/21, 71% of urgent breast cancer referrals were seen within 14 days compared to 86% in 2019/20 (target: 100%). Northern HSC Trust continued to experience demand and capacity issues which impacted on its 14-day performance (33%). 14-day performance also fell below the 100% target in the South Eastern (81%), Southern (68%) and Western (87%) Trusts.

- Over the year, 94% of people received their first definitive treatment within 31 days (target: 98%) which is broadly unchanged from the 2019/20 (93%) position. While 62-day performance regionally in 2020/21 (54%) has improved compared to 2019/20 (51%), this is likely due to the reduction in referrals (-11%) as a result of pandemic-related concerns leading to patients being reluctant to attend their GP or hospital.

The HSCB continues to work with clinicians in HSC Trusts to prioritise the care needs of patients referred into the HSC, and also to ensure that all available capacity is utilised as effectively and equitably as possible across the region.

The position is kept under daily review and reinstating red flag surgery and rescheduling patients as quickly as possible is the priority. Fortunately the vast majority of patients that experienced a delay from January 2021 to March 2021 have since already had their treatment completed or rescheduled, i.e. during the period 1 January to 28 March 2021, 1,161 suspected or confirmed cancer procedures were cancelled by HSC Trusts and at 31 March, 94% of these had been rescheduled.

Staff in HSC Trusts have also worked hard to ensure that systemic anti-cancer therapies and radiotherapy have been protected throughout the surge and these treatments have been offered as an alternative to surgery whenever possible.

A Cancer Reset Cell was established in June 2020 to oversee the resumption of cancer screening, diagnosis and treatment in clinically safe environments as quickly as possible. Working with the wider system and key partners, the cell also aimed to protect these services as much as possible throughout the pandemic, taking into account existing capacity constraints and the ongoing threat of Covid-19. Early work focused on the development of additional HSC and IS capacity, the equalisation of waits and opportunities to streamline cancer pathways. Some key outcomes included:

- The establishment of 15 additional computerised tomography (CT) sessions to enable enhanced access to cancer diagnostics. CT scans use X-rays and a computer to create detailed images inside the body, are heavily used across the care pathway, and have a particular role in the diagnosis, staging and treatment aspects of cancer care.

- Funding secured for the expansion of photo-triage to address cancer within dermatology with a regional roll commencing in April 2021. The model enables primary care to securely transfer an image of a suspicious skin lesion, along with a dermatology referral for eTriage, to secondary care. The pathway reduces demand for traditional outpatient appointments, with the triage outcome resulting in either reassurance for the patients in primary care or direct to surgery for patients who may need surgical intervention.

- Another key development was the introduction of a Faecal Immunochemical Test (qFIT) that analyses patient stool samples for blood as a possible sign of bowel cancer. This was key given that colonoscopy activity between March and December

2020 was reduced by 7,700 scopes compared with the same period last year as a result of the pandemic. The qFIT test enabled urgent cases to be prioritised. Despite an approximate 17% reduction in colorectal red flag referrals combined with a 54% reduction in lower GI scope activity during 2020, colorectal cancer diagnoses were only down 16% on the equivalent period in 2019 largely due to the introduction of qFIT. Consideration is now being given to the test being rolled out in primary care.

With the advent of the second Covid surge in October 2020 the attention of the Reset Group shifted to management of the Covid-response. However, from March 2021 recovery of services has once again become the focus.

A Cancer Recovery Plan, Building Back; Rebuilding Better is being finalised and will be considered by the NI Executive in May 2021. This plan seeks to make recommendations to redress the disruption to cancer services caused by the pandemic. The Cancer Recovery Plan is also aligned with many of the short term recommendations in the Cancer Strategy and will focus on a 3-year period until March 2024. There are substantial costs associated with the delivery of both the Recovery Plan and the Strategy.

1.4 Critical Care for Adults and Children

The HSCB, working very closely with the Critical Care Network for NI (CCaNNI), PHA, DoH, Trusts and key partners, played a key role in ensuring the continued provision of time critical care for both Covid and non-Covid patients throughout the pandemic. A number of examples of this work (not exhaustive) are listed below:

- A regionally agreed escalation plan for adults was put in place which ensured that critical care bed capacity in NI could be rapidly increased to meet anticipated demand. Furthermore, the HSCB worked with HSC Trusts to put in place arrangements to increase the capacity to ventilate people who require this during their inpatient stay and to ensure a sustainable and adequate supply of oxygen across all areas.
- A critical care operational hub was established, supported by HSCB and the Critical Care Network, which managed critical care bed capacity across NI for the period from January 2021. The hub was underpinned by a coordinated enhanced respiratory care response and supported by NIAS to smooth critical care demand across the region.
- Paediatric Surge Plans were drafted and agreed by the Child Health Partnership, working collaboratively across all HSC Trusts and specialties, which ensured essential children's health services could be maintained and, where possible, child health professionals could aid adult service colleagues at times of surge.
- The Critical Care Medicines Working Group played a key role in ensuring there was sufficient supply of medicines for critical care and high dependency patients during the pandemic.

- The HSCB brokered discussions with relevant stakeholders, including NHS Scotland, Woodgate Aviation, the NI Specialist Transport and Retrieval Service, Glenfields Hospital Leicester, DoH and the Ministry of Defence, and was able to agree a new service model for the air transfer of Covid-19 positive patients for ECMO (a life preserving service used when a patient has a critical condition which prevents the lungs or heart working normally).
- The HSCB worked closely with the PHA and HSC Trusts, supported by relevant specialists, to produce demand forecasts for Covid-19 to help the system to plan for the impact of the pandemic on hospital and other services. This was particularly important in the second and third surges where demand varied across the Trusts. This tool enabled individual HSC Trusts to make decisions about what services they could stand up or down and in identifying the appropriate time to start to plan for rebuilding services.

During 2020/21 the HSCB commenced work to put in place timely, effective and equitable arrangements for the assessment of people who continue to experience long term health effects as a result of a Covid-19 infection. This work will continue into 2021/22.

1.5 Primary Care

Throughout the last year primary care services (GPs including Out of Hours services, pharmacy, dentistry and optometry), working collaboratively with professional bodies and wider networks have rapidly adapted and changed how they provide care, both to support the response to Covid, but also to maintain core services as far as possible, particularly for urgent patients. This has also compounded workforce challenges, particularly with GPs; (see the Governance Statement for further details on GP services, including GP Out of Hours).

Much of the proactive work in primary care has been detailed in the news section and in regular ezines published on the HSCB website www.hscboard.hscni.net. Therefore only a few examples have been highlighted below.

General Medical Services

In NI General Medical Services comprise 321 GP Practices which are independent, small businesses, often operating from their own premises. Over the last year they have risen to a very different set of challenges to those faced historically. At the outset of the Covid pandemic, elements of the GMS contract were stood down as agreed by the HSCB, DoH and the NI General Practices Committee (NIGPC). Enhanced Services activity was also significantly reduced with an agreement of no financial detriment to practices and remained in place to end of 2020/21 financial year. Practices continue to provide specific enhanced services directly to ensure that appropriate and essential safe care is provided. These include vaccinations and immunisations; amber drugs (those for which responsibility for prescribing may be transferred from secondary to primary care once the patient is stabilised and agreed shared care arrangements for the patient have

been established between the specialist and GP); anti-coagulation monitoring; and services for the care of violent patients and seriously mentally ill.

- **Covid Centres** – the HSCB, in collaboration with the DoH, the Royal College of General Practitioners NI and the NI General Practitioners Committee, established 10 Covid Centres across NI. These dedicated facilities are designed to assess suspected Covid-positive cases separately from patients who do not have Covid symptoms thereby reducing the risk of transmission of infection and also allowing GPs to maintain key services in their own practices. The Covid assessment centres have seen nearly 40,000 patients, 15% of which were then transferred to secondary care for further treatment or assessment.

- **Covid Vaccination Programme** - the HSCB has played a major role, alongside partners, in planning, supporting and monitoring the roll out of the Covid Vaccination Programme in GP practices. This has included establishing a vaccine ordering system; managing the supply of vaccine into GP practices; developing a vaccine management system to record data; developing and implementing a NI Local Enhanced Service Specification for Covid-19 vaccination; and the recruitment of additional GP vaccinators. From 4 January to 29 March 2021 a total of 378,980 vaccinations were administered with a wastage rate of 0.37% across our 321 practices, which is very low given the logistical challenges of using multi dose vials.

- **Primary Care Infrastructure Programme** - continues to support service integration and bring care closer to home, through the co-location of GP services with Trust Community and Outpatient Services via a 'hub and spoke' model. The Lisburn Hub construction is nearing completion and business cases have been completed for an additional two hub developments. Business case development began in early 2020/21 for a Strabane Hub as identified in the Derry City Deal. Investment of £6m in GP spoke premises was completed in 2020/21, despite some delays to works as a result of Covid-19. Fifty premises projects benefited from this investment which addressed urgent need for additional capacity within GP practices, as well as enabling additional capacity to support the roll out of multi-disciplinary working in 5 GP Federation areas.

Pharmacy and Medicines Management

Community Pharmacy Services have met significant additional demands in response to the challenges raised by Covid-19 this year. A number of services have been developed and implemented across 528 community pharmacies.

- **Community Volunteer Service** - during the first wave of the pandemic the HSCB worked with the Community Development Health Network to establish a volunteer delivery service. During the first 3 months, in direct response to the need to transport medicines to shielded patients, this service delivered over 80,000 prescriptions. This provided time to properly commission a community pharmacy delivery service.

- **Emergency Supply Service** - an Emergency Supply Service was commissioned enabling community pharmacies to provide medicines for chronic conditions for patients unable to get a supply of their routine medicines. This reduced patient contacts with GP Out of Hours Services.

- **Improved Access to Medicines in Out of Hours (OOHs) and End of Life Care -** through enhanced pharmacy opening hours over public holidays; increasing the coverage of dedicated palliative care community pharmacies; and putting in place on-call arrangements for palliative pharmacies linking to Trust pharmacies.

- **Pharmacy Services to Care Homes** - enhancements have been made to existing contractual requirements to better support medicines management arrangements for care homes. These arrangements align a dedicated community pharmacy to a specific care home. Maintaining oxygen supplies in care homes was recognised as a key priority in pandemic planning. Refinements made to the provision of oxygen to care homes at the onset of the pandemic were maintained throughout 2020/21. This response will be built upon into 2021/22.

- **Medicines Supply to Covid Centres** - to support the rapid establishment of Covid Centres, arrangements were put in place to provide medicines for patients presenting at these centres. It is expected that further refinement and development of models for supply will be required. Development of GP OOH medicines supply arrangements will also be progressed, particularly regarding the supply of Controlled Drugs.

General Dental Services (GDS)

There are approximately 378 high street dental practices, which serve 1.2 million registered dental patients, across NI.

The impact of the Covid-19 pandemic on dentistry has been severe. Dental treatment, by its very nature, involves the dentist and patient to be in close proximity. Furthermore, the vast majority of dental treatments are aerosol generating procedures (AGPs); which are considered to increase the risk of transmission of the coronavirus.

Routine dental care involving AGPs recommenced on 20 July 2020. Practices must comply with the extant guidance regarding aerosol settling periods between patients, surgery cleaning and PPE. Whilst routine care is permitted, HSCB guidance advised that patients should be prioritised in relation to need, irrespective of whether they are registered with practices. Rate limiting steps taken include the need to triage patients; social distancing, PPE, and settling time after APG treatments (currently 10-25 minutes depending on ventilation and other mitigating factors). This has and continues to have a significant impact on activity levels in General Dental Services. As stated in the Rebuilding Better Framework from April 2021 to September 2021, the aim is to ‘achieve activity levels of at least 50% of pre-Covid output levels’.

Practices have also experienced staffing issues i.e. dental staff testing positive for coronavirus and/or needing to self-isolate due to Covid contacts.

During the reporting year the following measures were put in place to address some of the key challenges.

- **General Dental Services (GDS) Financial Support Scheme (FSS)** - at the outset of the pandemic, the DoH put in place financial support to ensure the delivery of essential dental services; to help stabilise dental services and allow a return to pre-pandemic levels of service when appropriate; and to fairly compensate practices for costs incurred including the reduction in income from patient charges. Additional funding of £10 million was secured during 2020/21 to enable the FSS to continue to operate until the end of March 2021.

- **Urgent Dental Care Centres** – to address significant restrictions in routine dental treatments and specifically the provision of all aerosol generating procedures (AGPs), in both general dental practices and OOH Emergency Dental Centres, the HSCB in conjunction with key partners, helped establish a central triage hub based at Dalriada Urgent Care and 5 Trust-based Urgent Dental Care Centres (UDCCs) across the region on a 7-day per week basis. As there was increased capacity in GDS practices to treat emergency cases from July 2020 onwards, UDCC provision was scaled down considerably, over a phased period, from September 2020. To date the UDCCs have treated approximately 5,300 patients.

- **Revenue Grant Scheme** - the HSCB invested £1.5 million in a revenue grant scheme in February 2021 to increase patient throughput in practices. It enables practices to invest in improved ventilation, dental equipment to reduce reliance on aerosol generating procedures, and in alterations to dental practices to increase capacity. The DoH and HSCB are also looking at improving support for practices for level 2 PPE and changes to the GDS financial support scheme to optimise clinical activity.

General Ophthalmic Services

The impact of the Covid-19 pandemic on Ophthalmic Services has been significant, including across the 271 practices delivering general ophthalmic services in NI. Constraints associated with social distancing, infection prevention and control, and the use of PPE had a significant adverse impact on capacity. To reduce the risk of coronavirus transmission, General Ophthalmic Services and Enhanced Services were suspended in all ophthalmic practices on 17 March 2020. Practices continued to provide Urgent Care for patients presenting with acute problems, and essential care which included essential sight tests and the provision of essential glasses and repairs. These services were provided remotely where possible; all domiciliary services were fully suspended. By 14 September 2020 all elements of General Ophthalmic Services, including all Enhanced Services, had been restored.

Like general dental services, rebuild of general ophthalmic services was facilitated by the arrangement of an ongoing Financial Support Scheme (FSS) and a revenue grant towards costs associated with infection prevention and control measures and the provision of PPE.

The scaling up of the primary care Optometry Ocular Hypertension (OHT) Review and Monitoring Service continues to reduce the demand for review appointments in the glaucoma service, allowing patients to access their care closer to home and in a timely manner. The service is further supported by direct access to consultant ophthalmologist advice and guidance.

In 2020/21, 751 patient review episodes occurred in primary care and almost 1,000 patients have been transferred from the glaucoma services regionally to primary care for ongoing review and assessment. OHT Monitoring Service was commissioned in Belfast Trust catchment area in 2018/19 aiming to manage up to 1,000 patients in the community setting, freeing capacity in secondary care. Because of a time lag in appointing patients to the service and these patients presenting in community optometry, there were 129 patient episodes in the calendar year January - December 2019. A combination of anticipated growth and uptake, and Trust and Community optometry Covid-19 response, has increased the activity in 2020/21 to 751 patient review episodes with more waiting, in line with clinically-indicated review interval.

In addition, the remaining ophthalmology provider Trust (Western Trust) has agreed to facilitate the scheme, allocating clinical and administrative resource in December 2020.

1.6 Social Care

The HSCB Social Care and Children's Directorate played a vital role during the last year, both in the response to the pandemic, as well as continuing to ensure the provision of safe and high quality social care services across NI working collaboratively with DoH, HSC partners and key community, voluntary and statutory stakeholders.

Care Homes

Throughout 2020/21, the Covid-19 pandemic has placed unprecedented demands on the care home sector. The HSCB, working closely with the DoH, PHA, Trusts and care home providers, led on the development of a Regional Surge Plan for the Care Home sector in NI at the start of the pandemic. A new approach to gathering data from each care home on a daily basis has been implemented. This is a significant development proving invaluable not only in responding to the demands of the pandemic, but also in supporting planning and commissioning of care home services moving forward. For further information, see the Governance Statement.

Regional Surge Plan for Domiciliary Care Services

The HSCB developed a Regional Surge Plan for Domiciliary Care Services in response to the demands of the Covid-19 outbreak. This plan incorporated key learning from a Rapid Learning Review undertaken by the DoH. The HSCB co-ordinated and monitored

the actions of HSC Trusts and independent sector providers required to meet the demands of the plan. For further information on domiciliary care, see the Governance Statement.

Support at Home

The HSCB worked with South Eastern HSC Trust to test the application of a new approach to care and support at home. This approach moves away from a time-tabled 'time for task' model, focusing instead on a more person-centred approach that seeks to deliver individual outcomes that have been determined by service users themselves. The approach has been tested within specific geographical locations where historically it has been challenging to identify providers. Results have been positive with people reporting that services are more flexible and better at meeting individual needs and supporting independent living. This approach will be scaled up across the Trust geography in 2021/22.

Social Care Review of Hospital Discharges

In 2020/21, the HSCB revised complex coding for delayed transfers of care to capture information relating to Covid related delays from acute settings, including care home delays. This has enabled a better understanding of the position and improved performance management.

Training for Front Line Social Care Staff

The HSCB worked with employers in both the statutory and independent sectors to ensure that social care staff had the requisite learning and development to continue to deliver care safely and effectively. Significant use has been made of remote/virtual opportunities. Training was provided on infection prevention and control techniques, use of Personal Protective Equipment, meaningful activities for care home residents, and undertaking dynamic risk assessments.

Children's Services

The HSCB co-ordinated the response to the pandemic in Children's Services across all five Trusts, identifying and supporting the reconfiguration of services to ensure core services were maintained and protected. An Action Card was developed and regularly reviewed and updated, setting out how the five Trusts continued to respond in maintaining safe services throughout the pandemic. A major prevalence study of Children's Mental Health was completed in 2020/21 and will provide critical data for future service development. A Draft Children's Disability Framework setting out a reform agenda was also developed during this period.

The implementation of Signs of Safety, a programme to transform Children's Social Services continued during 2020/21. The HSCB continues to support key partnerships in early years (Child Care Partnerships) and vulnerable children (Children and Young People's Strategic Partnership).

The Regional Panel for Secure Accommodation has continued to provide a critical oversight and governance role in the consideration and decision making regarding the admission of young people into Secure Accommodation. Reporting mechanisms are available within the HSCB, identifying key areas of progress and developing vital data to inform future developments and service needs for young people on the edge of care and those children who are looked after in Secure Accommodation.

Meeting the care and welfare needs of separated and unaccompanied asylum seeking children arriving spontaneously in NI has heightened pressures on care placement provision. Interim measures were put in place to meet these needs in the immediate term, whilst significant work has been completed by the DoH and HSCB to formulate a comprehensive service development proposal for the future.

Mental Health Services

During 2020/21 the HSCB co-ordinated the response and surge plan arrangements in Mental Health Services across the 5 HSC Trusts, responding to, and leading on the re-configuration and resetting of Mental Health Services to ensure core services were maintained and protected. The Mental Health Covid-19 Mental Health Response Plan (May 2020) set out 7 key themes; mental health and resilience response to Covid-19; public health messaging; provision of advice, information and support; evidence based support and interventions; CAMHS specific issues; existing mental health services contingency and service realignment. Using an outcomes based model (OBA) and Action Card approach, the Team followed a cell structure, to support Trusts to maintain safe and effective services through the pandemic, using a blended approach of face to face and virtual interventions. Mental Health Services continues to work with Trusts and DoH to develop regional and local Surge Plans to manage the anticipated mental health surge as a result of the pandemic.

1.7 Advances in eHealth

The Digital Health and Care NI (DHCNI) Team, in partnership with the DoH, Health Trusts and industry partners played a significant role in battling the Covid-19 pandemic. The response focused on five main strategic goals, including - mobilising the workforce; enabling locations and capacity; informing and supporting the public; developing data and insights; and supporting vulnerable people.

DHCNI set up the 111 Covid-19 Helpline to reduce some of the traffic that would have resulted in telephone calls to GPs or GP Out of Hours and created the region-wide mobile app COVIDCare NI App. In addition, a new digital service, the apps4dementia library, supports people living with dementia and their carers.

The team played a key role in establishing and supporting DoH Covid-19 dashboard which provides a range of statistics on the number of Covid-19 patient admissions and discharges, outbreaks in care settings; bed occupancy, ICU occupancy and gender and age breakdowns.

DCHNI continues to support vulnerable people through digital solutions helping them receive the best care, while reducing pressures on acute facilities. The team established the shielded patients register and launched the digital interpreting service for the deaf community on April 24. It has played an integral role in facilitating virtual visits by community and primary care teams using video conferencing.

1.8 Strategic Planning and Networks

During the reporting year, despite the challenges of responding to the Covid pandemic, the HSCB continued to lead on the strategic planning of services and in supporting regional Networks to ensure the provision of high quality, safe and accessible care. A few examples are highlighted below:

Strategic Planning

Trauma care - 2020/21 witnessed the attainment of two significant milestones in major trauma care provision in NI which are detailed below:

- **Major Trauma Ward (MTW)** opened in September 2020 and is situated on Level 8 of the Royal Victoria Hospital's new Critical Care Building. The 8-bedded ward is a consultant-led facility which is staffed by a dedicated multidisciplinary team and provides specialist trauma care services to the most seriously injured patients. Since it opened, the MTW has admitted 110 patients and of those, 66 patients have been directly discharged home from the ward following treatment; this underlines the benefits of providing highly specialist care.

- **Major Trauma by-pass** - from October 2020 seriously injured patients, within 45 minutes drive-time, are taken directly to the Major Trauma Centre (MTC) at the Royal Victoria Hospital in Belfast as clinically appropriate. New protocols to enhance collaboration between all acute hospitals, and a new dedicated trauma ward at the MTC, ensure that NI patients have access to the best model of care, minimising any potential delays. Major trauma, such as head injuries, serious burns, road traffic collisions or agricultural accidents, is one of the leading causes of death and disability globally. In the UK it is the main cause of death for people under the age of 45. Evidence has shown that when hospitals work together as a network, with a MTC at the hub, patient survival rates may improve by as much as 20%.

- **North West Cancer Centre (NWCC) - t**he North West Cancer Centre (NWCC) Cross-border Service Level Agreement (SLA) Review was completed during the Covid-19 pandemic in 2020/21. HSCB Commissioning staff led the review, in joint collaboration with Health Service Executive staff from the National Cancer Control Programme, in conjunction with Western HSC Trust, Saolta University Hospitals and representation from both DoH NI and the DoH ROI. Reflection on the most up to date evidence available during this review has facilitated the continued and expanded cross-border commissioning and delivery of high

quality, safe, effective Radiation Oncology services at the NWCC for the population of the North West of Donegal.

Regional Networks

Established clinical and managerial networks in a number of vital service areas such as critical care, cancer, imaging, pathology and stroke, enabled the HSC to work both within and across networks to rapidly mobilise resources across the region in response to Covid-19. Networks were able to:

- Ensure access to imaging services continued throughout the pandemic, supporting emergency and inpatient services in the first instance, as well as ensuring continued access to urgent diagnostic scanning for suspected cancer and other urgent patients.

- Move rapidly to agree regional Covid-19 guidance, for example, NICaN produced guidance on Covid testing for cancer patients to optimise patient safety.

- Develop and implement escalation plans, for example, the Critical Care Network led on the development of escalation plan for increasing ICU provision.

- Work with the service to develop new services and to ramp up capacity, e.g. the Pathology Network worked with Trusts to develop Covid-19 testing services and to significantly grow capacity within a short period of time.

- Establish a regional diabetes telephone support helpline and email support facility through the Diabetes Network for NI, in partnership with HSC Trusts. This helped to provide additional clinical support and advice to people living with diabetes and their carers. The service supported 430 people over the initial 12-week Covid first surge period 8 April to 28 June 2020.

- Develop Covid Contingency protocols for stroke services in NI to ensure access for all patients.

- Embrace new technology and move forward with virtual consultations.

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 NI and reducing inequalities for people living in more deprived communities and circumstances.

NI 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 significant impact on health and wellbeing. Improving health, and reducing health inequalities, requires co-ordinated 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 identified in the HSCB Commissioning Plan 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 NI comes from 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.

In 2020/21, the HSCB worked with the wider HSC and a wide range of statutory and voluntary partners, through Local Commissioning Groups, Integrated Care Partnerships and other networks to deliver some innovative, and life changing work to help reduce inequalities and to improve the health and wellbeing of the population. A number of examples of this work are highlighted below.

2.1 Social Care – Local Commissioning Groups – Living Well Moyle

Living Well Moyle is an excellent example of some of the innovative and partnership approaches happening at a local level supported by LCGs. Funded by the Northern LCG, the Dalriada Pathfinder Partnership, which involves a range of community, voluntary and statutory organisations working closely together, established the Living Well service. It provides support to people in the community who are dealing with ongoing health issues and who may be lonely or isolated. During the Covid period, this service adapted to enable the co-ordinators and the volunteers to continue to provide much needed support to individuals who were particularly impacted by the restrictions.

An evaluation which focused on the period from the inception of Living Well Moyle in October 2016 to October 2019 demonstrated very positive outcomes. The evaluation illustrated how this approach, providing people in the community with person centred support drawing on the wealth of experience in the local community and volunteers, can help to improve health and address health inequalities.

The qualitative information in the report indicated that:

- Participants have reported sustained improvement in their physical and mental well-being.
- Staff and volunteers involved in delivering services report a benefit to the individual and to themselves as a result of the Living Well approach.
- The community has been involved in providing ongoing support for individuals experiencing significant life challenges and social stress.

For those under review:

- Participants have reported sustained improvement in their physical and mental well-being.
- Attendance at Emergency Departments fell by 31%.
- Hospital admissions reduced by 45%.
- Acute bed days were down by 78%.
- There was increased usage of domiciliary care, district nursing, some GP services - all of which would indicate an appropriate shift to the use of community and primary care services for individuals who would appear to have been using acute services to access support for long term conditions.

2.2 Integrated Care Partnerships (ICPs)

Integrated Care Partnerships (ICPs) are collaborative networks of service providers. They include healthcare professionals, such as doctors, nurses, pharmacists, social workers, and hospital specialists; the voluntary and community sectors; local council representatives; and service users and carers.

In April 2020, the ICP work plan was suspended to focus efforts on the response to Covid-19. Leaders from within the ICPs were central contributors to a range of Covid-related planning groups, including Community Support Hubs and primary care Covid Centres.

Innovative work was undertaken in developing a joined-up approach to supporting individuals who were shielding. This included ensuring that GPs and Community Pharmacists were aware of the support available for people who were shielding and that they could refer vulnerable people to the community support hubs.

Despite the challenges associated with managing the pandemic, the need to for a strong focus on specific delivery areas outlined in the HSCB Commissioning Plan was recognised. This included:

- The impact of Covid-19 on disadvantaged communities and the need for a greater focus on reducing health inequalities.
- The impact Covid-19 and associated restrictions was having on people's mental health and the need to ensure appropriate access to mental health support.

– The renewed focus on Palliative and End of Life Care i.e. the need for better public awareness of the public health approach to death and dying and the need for end of life planning.

2.3 Community Pharmacy Living Well Service

Community pharmacies continue to be the most accessible and accessed health care providers both before and during the Covid-19 pandemic. Therefore, the Community Pharmacy Living Well Service - commissioned and delivered in 2020/21 - was a unique and valuable opportunity to provide the wider community with health and wellbeing information in pharmacies; to reassure and support self-care; and to signpost to other services through a series of campaigns.

2.4 Community Flu Vaccination Service

This service was launched in September 2020 to support the implementation of the Seasonal Influenza Vaccination Programme. In total, 363 Community Pharmacies were contracted to provide this service to HSC workers aged 16-years and over. Later in 2020/21 the Programme was expanded to cater for over 50 year-olds. This laid the foundation for the expansion of the community pharmacy into the Covid-19 vaccination programme.

2.5 Regional Communication Support Services Programme

During 2020/21, the unique circumstances of the Covid-19 pandemic provided the catalyst for the implementation of a temporary Remote Sign Language Interpreting service, and an opportunity to test and learn more about what works for the deaf community and our partners across the HSC system with regard to remote access. Between April 2020 and February 2021 more than 8,000 phone calls and remote interactions supported by Video Relay Service and Video Remote Interpreting have occurred between HSC staff and deaf people. Comparatively in 2018/19 sign language interpreters provided 3,573 face to face interpreting assignments in HSC settings across NI.

2.6 Changing Lives through Community Pain Support Programmes (PSPs)

The HSCB, working in collaboration with the Healthy Living Centre (HLC) Alliance and the PHA, has run a number of Pain Support Programmes across NI since September 2019. Open for self-referral they were delivered in small groups virtually. Around 500 people living with chronic pain attended the first series of programmes.

Results from the 2019/20 programmes showed that whilst only 15% of attendees used self-management strategies in addition to medication at the beginning of the programme, this increased to 83% at week 12, and 91% 3 months after the end of the programme.

In October 2020 the project won two prestigious 'PrescQIPP' NHS Health Awards, securing the 'Delivering Across Integrated Care Award' and the overall Silver Award. Between January and March 2021, programmes continued to run in 23 HLCs.

2.7 Sexual Health

An innovative STI online testing service SH24, providing confidential home-testing for chlamydia, gonorrhoea, syphilis and HIV has continued in 2020/21. The service has been able to reach a different group of people than the traditional GUM services thereby addressing issues of unmet demand and geographical location. It has allowed HIV to be detected in people who would otherwise be reluctant to attend a clinic. Access to the service has the potential to lower the population risk of HIV by detecting and treating other STIs in those at risk, as concurrent STIs increase the risk of HIV transmission.

2.8 Co-operation and Working Together (CAWT)

CAWT is the cross border health and social care partnership for the Health Service Executive in the Republic of Ireland and the Southern and Western Health and Social Care Trusts, the HSCB and the PHA in NI. For further information about how this partnership is improving health and wellbeing in both jurisdictions, the CAWT annual progress report can be viewed on its website at https://cawt.hscni.net/about-us/what-we-do/.

2.9 Community Planning

As part of the community planning process, the HSCB works with each of the Councils and other community partners, including the PHA, local Health and Social Care Trusts and voluntary and community groups. Collaborating with 11 Community Planning Partnerships, the HSCB contributes to the implementation of Community Planning to promote wellbeing, reduce inequalities, enhance quality of life and improve community cohesion as described on the HSCB website at www.hscboard.hscni.net.

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 planning and commissioning safe and high quality services which meet the emerging and changing needs of local populations, whilst ensuring available resources are financially managed to ensure financial stability and demonstrate value for money in their deployment.

To ensure financial stability within available resources of the entire HSC system, the Finance Directorate of the HSCB works closely with, and supports, the DoH.

3.1 Financial Planning

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

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

There continues to be a risk that the financial context will impact on the quality and safety of HSC services which the HSCB, along with the sector, continues to try to mitigate.

3.2 HSC Financial Stability

Throughout the year the HSCB supported the DoH in ensuring the financial stability of the health and social care system within NI. The significant pressures and ongoing financial constraints required rigorous planning, monitoring, management and decision making with respect to the budget during 2020/21, despite these significant challenges the HSCB and the HSC overall delivered a breakeven position.

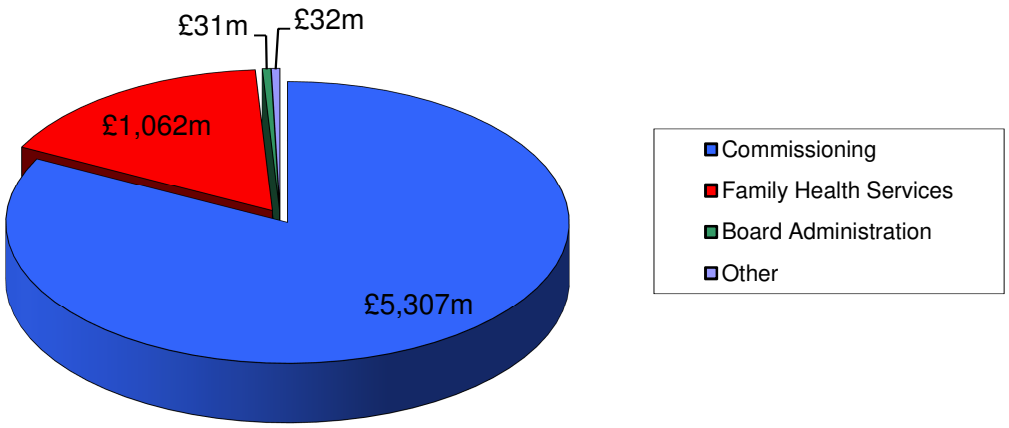
3.3 HSCB Breakeven Duty

During 2020/21, the HSCB received a budget of £10.5m capital resource and £6,393m revenue resource from the DoH, along with income from other sources of £40m. The financial statements presented in this Annual Report and Accounts show a surplus of £12.7m. The surplus held by HSCB offsets the £12m control total relating to the deficit reported by the Western Health and Social Care Trust, which has been authorised by the DoH in 2020/21. This has ensured that the HSC achieved a breakeven position across all organisations.

This significant achievement was delivered by the HSCB Finance Directorate and all budget holders within HSCB 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 2020/21.

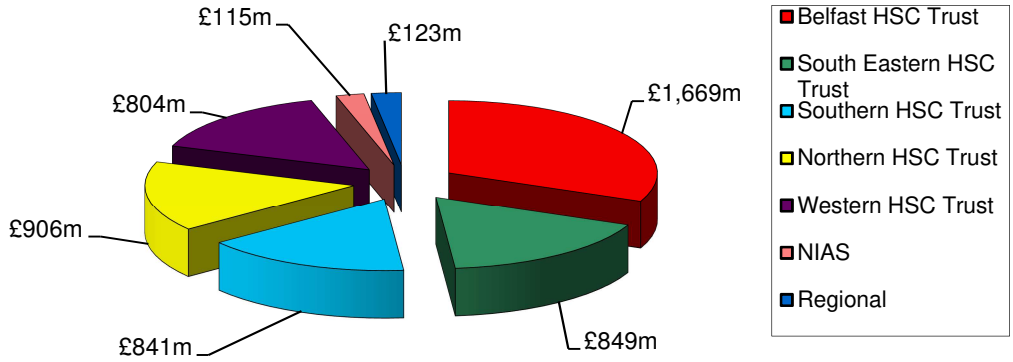
HSCB Revenue Expenditure* 2020/21



** Gross expenditure, before income.*

Commissioning relates to all allocations that flow through HSCB, predominantly to Trusts, for the commissioning of health and social care services, excluding those relating to Family Health Services (FHS). FHS expenditure relates to general medical, dental, pharmaceutical and ophthalmic services. The category of 'Other' includes any Service Level Agreements (SLAs) with the Business Services Organisation (BSO) for Shared Services as well as other costs such as depreciation. The £31m for Board Administration relates to the management and running costs of HSCB. A further breakdown of these categories is shown in the following charts.

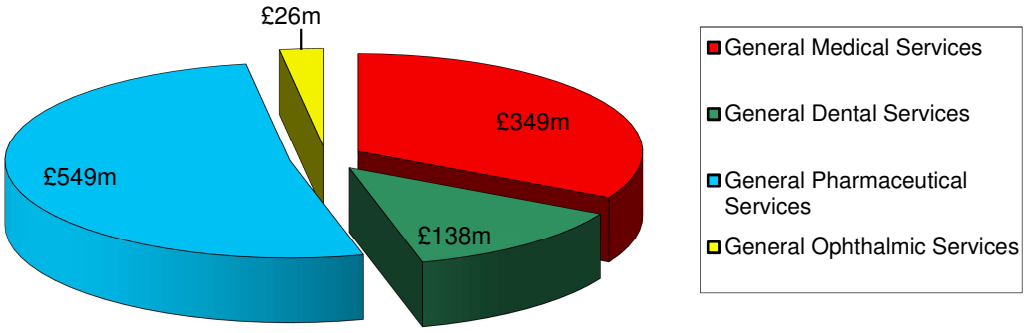
a. Commissioning Expenditure* Analysis by Provider 2020/21



** Gross expenditure, before income.*

The category of 'Regional' relates to items such as expenditure on Extra Contractual Referrals (ECRs), expenditure with the voluntary and independent sectors, and regional expenditure on Information Technology (IT).

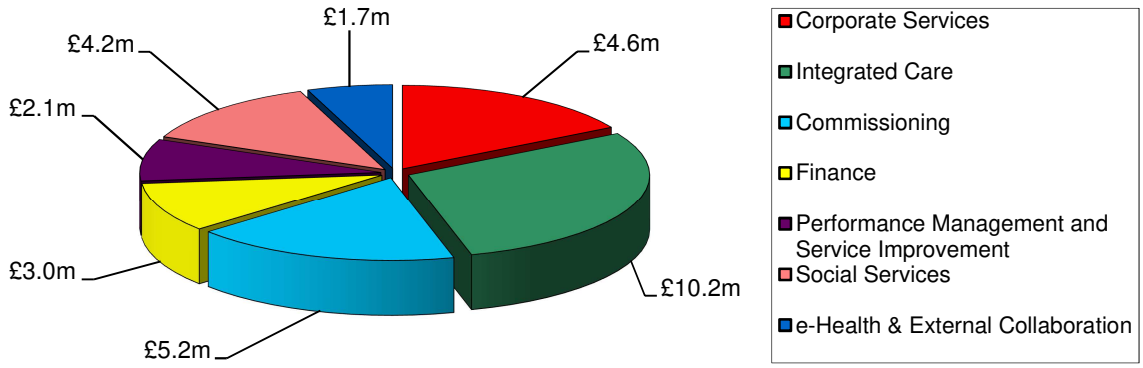
b. Family Health Services Expenditure* 2020/21



** Gross expenditure, before income.*

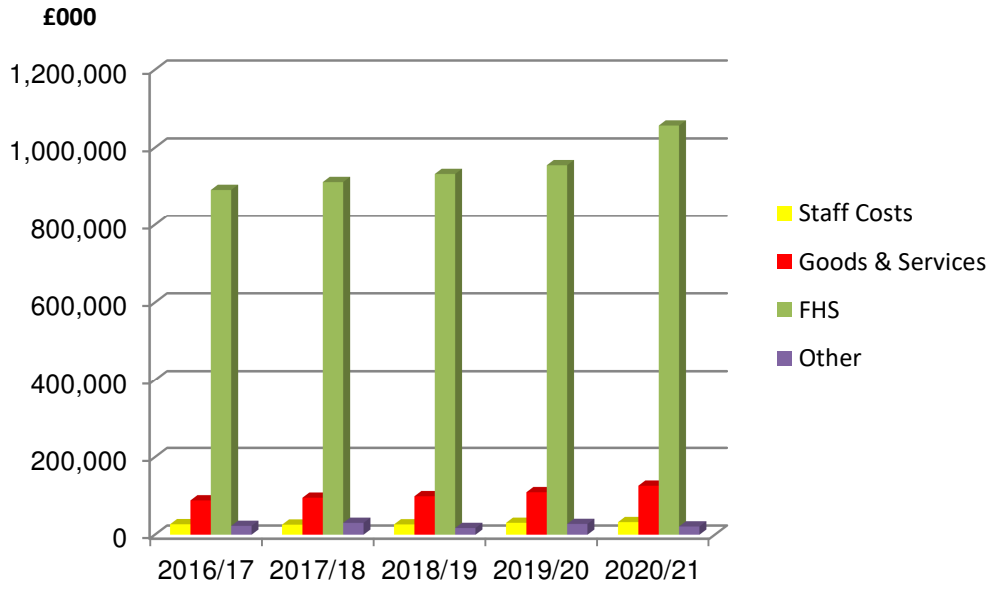
c. HSCB Management Costs 2020/21

Management costs are calculated in line with DoH guidance and the following chart shows the 2020/21 total value split across the various directorates within HSCB.



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.



Other expenditure includes operating expenses classified as establishment and premises.

3.5 Covid-19 Allocations and Expenditure

During 2020/21, specific ring-fenced allocations earmarked for Covid-19 were allocated to HSCB from DoH as laid out in the table below.

Allocation	£m
Allocation from DoH	694
Trust Allocations to March 2021:	
Belfast HSC Trust	164
Northern HSC Trust	101
South Eastern HSC Trust	113
Southern HSC Trust	96
Western HSC Trust	97
NI Ambulance Service	17
Total Allocated to Trusts	588
HSCB Allocations	106

Allocations made to Trusts related to additional costs in respect of the Covid-19 response, such as the cost of protective personal equipment (PPE). The HSCB allocations were predominantly used within the Integrated Care Directorate, in respect of Covid-19 related pressures and initiatives within Community Pharmacy, Optometry and Dental services as well as within General Medical Practice across Northern Ireland.

3.6 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:

	2021 Number	2021 Value £000s	2020 Number	2020 Value £000s
Total bills paid	11,661	£165,845	15,819	£118,816
Total bills paid within 30 day target or under agreed payment terms	10,719	£158,765	14,719	£114,455
% of bills paid within 30 day target or under agreed payment terms	**91.9%**	**95.7%**	**93.0%**	**96.3%**
Total bills paid within 10 day target	9,380	£141,312	12,695	£102,088
% of bills paid within 10 day target	**80.4%**	**85.2%**	**80.3%**	**85.9%**

b) The Late Payment of Commercial Debts Regulations 2002

The HSCB did not pay any compensation or interest for payments made late in either 2020/21 or 2019/20.

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

The HSCB is committed to engaging with patients, carers and the public in an open, transparent and collaborative way in relation to co-producing and shaping services through the work of Local Commissioning Groups, Integrated Care Partnerships and other networks, as well as ongoing involvement in a range of partnerships, projects and service design.

One example of stakeholder engagement is the ongoing review of the Gender Identity Service. The HSCB is leading on the review with the aim of bringing forward proposals for a service model which is sustainable, accessible and meets DoH waiting time targets. Engagement with people who have lived experience of gender identity issues is a key part of this review. Listening exercises were held in 2019 with a view to hearing at first hand the priorities and issues of transgender individuals and their families; two of whom have joined the Gender Review Group. Further involvement is being taken forward through the recruitment of a Gender Identity Liaison Panel with the lived experience of service users and their families informing the revised pathway for this service. The joint chairs of the Panel will also join the review group in order to ensure a diversity of representation in this process. Also see the Governance Statement for further information on Public Stakeholder Involvement.

4.1 Communications, Engagement and Digital Channels

In 2020/21 the Communication Team's effort was primarily focussed on supporting the response to the Covid-19 pandemic, working closely and collaboratively with the DoH, Public Health Agency and other HSC communications teams to ensure a joined up and appropriate approach to communications messages, media management, engagement, internal communications and digital. Some key highlights include:

- Proactive messaging - throughout the year the team have dealt with a significant increase in the number of media enquiries as a result of the pandemic. They have also been instrumental on leading on a wide range of proactive messaging, across the full range of channels, on key issues, including surge planning; impact on hospitals, primary care and social care services; mental health support; not delaying seeking urgent treatment; rebuilding plans; care homes; visiting; and in relation to the Covid-19 vaccination roll-out.

- Stakeholder Engagement - a key focus has also been on engaging and informing stakeholders. Over the last year the HSCB played a key role in developing links with key statutory and voluntary sector partners, including faith groups, sporting organisations, community organisations, social care representatives, care home providers through a range of channels – briefings, video calls, factsheets and ezines (sent to over 1000 stakeholders). The HSCB Communications team also worked in partnership with Community Health and Development Network to cascade important

messages out at local level and also to challenge misinformation, which involved linking in with Factcheck NI.

- Social Media - during the first four months of the pandemic social media content on HSCB channels (Facebook, Twitter, Instagram) achieved nearly 6 million impressions, with 10,000 new followers, and engagement rates on Facebook up by 73%, with positive feedback on messaging and impact.

- 'Phone First' - the HSCB Communications team, on behalf of the wider HSC, and in partnership with service users and clinicians led on the local roll outs of 'Phone First' – a major change to how the public access urgent and emergency care. To date the feedback from service users has also been very positive. Based on learning from the local launches and continued involvement, plans are underway to roll the service out on a NI wide basis in the coming months supported by one regional number, and a mass media campaign.

4.2 Learning

The HSCB is firmly committed to developing and enhancing a learning culture across the organisation and wider HSC in partnership with service users and stakeholders. The summary below includes an overview of two key areas of this work.

4.3 Serious Adverse Incidents (SAIs)

When a serious event or incident occurs within the HSC it is important there is a systematic process in place for safeguarding service users, staff and members of public. The SAI process provides a mechanism to effectively share learning from these events; with a focus on safety and quality and meaningful engagement with families, ultimately leading to service improvement for our population.

Despite the challenges posed by the pandemic, the HSCB and PHA have worked closely with HSC Trusts, to ensure SAIs have continued to be reported and reviewed.

- **SAIs Reported -** during the reporting period, a total of 550 SAIs were reported to the HSCB. See below a breakdown by Programme of Care:

Programme of Care	No of SAIs Reported
Acute Services	200
Corporate Business / Other	13
Elderly	35
Family and Childcare (inc CAMHS)	58
Learning Disability	34
Maternity and Child Health	42
Mental Health	154
Primary Health and Adult Community (includes GP's)	14
Total	**550**

- Learning from SAIs - during 2020/21 a total of 469 SAIs were closed by HSCB/PHA. In almost all cases local learning for the reporting organisation will have been identified and actioned. In many cases, regional learning was also identified by the HSCB/PHA and, as a result a number of Safety and Quality Alerts in the form of learning letters, reminders of best practice and professional letters, were issued across the HSC and to primary care practitioners. Learning from SAIs which fell within a specialist area, was shared with relevant networks, and newsletters which covered a range of topical areas were issued across the HSC.

Method of Learning	Frequency Learning Method Used
DoH Learning issued	2
HSC SAI Learning Event - Presented	1
Immediate/Rapid Learning to HSC	1
Learning Letter	3
Newsletter Articles	43
Professional Letter	9
Referred onto a Group for Action	22
Reminder of Best Practice Letter	37
Total	**118**

Some SAIs have more than one method of dissemination.

- **SAI Learning Report** - an annual SAI learning report was issued in September 2020 covering the period 1 October 2019 to 31 March 2020. A further report covering the period 1 April 2020 to 31 March 2021 will be issued over the coming months. This can be accessed via the HSCB website (at www.hscb.hsci.net).

- **Improvement Plan for SAIs and SQAs** - the HSCB, in conjunction with the PHA, has recently put in place a Safety and Quality Improvement Plan. The plan focuses on the management of SAIs, Early Alerts and SQAs, with a particular emphasis on quality improvement, underpinned by a robust performance management framework which has been developed in collaboration with HSC Trusts.

For further information on SAIs, see the Governance Statement.

Complaints

- **HSCB Complaints** - during 2020/21, 16 complaints were received regarding the HSCB. These related to policy, commercial and purchasing decisions of the HSCB, as well as the handling of complaints.

- **Honest Broker** - the HSCB 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 HSCB acted in this role in 69

complaints. 56 complaints were received concerning General Medical Practitioners, the main categories of complaint being treatment and care, communication and staff attitude; 12 complaints were received concerning General Dental Practitioners; and also a very small number of pharmacy complaints.

- **Oversight** - as part of the HSCB's requirement to have oversight of complaints in HSC, it receives anonymised copies of written complaints and responses from FPS Practices. Complaints of a clinical nature are shared with the HSCB's Medical Advisers to review and advise if there are any clinical/professional/regulatory issues, and, to recommend any further action.

- **Audit on Complaints Management** - during the previous year (2019/20) an audit of the HSCB's complaints management processes resulted in a limited assurance with 14 recommendations for improvement being made. An action plan was developed to address the deficiencies and a follow-up review undertaken by Internal Audit in 2020/21, resulted in satisfactory compliance being achieved. A major concern found by audit was the delay in the dissemination of learning from complaints and a 'Complaints Special' edition of Learning Matters addressed the backlog in disseminating regional learning. Revised processes have been put in place to ensure there is no further delay in this regard.

- **Complaints Annual Report –** the HSCB Annual Complaints Report provides a review of events during the year 2019/20, including an overview of complaints activity throughout this period and is available at www.hscb.hsci.net.

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

The HSCB strives to maintain and develop effective internal systems and processes and maximise the potential of staff by ensuring that they are skilled, motivated and valued.

5.1 Valuing Staff

Looking after staff health and wellbeing, throughout this very challenging year, has remained more important than ever.

- **Working from home** – with Government guidelines requiring staff to work from home where possible, the HSCB, working closely with HR and Trade Union colleagues, committed to ensuring that support systems and processes were in place to ensure staff felt engaged, motivated and valued.

- **Health and Wellbeing** – HR colleagues ensured that HSCB staff had access to workplace wellbeing services such as mental health support, counselling and wider resources.

- **HR services** - BSO 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) working in partnership with managers, staff and Trade Unions.

- **Development** – as an Equal Opportunities employer, training and development opportunities were offered to staff, where appropriate, throughout the year.

5.2 Preparing for Change: Organisational and Workforce Design

As outlined in the Chief Executive's Overview, a key priority area is the successful migration of HSCB functions into the Department of Health planned to complete on 31 March 2022. An essential part of this will be the implementation of a new 'People Strategy' and continued communications, engagement and involvement of staff and Trade Union colleagues in shaping and finalising the new arrangements. For further information, please see the Chief Executive's Report and the Governance Statement.

5.3 Equality, Human Rights and Diversity

The HSCB is firmly committed to embedding quality, human rights and diversity into all aspects of its work. The HSCB Equality Forum, chaired by the Director of Strategic Performance, contributes to driving the equality agenda across the HSCB, in particular the mainstreaming of equality in all its work, and supports the HSCB in complying with statutory equality and disability duties and obligations under Human Rights legislation. A few examples of this are outlined below:

- Staff are required to attend 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.

- During 2020/21, the HSCB and its regional HSC partner organisations recognised that staff who have a disability, and those who are carers, were particularly impacted by the pandemic. The organisations engaged closely with staff via Tapestry, the staff disability network https://tapestry.hscni.net/ to identify any changes to their support needs as a result of working under Covid restrictions and how best to meet these. To raise awareness amongst colleagues and managers, an awareness day was held focusing on the particular difficulties faced by people who are deaf and hard of hearing during the Covid-19 pandemic.

- Building on work during the previous year relating to the Recruitment Agencies Contract, the BSO Equality Unit, on behalf of the HSCB and the regional HSC organisations, analysed equality monitoring data provided by agencies for some people who had been placed with the organisations under the contracts. This exercise served to ascertain the nature and extent of monitoring undertaken by the agencies. In turn, the learning will inform future tenders and contracts.

The HSCB 2019/20 Annual Progress Report to the NI Equality Commission was formally approved by the Board at its meeting on 11 March 2021; it is available on the HSCB website at www.hscboard.hscni.net.

5.4 Emergency Planning

As outlined throughout the report, the HSCB played a significant role in supporting the emergency response to the Covid pandemic. Below is a summary of some of the key actions undertaken.

- To ensure adherence to a Joint Emergency Planning response, HSC organisations follow the Gold/Silver/Bronze (GSB) reporting structure. During March to July 2020, the HSCB chaired HSC Silver's (HSCB/PHA/BSO) response to the 'delay' phase of the Covid-19 pandemic. This involved seven-day daily SitRep reporting to ensure consistent and timely receipt of information from HSC Trusts and Silver Cells. These discussions facilitated the identification of issues that required escalation to Gold. In addition, a HSCB-led Emergency Operations Centre was established to receive and respond to queries from HSC organisations outside of the Gold/Silver/Bronze reporting process.

- During April 2020, the Gold/Silver/Bronze SitReps were further revised to take account of changing Department of Health (DoH) information requirements. As the first surge de-escalated, SitRep reporting reduced in frequency with HSC Silver officially standing down on 9 July 2020. A debrief was held with Silver IMT members on 29 July 2020, to ascertain how processes could be improved moving forward, and feedback was also sought from HSC Trust colleagues at this time. This informed the DoH review and assessment of the first surge.

- In response to the second wave of the pandemic, revised Gold/Silver/Bronze arrangements were established by DoH during October 2020, with daily (Monday-Friday) SitRep reporting from HSC Trusts and ALBs facilitated by HSCB Health Silver. Twice weekly Surge Command Group meetings replaced daily Gold meetings; teleconferences with HSC Trusts were held on a 'when required' basis. Escalations received from HSC Silver were shared with the relevant DoH Policy Cells (established in October 2020) and an ongoing 'Issues Log' maintained. SitReps required HSC organisations to determine their ability to maintain services using the Gold/Silver/Bronze risk assessment tool. The SitRep process was further enhanced in December 2020, to take account of any potential EU Exit implications. Trust mortuary data was shared with the Department of Justice on a weekly basis. Supplementary to this reporting process, the Director of Commissioning liaised daily with Trust Directors of Planning to develop a weekly forward-look report. This identified services that would be stood down in the coming week. These processes continued until the 22 March 2021, when the Gold/Silver Bronze arrangements were officially stood down by DoH.

5.5 Risk Management

During the reporting period, the HSCB revised its Risk Management Policy and carried out a root and branch review of its risk register to ensure it is fit for purpose during the transition period and when the HSCB migrates to DoH on 1 April 2022. This is further described within the Governance Statement.

5.6 Departmental/Private Office and Freedom of Information Requests

During 2020/21, 106 FOI requests were received by the Health and Social Care Board with 72% being answered within 20 working days. 8 Subject Access Requests were also received with 63% being answered within one calendar month. Two serious personal data related incidents occurred during 2020/21 – both incidents were investigated internally and reported to the Information Commissioners Office. Reviews of internal processes were completed on both occasions and the necessary changes taken to prevent further incidents of this nature occurring.

Theme 6: Delivering Together Transformational Activity

Health and Wellbeing 2026: Delivering Together (available at www.health-ni.gov.uk), a 10 year approach to transforming health and social care, was launched by the Minister of Health in October 2016.

During the reporting year, the pandemic had a significant bearing on transformation progress - with planned growth in many existing initiatives curtailed. However it is important to recognise that progress in existing Transformation initiatives was protected throughout the pandemic and, in many cases, supported the Covid-19 response in areas such as ambulatory and unscheduled care, in the primary care response, and in support for the care home workforce.

Indeed, many existing Transformation initiatives quickly morphed in response to the pandemic, delivering transformative services in new ways. For example, through virtual consultations for dysphasia patients, and through online engagement and new technologies to manage cardiac rehabilitation services.

6.1 Transformation progress

During this reporting year much progress has been made in continuing to transform services. This, combined with the learning and innovation emanating from the pandemic, and new work to rebuild services post-pandemic, is supporting the system to develop a plan for how vital services must continue to rebuild and transform, in line with the commitments set out within Delivering Together.

Examples of progress to date include, but are not limited to:

- Significant progress on the implementation of the new Diabetes Strategic Framework to support effective treatment and care for people living with diabetes.

- Progress on the implementation of plans to modernise and improve treatment and care for children and their families through existing Paediatric Strategies.

- Further development of the Day Case Elective Care Centre prototype, with a new centre for care established at Lagan Valley Hospital, as well as continued progress in the areas of day care cataracts and veins surgery

- Progress on the development of a new model for commissioning services in Northern Ireland informed by population health model and based on clear outcomes.

- Further development of the Primary Care Multi-Disciplinary Model, with services now in place in 5 Federation areas across Northern Ireland, there is an enhanced focus on mental health services and support in response to the impact of the pandemic.

Sustainability

The HSCB is committed to sustainability, environmental, social and community issues. To support this, a number of key policies and protocols are in place. The principles are also embedded within the business principles. During 2020/21 90% of HSCB staff were provided with remote access, to enable compliance with Government advice. The majority of staff are working from home for at least part of their working week. All meetings, including public Board Meetings, are held virtually. In order to facilitate this, 87 staff were provided with Zoom licences which has significantly reduced the need to travel for business purposes and has reduced the HSCB carbon footprint.

During 2020/21, whilst fewer people travelled to work, there are still a number of initiatives in place to encourage more sustainable travel including Sustrans and Business Rail Translink Scheme. Three applications were processed for the Cycle to Work Scheme which also promotes a healthier lifestyle.

A programme of works promoted sustainability in the workplace: sensor flushes and taps throughout 12/22 Linenhall Street, and sensor taps, flushes and lighting in Gransha Park House. Both schemes deliver on reducing environmental impacts.

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

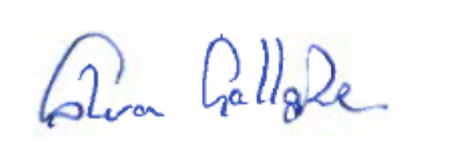
The HSCB has a statutory duty, operational from 1 June 2018, under the 'Rural Needs Act (NI) 2016' (available at www.legislation.gov.uk) which requires the HSCB to have due regard to rural needs defined in the Act as the 'social and economic needs of persons in rural areas'. A Rural Needs Impact Assessment process is undertaken when developing, adopting, implementing or reviewing policies and any strategies or plans to design and deliver public services. During the period 1 April 2020 to 31 March 2021, the HSCB carried out one Rural Needs Impact Assessment in relation to 'Shared Lives' (see below for further details).

As part of the GMS Contract due regard is given to rural needs when developing, adopting and implementing Enhanced Services and Practice Boundary applications. As DoH agreed with NI General Practitioners Committee (NIGPC) and the HSCB to stand these down during 2020/21, this impacted on the number of Rural Needs Impact Assessments undertaken.

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 2020/21 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: • Acute Services	Health and Social Care	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.
Rural Needs Impact Assessment Procurement of Shared Lives NI for Older People available at www.communityni.org	Health and Social Care	The aim of Shared Lives is to deliver an accessible regional service for Older People which will provide an alternative to day opportunities, short breaks or long term care for some adults in need of support. Shared Lives will have a positive impact on people in rural areas. The very nature of this service means that it is accessible to **rural** communities and is suited to **rural** circumstances. The needs and special considerations of rural communities and areas have been objectively considered as part of the development process. This approach offers a model of social care that is based on relationships which enables service users to remain living in their communities (rural and urban), build long term sustainable relationships and reduce social isolation. A number of methods and sources were used to identify the social and economic needs of people in rural areas including: 'Shared Lives NI Annual Report 2017-18, Demographic analysis of Northern Ireland' for targetable host carer recruitment (June 2019); potential suppliers; 5 HSC Trusts and service users. Taking account of the above several proactive key actions will form part of the tender specification and contract terms of reference e.g.: - Advertising of the specification will be communicated via Rural Support Networks, RDC and RCN. - Development of a wide range of communication mediums to raise awareness of the scheme to potential service users and host carers in rural areas.

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*
		- Data system developed to ensure monitoring of geographical location of service users and host carers.



Sharon Gallagher

Chief Executive

Date: 10th June 2021

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 NI. The Directors are independent and reflect wider outside and community interests in the decision making of the Board. "On Board" training was provided to HSCB Board Members in November 2020.

During the period 1 April 2020 to 31 March 2021, the membership of the HSCB Board changed: a new Chair took up post on 1 April 2020, three Non Executive Directors, accepted an extension of Term of Office, effective from 1 April 2020 and left office on 31 August 2021 following the appointment of replacements from 1 August 2021 with a further 2 Non Executive Directors taking up post from 1 September 2020. All have been appointed until 31 March 2022.

A new Chief Executive, who also has a dual role as Deputy Secretary for the Transformation, Planning and Performance Management Group in the DoH, took up post on 28 September 2020. The Director of Commissioning retired in May 2020 and was replaced by an Interim Director of Planning and Commissioning in July 2020. The Director of Finance retired on 30 April 2020 and returned on 4 May 2020 until 8 October 2020. Three Assistant Directors of Finance acted as Interim Director until a substantive appointment was made in February 2021. The Director of Social Care and Children's Services retired in December 2020 and returned on 7 January until 31 March 2021. A substantive appointment took up post on 7 April 2021.

Board membership is comprised of the following Directors:

Non-Executive Directors

Les Drew
Chairman

Stephanie Lowry

Dr Theresa Donaldson

Dr Nazia Latif

Catherine McCallum

Norman McKinley

Dr Thomas Moore

Executive Directors

Sharon Gallagher[1]
Chief Executive

Tracey McCaig[2]
Interim Director of Finance

Paul Cavanagh[3]
Interim Director of Planning and Commissioning

Lisa McWilliams
Interim Director of Performance Management and Service Improvement

Marie Roulston
Director of Social Care and Children

[1] Ms Gallagher took up post of HSCB Chief Executive in September 2020
[2] Ms McCaig took up post of Interim Director of Finance in February 2021
[3] Mr Cavanagh took up post of Interim Director Planning and Commissioning in July 2020

Board of Directors

Les Drew, Chairman

Les Drew was previously employed by NI Electricity Networks as Head of Procurement. He has held a number of other senior management posts during his 39-year career, including Group Financial Controller, Governance and Risk Manager, Regulation Officer, Information Technology Contract Manager, and was Head of Procurement until March 2017. Les is a self-employed business consultant providing strategic advice regarding business improvement and change management. Les was also previously a Non-Executive Director in the PHA prior to taking up the post of HSCB Chair.

Sharon Gallagher, Chief Executive (since September 2020)

Sharon Gallagher took up post as Chief Executive of the Health and Social Care Board and DoH Deputy Secretary in September 2020. Sharon has enjoyed a number of challenging and rewarding roles during her NI Civil Service career. She has undertaken the responsibilities of Director of HR for the Department of Social Development (DSD), Policy Advisor for Welfare Reform, Social Security Agency (SSA), Director of Organisational Change (SSA), Director of Corporate Services (DHSSPS), Director of Service Delivery (DHSSPS) and Director of Transformation (DoH). Sharon has advised Ministers on matters pertaining to her area of responsibility, and has played a key role in contributing to the strategic direction of the organisations within which she worked. She has extensive leadership experience over a range of settings and works to successfully develop her staff to build their capacity and ultimately deliver improved outcomes.

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; 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 Theresa Donaldson, Non-Executive Director (since August 2020)

Dr Theresa Donaldson is a Chartered Director with the Institute of Directors. She holds Non-Executive Director roles with NI Probation Board, NI Equality Commission and Eirgrid PLC. Theresa is a member of the Lord Chief Justice Solicitors' Disciplinary Panel for NI and is a member with NI Appeals Committee for BBC Children in Need. She was Chief Executive of Lisburn and Castlereagh City Council (June 2014 - September 2018) and Chief Executive of Craigavon Borough Council (2010 - 2014). Prior to this Theresa held several senior management positions in Health and Social care and legal services in NI, including as Director of Policy and Civil Service Delivery in the NI Legal Services Commission and Deputy Director NI Guardian Ad Litem Agency.

Dr Nazia Latif, Non-Executive Director (since September 2020)

Dr Nazia Latif has extensive experience of working on human rights and equality issues in NI and internationally. A highly experienced trainer and researcher, Nazia believes in encouraging collaboration between staff and service users to bring positive change in the delivery of public services. She worked for the NI Human Rights Commission for 13 years where she led a number of systemic investigations of international significance, including In Defence of Dignity, an investigation into the human rights of older people in nursing homes. Nazia currently runs Right Practice and specialises in providing practical assistance to organisations to initiate and manage change in order to improve service delivery. Her focus is on helping organisations meet their human rights and equality obligations. Nazia is a graduate of Queen's University Belfast, holds a MA from the University of Durham and a PhD from the University of Newcastle-upon-Tyne.

Catherine McCallum OBE, Non-Executive Director (since August 2020)

Mrs Catherine McCallum OBE, a retired senior civil servant, held a number of positions throughout her 38-year career. Most of her career was spent in the Department for Social Development, working in social security, child support services and training. She was Chief Executive of the Rivers Agency for a number of years and, in her final years of service, she was Director of Rural Affairs at the Department of Agriculture, Environment and Rural Affairs.

Catherine is a volunteer with the Society of St Vincent de Paul and is President of her local Conference. She is a graduate of Queen's University and holds a Master's Degree in Business Administration from Ulster University. She is married with three adult children and two grandchildren. In 2017 Catherine was awarded an OBE for services to Government and the community.

Norman McKinley, Non-Executive Director (since August 2020)

Mr McKinley has extensive senior leadership experience within the voluntary sector both nationally and locally. His early professional career was in social work and he is currently Executive Director for UK Operations with the British Red Cross. Previously he served as a Non-Executive Director and Chair of the Audit Committee with the NI Ambulance Trust. Mr McKinley holds Masters' Degrees in Social Work and Business Administration. He brings a diverse range of experience in governance and in the successful delivery of large-scale transformational change.

Dr Thomas Moore, Non-Executive Director (since September 2020)

Dr Thomas Moore has worked in senior academic and leadership roles in several universities and colleges across the UK. Most recently he was the Principal and Chief Executive of Blackburn College in Lancashire. He led the establishment of a Strategic Alliance engaging with a range of stakeholders to support NHS workforce reforms. In Wales, Dr Moore was the Senior Officer at the Welsh Regulatory Body responsible for the Regulation of Nursing and Midwifery; and was subsequently the Academic Provost and Executive Dean for Health and Social Care at Glyndwr University. In Scotland, Dr Moore was the Principal and Chief Executive of Perth College, part of the Federated University of the Highlands and Islands. He led Perth College through Regionalisation of

the FE Sector and the significant changes which resulted. He was the FE Sector representative on the QAA Committee for Scotland. Dr Moore started his career as a nurse in NI.

Marie Roulston OBE, Director of Social Care and Children (until March 2021)

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

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 NI'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.

Paul Cavanagh, Interim Director of Planning and Commissioning (since July 2020)

Previously, as Assistant Director in the HSCB's Commissioning Directorate, Paul led on the local commissioning of health and social care services in the Western area. In addition he led regionally on the commissioning of ambulance services, radiotherapy services, major trauma care, the Helicopter Emergency Medical Service and Intermediate Care. In this role, Paul was also responsible for external contracting and direct patient services including patient travel. Paul was national contact point for the EU directive on cross-border healthcare. A former Chief Executive of the City Centre Initiative in Derry and Co-ordinator of the North West Community Network, Paul currently sits on the Social Impact Committee for Comic Relief, is a former member of the Board and NI Committee of the Big Lottery Fund and was a founding NI Charities Commissioner.

Tracey McCaig, Interim Director of Finance (since February 2021)

Prior to this appointment Tracey held the post of Assistant Director of Finance in the Northern Health and Social Care Trust from May 2017. During her 32 year career in

Health and Social Care finance, Tracey, who is a Chartered Management accountant, has headed up a number senior finance roles across the HSC, ranging from internal audit to head accountant roles in the NI Ambulance Service, Health and Social Care Board and Public Health Agency.

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

Valerie Watts, Chief Executive (until September 2020)

Valerie Watts was HSCB Chief Executive since July 2014. She has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital and in local government – as Town Clerk and Chief Executive of Derry City Council and Chief Executive of Aberdeen City Council a post she held until her appointment to HSCB.

Dr Miriam McCarthy, Director of Commissioning (until May 2020)

Dr McCarthy was the Director of Commissioning at the HSCB since December 2017. She trained in both general practice and public health and previously was a Consultant in Public Health, based at the PHA. She was a member of the National Institute for Health and Care Excellence (NICE) Technology Appraisal Committee between 2013 and 2017.

Paul Cummings, Director of Finance (until October 2020)

Mr Cummings was the HSCB Director of Finance since 2009. Prior to his appointment, he held senior Finance posts in a number of HSC Trusts and was the first person outside of the English NHS to serve as National Chairman of Healthcare Financial Management Association (HFMA).

The Assistant Directors of Finance (Christine Frazer, Colin Bradley and Lindsay Stead) covered the role on an interim basis until the appointment of an Interim Director of Finance in February 2021.

Dr Melissa McCullough PhD, MSc Clinical/Bioethics, LLB, Non-Executive Director (until August 2020)

Dr McCullough was a Non Executive Director of the HSCB since 2010. She 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 was appointed as a Panel Assessor and Chair for Undergraduate Medical Education with the Medical Council Ireland.

John Mone MSc, BA, Non-Executive Director (until August 2020)

Mr Mone was 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.

Stephen Leach CB, Non-Executive Director (until August 2020)

Mr Leach was a Non-Executive Director of the HSCB from 2009. He is a former senior civil servant and was Chair of the NI Criminal Justice Board from 2000 to 2009. He was a Parole Commissioner for NI from 2009 to 2015 and was the NI Commissioner on the UK Criminal Cases Review Commission from 2014 to 2019.

Board Meetings

The Board met virtually on 11 occasions, including a Special Board Meeting on 7 July 2020, all of which were quorate and during the period there were 6 conflicts of interests. Members absented themselves from the discussion which was recorded in the minutes of meetings held on 13 August, 10 December 2020 and 11 March 2021. There was no dissention from voting.

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 (to September 2020)
- Ms Louise McMahon, Director of Integrated Care, HSCB (from October 2020)
- Dr Stephen Bergin, Interim Director of Public Health, PHA/Medical Director, HSCB (from November 2020)
- Rodney Morton, Director of Nursing and Allied Health Professionals, PHA

The meetings 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.

Since June 2020, members of the public have been invited to virtually observe proceedings, and a deputation addressed the virtual Board Meeting on 11 March 2021.

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.

Dr Theresa Donaldson (Non-Executive Director) is a Board Member of the Centre for Effective Services; Dr Mark Timoney (Chair of South Eastern Local Commissioning Group) is a pharmacy supplies and pharmacy owner; and Dr Gerry Millar (Chair, Southern Local Commissioning Group) is a Trustee of the NI Hospice and Facilitator in Cancer and Palliative Care, NI Children's Hospice, and Southern HSC Trust.

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 HSCB's statutory audit was performed by ASM Chartered Accountants on behalf of the NI Audit Office and the notional charge for the year ended 31 March 2021 was £54,000.

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.
- 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 (NI) 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, and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

The Permanent Secretary of the DoH, as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland, has designated Sharon Gallagher as the Accounting Officer for the HSCB. The responsibilities of an Accounting Officer, including responsibility for the regularity and propriety of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the 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.

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

* At a meeting of the NI Executive on 16 March 2021, the Minister of Health tabled the Second Stage of the Health and Social Care Bill [NIA Bill 18/17-22]. The progress on this legislation advances arrangements for the closure of the HSCB in March 2022. The Bill transfers responsibility for HSCB functions to the DoH and supports the move to a new operating model for transforming how health and social care services in NI are planned and managed. The HSCB will, therefore, continue as constituted for the 2021/22 financial year and these 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) - 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 – HSC Trusts provide services in response to the Commissioning Plan and must meet the standards and targets set by the Health Minister. 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 HSC 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.

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 NI.

In March 2021, a Memorandum of Understanding was agreed between the DoH and HSCB to govern the relationships between the Chief Executive (as a Civil Servant), DoH and HSCB Board during the transition to the new operating model.

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:

- An annual review of Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority.
- Annual review of Register of Interests.
- Gifts and Hospitality Policy.
- The annual completion of the National Audit Office self-assessment checklist and HSCB Governance Self-Assessment Tool.

Performance Appraisal System

The considerable change in Non-Executive Director membership impacted on the performance appraisal system during 2020/21. Whilst three Non-Executive Directors left office on 31 August 2020, one Non-Executive Director continued in post and five new appointments were made during August/September 2020 and only the appraisal of the extant Non-Executive Director was undertaken by the Chair in January 2021.

Local Commissioning Group (LCG) Chairs were appointed on 1 October 2020 until 31 March 2022 and met with the HSCB Chair on a regular basis during the period under review.

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through a system of corporate governance.

The following sections describe 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. 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.

Name	Title	Meetings attended	Meetings scheduled to attend
Mr Leslie Drew	Chair	11	11
Dr Theresa Donaldson	Non-Executive Director (from 1 August 2020)	6	6
Dr Nazia Latif	Non-Executive Director(from 1 September 2020)	5	5
Mr Stephen Leach	Non-Executive Director (until 31 August 2020)	6	6
Mrs Stephanie Lowry	Non-Executive Director	11	11
Ms Catherine McCallum	Non-Executive Director(from 1	4	6

Name	Title	Meetings attended	Meetings scheduled to attend
	August 2020)		
Dr Miriam McCarthy	Director of Commissioning (to 30 June 2020)	3	3
Dr Melissa McCullough	Non-Executive Director (to 31 August 2020)	5	6
Mr Norman McKinley	Non-Executive Director (from 1 August 2020)	6	6
Dr Thomas Moore	Non-Executive Director (from 1 September 2020)	5	5
Mr John Mone	Non-Executive Director (to 31 August 2020)	6	6
Mrs Valerie Watts	Chief Executive (to 30 September 2020)	6	7
Ms Sharon Gallagher	Chief Executive (from 28 September)	4	4
Mr Paul Cummings	Director of Finance (to 8 October 2020)	7	8
Mrs Tracey McCaig	Interim Director of Finance, HSCB & PHA (from February 2021)	1	1
Mr Paul Cavanagh	Interim Director of Planning & Commissioning (from July 2020)	5	6
Mrs Lisa McWilliams	Interim Director of Performance Management and Service Improvement	9	11
Ms Marie Roulston	Director of Social Care & Children	11	11

Meetings of the Board are also attended by the Chairperson of each of the HSCB's five LCGs, whose appointments were noted at the HSCB Meeting on 7 October 2020, and an invitation is extended to representatives of the Patient Client Council. "On Board" training delivered in November 2020 included a number of LCG Chairpersons.

Audit Committee and Governance Committee

At its meeting on 10 December 2020, the Board agreed to establish a Governance and Audit Committee (GAC) which became operational on 1 January 2021. The separate Governance and Audit Committees and the Joint Meeting of these Committees were formally stood down at the HSCB Meeting on 8 April 2021.

The Audit Committee did not meet during the period 1 April - 31 July 2020 as it was inquorate and business was transacted through the joint meeting of the Audit and Governance Committees. Following the appointment of new Non-Executive Directors the Audit Committee met on one occasion with 100% attendance.

The Governance Committee was quorate but did not meet during the period 1 April – 31 July 2020 with business transacted through the Joint Meeting of the Audit and Governance Committees. Following the appointment of new Non-Executive Directors the Governance Committee met on one occasion with 100% attendance.

A joint meeting of the Audit and Governance Committees was convened on three occasions during the reporting period (May 2020-July 2020) with 100% attendance at two meetings and 75% attendance at one meeting.

Governance and Audit Committee

The GAC assists the Board of the HSCB in its responsibilities by providing an independent and objective review of:

- All control systems
- Compliance with law, guidance and Code of Conduct and Code of Accountability
- Governance processes within the Board

The GAC has an integrated governance approach encompassing financial governance, clinical and social care governance and organisational governance, all of which are underpinned by sound systems of risk management. It supports the Board of the HSCB and Accounting Officer with regard to their responsibilities for issues of risk, control and governance and associated assurances through a process of constructive challenge. The GAC provides an assurance to the Board of the HSCB on the adequacy and effectiveness of the system of internal control in operation within the HSCB.

The Committee is comprised of four Non-Executive Directors, with a quorum of three. Where possible, at least one member shall have financial expertise and the remaining members shall include representation from clinical and social care backgrounds. The Chair, Non-Executive Directors, SMT, the internal and external auditors and the HSCB Governance Manager will attend the meeting by invitation. The Chief Executive will be invited annually to attend for the presentation of annual accounts. A representative from the DoH will attend a meeting once a year for the purposes of oversight of the HSCB systems. The Chair of the GAC will report to the Board on a regular basis on the work of the Committee.

Other Committees

In addition to the overarching Governance and Audit Committee (former Governance and Audit Committees) the other Committees of the Board are:

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

Local Commissioning Groups meet on a minimum of six occasions and the other Committees meet as and when required. The respective Terms of Reference are kept under review and can be accessed at http://www.hscboard.hscni.net/wpfb-file/hscb-standing-orders-pdf/ (available at www.hscb.hscni.net). In 2020/21, the Pharmacy

Practices Committee received no full applications for inclusion in the Pharmaceutical List and considered 17 applications for Variations in Contracted Opening Hours across the region.

Over the next number of months and in line with HSCB migration, it is the intention to review current governance arrangements. These arrangements will be aligned to DoH Frameworks and will incorporate the necessary assurance, escalation and reporting mechanisms in readiness for the transfer of responsibility for HSCB functions to the DoH.

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

Many of the HSCB's objectives and responsibilities 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.

Corporate Plan

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 NI, and how it conducts its business and ensures that its organisational arrangements are fit for purpose.

The key objectives within the Corporate Plan for 2019/20 were rolled over for the current reporting period as a result of the Covid-19 response. The pausing of ALB's governance and sponsorship activities was outlined in DoH correspondence, from the Director of Corporate Management.

The Corporate Business Continuity Plan was activated in March 2020 and re-activated in October 2020 as the service entered the second surge of Covid-19. At that time work was undertaken to ensure that the core critical services of the HSCB could continue.

In addition, a review across the HSCB's directorates identified staff who could be redeployed to assist with the Covid-19 response as well as determining key areas of work which could be 'paused' or delayed. This review also identified further important areas of work at directorate level which still required to be delivered during the surge.

The HSCB is currently developing its Business Plan for 2021/22 which will be aligned to Departmental Frameworks. The Business Plan is due to be approved by GAC in June 2021 for onward referral to the Board of the HSCB.

Commissioning Plan

The HSCB publishes a Commissioning Plan, in partnership with the Public Health Agency (PHA), in response to the direction set by the Department of Health.

From June 2020, the Health Minister directed the HSCB, PHA, Trusts and Business Services Organisation to prioritise service planning, delivery and deployment of resources, for a two year period, to stabilise and restore service delivery as quickly as possible by achieving the right balance between delivering Covid-19 and non-Covid-19 activity.

In pursuance of this priority the Commissioning Plan Direction (CPD), Commissioning Plan and associated Service and Budget Agreements (SBAs), for the 2019/20 financial year were rolled forward into the years 2020/21 and 2021/22 and updated to reflect Departmental budget allocations in each of these years.

Risk Management

The HSCB recognises risk management is a key component of its 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.

Risk Management Review 2020/21

During the reporting period, the HSCB revised its Risk Management Policy in order to bring it into line with DoH Frameworks and to ensure a smooth transition in respect of risk when the HSCB migrates to DoH on 1 April 2022. The Policy was approved by the HSCB Governance and Audit Committee at its meeting on 19 January 2021.

This was followed by a root and branch review of the HSCB's risk register at both corporate and directorate levels. This was as a result of the commitment by SMT to HSCB Non-Executive Directors to ensure the organisation's risk register is fit for purpose during the transition period and in light of the limited assurance provided to a risk management audit carried out by Internal Audit earlier in the year (see Internal Audit section of this Statement).

The review was led by the HSCB Governance Team in conjunction with SMT and staff from all directorates.

Categorisation of Risk

The HSCB Risk Management Policy includes an assessment process to enable those risks identified and included within the risk register to be analysed and assessed on a consistent basis across the organisation. This exercise involves determining the existing controls and analysing the risks in terms of their impact and likelihood with those controls in place. In doing so, this will determine the residual risk which together with an agreed risk appetite can allow the target risk to be set which is essentially the level of risk that is considered acceptable and sufficiently mitigated.

Risk Appetite

The HSCB defines risk appetite as the amount and type of risk that an organisation is willing to take in order to meet its objectives. The five risk appetite levels outlined within the HSCB Risk Management policy are: averse, minimalist, cautious, open and hungry.

It is impossible and not always desirable to eliminate all risks and 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.

For that reason the HSCB strives for a 'hungry' risk appetite but recognises the need for an 'open' risk appetite in those areas where the HSCB cannot afford to fail.

Embedding Risk and Risk Leadership

Corporate Risks

In the development of the HSCB Business Plan, HSCB SMT must identify key risks to the achievement of its strategic objectives and carry out an assessment of each risk.

Following approval by SMT, the Corporate Risk Register is submitted to the Governance and Audit Committee for approval on a quarterly basis and to HSCB Board for noting on an annual basis at the same time as the HSCB Business Plan. Although individual risks will have lead directors the HSCB SMT is collectively responsible for the management of risks.

Directorate Risks

Directors must develop risk registers in response to their Directorate objectives and are responsible for ensuring that their Directorate objectives are fully linked to their Directorate risk register. Directorate risk registers are reviewed on a quarterly basis at the same time as the corporate risk register and approved by the relevant Director. Directorate registers are noted by SMT on a rotational basis throughout the year.

Where a risk identified at Directorate level becomes unmanageable within the Directorate's resources, or where it threatens to impact on corporate objectives or across Directorates, it can be escalated to SMT for inclusion on the Corporate Risk Register. The relevant Director, in consultation with the Chief Executive, is responsible for the formal escalation.

Accountability

The HSCB Governance Lead, under the direction of the Director of Performance Management and Service Improvement and Corporate Services, is responsible for co-ordinating the development of the HSCB risk register. Each Director is, however, ultimately responsible for the identification, management and required escalation of their own Directorate risks and for those risks where they are the nominated lead for any corporate risk on behalf of SMT.

Risk Management Training

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 79% of staff trained. Further training has also been carried out during the reporting period by way of the directorate workshops carried out with individual Directorates in light of the introduction of the revised risk management policy and during the review of the risk register as indicated above.

Stakeholder Risk

The HSCB, working in conjunction with the PHA, has in place a robust structure to support safety and quality; to learn from when things go wrong within primary, secondary and community care and put in place the necessary mechanisms to avoid recurrence. The management of Serious Adverse Incidents (SAIs), Complaints and Safety and Quality Alerts (SQAs) is further detailed within the Performance Report in Section 4.1.

5. Information Risk

Safeguarding the HSCB's information is a critical aspect of supporting the organisation in the delivery of its objectives. Central to achieving this is the effective management of information risk. The arrangements in place to manage this risk include:

- A Senior Information Risk Owner (SIRO) and Information Asset Owners (IAOs) are in place to reduce the risk to personal information within the HSCB.
- A Data Protection Officer (DPO) provides independent advice and guidance regarding the processing and protection of personal information in line with the UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA).
- 2020/21 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.
- Annual assurance from IAOs regarding the personal information assets they manage was provided to the SIRO.
- IAOs are aware of their responsibilities to ensure information is securely stored, access controlled and disposed of appropriately.
- Established data incident and breach management procedures and reporting are in place.
- Information Management Assurance was provided to the Department by the HSCB Chief Executive as per Departmental policy in September 2020.

Regular mandatory awareness training continues to be delivered to HSCB staff, providing them with an up-to-date understanding of information governance issues and risks. Restrictions exist to protect access to and disposal of electronic and paper records and the HSCB has a Records Management Policy underpinning its records management

arrangements. Appropriate guidance, central controls and a disposal schedule process all govern the retention and disposal of HSCB records.

Two data incidents were recorded in the HSCB during 2020/21. Both incidents were reported to the Information Commissioner's Office. In each case appropriate mitigations were put in place to prevent similar occurrences in the future.

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

6. 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 supported in fraud awareness in respect of the Anti-Fraud Policy and Fraud Response plan, which are kept under review and updated as appropriate.

A fraud report is brought to the Governance and Audit committee on a regular basis.

7. 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; 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; the 'Co-Production Guide for Northern Ireland - Connecting and Realising Value through People' (DoH, 2018) a practical guide, available at www.health-ni.gov.uk, to a co-production

approach across the health and social care system. The guide was developed as part of the DoH's programme of work to transform health and social care as envisaged in 'Delivering Together 2026'.

The HSCB is committed to integrating this partnership based ethos into the culture and ethos of the organisation as evidenced in a number of key service developments across Social Care and Children's including:

- Regional Communication Support Service project which will deliver a new regional sign language interpretation service.
- DoH/HSCB Task and Finish Group on Regional Service Development Proposal for Separated/Unaccompanied children and young people.
- Dementia Pathfinder Project.
- Development of a new model of domiciliary care/care and support at home.

8. Assurance

Assurance Framework

The HSCB Assurance Framework 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 Assurance Framework is reviewed on an annual basis, however, in light of the Covid-19 response reviews have been suspended since March 2020. A full review of the Assurance Framework will be undertaken for the period 2020/21 in line with the HSCB migration project. This process will be further enhanced by developing a framework which encompasses business planning, risk management and assurances. This will be fully aligned to DoH Frameworks in order to ensure a smooth transition in respect of Governance related processes when HSCB functions transfer to DoH on 1 April 2022.

Whilst a full review of the assurance framework will be undertaken for the period 2020/21, internal assurances for this period have already been sought on those areas of risk previously assessed as controls assurance standards. These assurances are detailed below:

– The HSCB provides an annual assurance to the DoH in respect of Information Management. The assurance for 2019/20 was provided by HSCB in September 2020. The DoH has advised that the assurance process for 2020/21 is now commencing and assurance will be sought in the coming weeks. The year-end Information Governance Report for 2020/21 will be presented to the Information Governance Steering Group on 17 May 2021 and will be tabled at the next available SMT Meeting before inclusion at the Governance and Audit Committee meeting in June 2021.

- The Joint Response Emergency Plan (JREP) was activated in November 2019 until January 2020 in relation to a period of planned industrial action undertaken by HSC staff which caused significant disruption across HSC services. HSC Silver was established, led by the HSCB and daily SitReps were submitted by the HSC Trusts to facilitate daily discussion with HSC Trusts, and subsequently with Gold. SMT and the Board were kept fully updated during this period of disruption. The JREP was further activated in late January 2020 in response to the Covid-19 pandemic. During the initial response and subsequent second surge, the Covid-19 response was a substantive agenda item on the SMT and Board agendas. During the Covid-19 response the DoH stood down the requirement to submit Emergency Planning Core Standards for 2019/20 and an Emergency Planning PHA/HSCB/BSO Annual Report for 2019/20 and 2020/21. Core Standards for 2020/21 are to be submitted to DoH in September 2021.
- In relation to Building, Lands & Plant, Health and Safety, Security, Fire Safety, Environmental Management and Waste Management, a self-assessment process was undertaken in conjunction with PHA to review each area of risk. As all scores had not changed since the previous year, substantive compliance was achieved in 2019/20. The Service Level Agreement with BSO provided an assurance in respect of Human Resources. The 2020/21 review of these areas will be undertaken in April 2021.
- In relation to Digital/ICT Services a range of services are audited by agreement with BSO Internal Audit. The Service Level Agreement with BSO and its ongoing review provides assurance in respect of the digital services provided by BSO ITS.
- Regional templates were agreed regarding assessment of internal assurances for Financial Management and Procurement, the HSCB has scored its arrangements as substantive against these regional standards, with no significant changes from the prior year.

Delegated Statutory Functions

Health and Social Care Trusts submit an annual monitoring report on the delivery of statutory functions with a mid-year return on Corporate Parenting. DoH agreed that submission date of this report was extended by three months this year due to the Covid-19 pandemic and its impact on Social Care and Children's Services. Both the narrative and statistical reports are analysed by HSCB and an overview report on findings was considered by the Board at its meeting on 10 December 2019 and submitted 14 September 2020 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.

Assurances on Safety and Quality Alerts

The HSCB/PHA has in place a Regional Safety and Quality Alerts Procedure which oversees the identification, co-ordination, dissemination and assurance on implementation of regional learning issued by the HSCB/PHA/DoH/RQIA and other independent/regulatory bodies. Once a Safety and Quality Alert (SQA) has been issued

to Arm's Length Bodies (ALBs) it is the responsibility of the HSCB/PHA to ensure adequate responses on assurances to the actions specified within relevant SQAs have been implemented accordingly. This process is overseen by the HSCB/PHA Safety and Quality Alerts Team and the Quality, Safety and Experience Group.

9. Sources of Independent Assurance

The HSCB obtains independent assurance from the following sources:

- Internal Audit
- Business Services Organisation (BSO)

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 2020/21 Internal Audit performed the following audit assignments, with overall levels of assurance given as shown in the table below.

Audit area	Level of Assurance*
Finance Audits:	
Financial Review	Satisfactory
Corporate Risk Based Audits:	
Management of Contracts with Community & Voluntary Sector	Satisfactory
Family Practitioner Services – in context of Covid-19	Satisfactory
ICT Procurement and Contract Management	Satisfactory
Governance Audits:	
Governance during Covid-19	Satisfactory
GP Federations	Limited
Risk Management	Limited
Complaints Management	Satisfactory

** Internal Audit's definition of levels of assurance:*

Satisfactory: *Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.*
Limited: *There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.*

Unacceptable: *The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.*

Internal Audit provided limited assurance within the following areas:

- GP Federations
  Limited assurance was provided in relation to the HSCB's governance and assurance arrangements with GP Federations. The HSCB has developed an action plan to address outstanding recommendations and has engaged directly with the DoH and GP Federations to address the matters raised in the report. As at March 2021, the majority of the outstanding recommendations in the area have been implemented.

- Risk Management
  Internal Audit provided limited assurance in risk management processes. Subsequent to this, the Corporate Risk register was updated and presented to the Governance Committee in November 2020 and further, an extensive programme to refresh the Corporate Risk register and Directorate Risk registers was performed. The new Corporate Risk register was presented to the Governance and Audit Committee in March 2021. In their formal year end follow up on outstanding audit recommendations, Internal Audit has confirmed that all recommendations relating to this area have now been implemented.

Consultancy/Non-Assurance Assignments:

No consultancy or non-Assurance work was conducted during 2020/21.

Follow-up on Previous Recommendations

A review of the implementation of previous priority one and priority two Internal Audit recommendation was carried out at mid-year and again at year end. At year end, 85% of the recommendations examined were fully implemented, and a further 15% were partially implemented at the end of 2020/21. Action plans are being developed to ensure that the remaining recommendations are implemented in 2021/22 where possible.

Elective Care - Management of Independent Sector

In compliance with Procurement Regulations 2015, the HSCB developed a Pseudo Dynamic Purchasing System (PDPS) for the procurement of acute elective and diagnostic capacity. This was developed with the support of BSO and Trusts and required detailed work to be completed on qualifying criteria, governance and controls assurances, insurance requirements and a new and comprehensive data processing specification for 37 separate Lots. The PDPS will be in place for four to seven years and will facilitate providers from NI and beyond with a more straightforward route to offer services to Trusts and more efficient and speedier award of contracts in response to waiting list initiatives. PDPS was launched on 15 February 2021.

Business Services Organisation Assurances

The BSO provides a range of services to, and on behalf of, the HSCB, these include:

- Legal Services
- Procurement and Logistic Services
- Information Technology Services
- Counter Fraud and Probity services
- Shared Services encompassing FHS payments, Payroll, Recruitment, Accounts Payable and Receivable and Business Services
- Human Resources
- Elements of Financial services
- Interpreting Services

An annual assurance statement is received from the BSO Accounting Officer highlighting any governance or performance issues which are required to be drawn to the attention of the HSCB. Performance is also regularly monitored. No issues of serious concern have been raised except for those highlighted by Internal Audit and set out below.

BSO Shared Services Audits

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

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

Overall opinion:

In her Annual Report, the Head of Internal Audit provided the following opinion on the HSCB's system of internal control:

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

External Audit

For the year ended 31 March 2020, the Comptroller and Auditor General certified the 2019/20 financial statements with an unqualified audit opinion, without modification. The NIAO Report to Those Charged with Governance identified two findings: one Priority 1

finding, with no recommendation attached relating to the funds retained by HSCB to counterbalance the WHSCT deficit enabling HSC to breakeven, and one Priority 3 issue.

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

11. Internal Governance Divergences

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

During the reporting period a Root and Branch review of the HSCB Risk Register was undertaken, which resulted in a number of risks being removed from the Corporate Risk Register and no-longer considered to be internal governance divergences. These continue to be managed by way of the Directorate Risk Register in line with the HSCB Risk Management Framework.

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. In this report, Internal Audit provided a dual assurance level of satisfactory assurance in respect of elementary PSSC processes and limited assurance in respect of timesheets, management of overpayments and reconciliations on Real Time Information (RTI) between the payroll system and HMRC data. Due to the nature of the working patterns of staff within HSCB, these areas do not have a significant impact on the daily operational requirements of HSCB, therefore this matter is considered to be resolved.

Domiciliary Care/Independent Home Care

Whilst Covid-19 presented domiciliary care with a new and unprecedented range of challenges, the service proved itself capable of managing these new demands, including enhanced requirements around areas such as infection control and PPE. The sector has responded well and shown great resilience, in many cases finding new and innovative ways of working.

Domiciliary Care is no longer on the HSCB risk register due to controls now in place and detailed below. This included fortnightly monitoring meeting between HSCB, HSC Trusts, PHA and RQIA to identify emerging service pressures, ongoing engagement with providers themselves; implementation and monitoring of the regional Covid-19 action plan; the successful activation of service continuity plans where this has been required in instances of provider instability; and also the positive impact of the income guarantee funding provided to the sector by the DoH.

The HSCB continues to lead on work regionally around developing a new model for domiciliary care, with HSC Trusts and other stakeholders actively engaged in this. The new model has been piloted in Trust areas with positive results. It will seek to address challenges including staff recruitment, procurement, retention and delivery of personalised service user outcomes.

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. The broader issue of Supported Housing and emerging pressures will be kept under constant review in scheduled HSCB meetings with Trusts and the NIHE.

In light of the above supported housing is no longer considered an internal control issue and has been removed from the HSCB risk register.

Instability in Independent Care Home Market

Covid-19 focused attention on the care home sector in an unprecedented manner. Care Homes worked hard to successfully manage a range of new challenges relating to infection control, testing, access to PPE, admissions, social distancing and visiting.

The independent care home sector is no longer included on the risk register because of the controls that have been established, as detailed below. These include fortnightly meetings with Trusts, PHA, RQIA to identify emerging sector pressures; implementation and monitoring of the regional Covid-19 Action Plans; successful activation of the regional Care Home Business Continuity Response plan on occasions of care home instability; the positive impact of the regional income guarantee funding, provided by DoH; and also the ongoing and additional support provided to the sector by statutory services in terms of addressing workforce, PPE and infection control issues.

Nursing homes and most residential homes are owned and managed by independent providers. During Covid-19, the statutory and independent sector worked closely together in terms of access to PPE, infection control/deep cleaning and workforce issues. Such partnerships continue to provide support and greater stability to the sector going forward.

To manage the pressures within the sectors, the HSCB continues to:

- Host fortnightly meetings with HSC Trusts, PHA, 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 real-time updates on bed availability. Work in this area in partnership with RQIA and PHA is already being advanced.
- 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.

The HSCB continues to work closely with the sector, HSC Trusts, PHA, RQIA, Departmental and others to monitor the sector as it emerges from Covid-19. It continues to 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 failure within the care home sector.

Child Sexual Exploitation (CSE)

This has been removed from the Directorate Risk Register due to the work achieved following the Marshall Report and the consistent approach adopted regionally in managing risks to young people.

The HSCB continues, through HSC 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 co-ordinate responses to CSE.

Recurrent funding has been secured for a Lead Officer for CSE within the HSCB. Reporting to the Commissioning Lead for safeguarding, this post will deliver consistency in the responses enacted to CSE across the region and will ensure that reporting trends are kept under review.

Board Succession Planning

This risk was removed from the Corporate Risk Register as a new Chair took up post on 1 April 2020. Three Non-Executive Directors continued until 31 August 2020, with their replacements appointed at 1 August 2020; a further two Non-Executive appointments were made at 1 September 2020. The Term of Office for all appointments is in accordance with the planned date of HSCB closure on 31 March 2022.

The Chief Executive as Accounting Officer remained in post until 30 September 2020, and since other Senior Officer changes did not take place until mid-2020, this ensured there was no governance risk to HSCB during 2020/21.

Service and Budget Agreements

The completion and agreement of Service and Budget Agreements (SBAs), whilst previously considered a corporate risk, have now been addressed through the HSC Framework Document issued by the Permanent Secretary. A new paragraph 2.38, concerning SBAs, was added to the Framework Document and directed that the SBA Commissioning Plan Directions and the Commissioning Plan process be suspended for a period of two years 2020/21 and 2021/22. The Permanent Secretary stated that the 2019/20 documents should be rolled forward into 2020/21 and 2021/22, with updates to reflect the Departmental budget allocations.

Acute Service Continuity

The current challenges in maintaining services at smaller acute hospitals are now being addressed through a range of initiatives involving a whole systems approach to delivering care to patients. New Integrated Care Systems and Multidisciplinary Teams are developing innovative schemes to support hospital services with appropriate primary care developments. The ‘No More Silos’ project aims to further integrate HSC services preventing hospital admissions, reducing hospital stays and promoting community care schemes; see the Performance Report for further details.

The HSCB will continue to work with HSC Trusts and other key stakeholders to identify and, as far as possible, mitigate potential risks to service continuity.

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 CHPP was not being fully delivered and was consequently added to the HSCB Corporate Risk Register. This risk has now been removed as it is

the responsibility of the PHA in line with the wider workforce issues that are being addressed via the Delivering Care Workforce Framework.

EU Exit

The HSCB is a member of the DOH EU Exit Forum, which continues to consider potential impacts on the HSC of the exit of the UK from the EU. Any continuing associated relevant impacts will be considered as part of the review of the Corporate Business Continuity Plan as referred to in section 4 of this statement.

Confidence and Supply Funding – Business Case Approval Process

Internal Audit noted that for a number of Confidence and Supply Investment Proposal Templates, 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. 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.

Following the review Internal Audit have sought and received evidence that key recommendations from the review have since been addressed satisfactorily. This has been confirmed through the formal year-end processes with Internal Audit. In addition, strengthened controls proposed to the funding allocation process in 2021/22 will require Directors to provide assurance of Senior Management Team approval for business cases over £1m before funding allocations are released.

Workforce Pressures

The Social Work Workforce Strategy is now the responsibility of the DoH and is therefore no longer considered an internal control issue for the HSCB.

GP Out of Hours (OOH) Services

Not all OOH providers are meeting KPI standards set out in the 'Service Specification for the Provision of Urgent Primary Care Out-of-Hours in Northern Ireland 2020-21'.
A range of actions to improve the situation has been implemented as outlined below:

- £1.7million allocated in 2020/21 to OOH Providers to help retain current complement of GPs undertaking OOH work and to incentivise new GPs.
- £500k allocated for OOH Local Enhanced Services (LESs) in 2020/21.
- £880k allocated to support GP OOH providers in meeting the increased service demands during the busy winter period.

As a result, this risk has been removed from the HSCB Corporate Risk Register and is being managed as an Integrated Care Directorate Risk in line with the HSCB Risk Management Framework.

Continuity of Transformation Initiatives including Multi-Disciplinary Teams (MDTs)

As part of the UK government's Confidence and Supply agreement, the DoH secured Transformation funding on a non-recurrent basis for the financial years 2018/19 and 2019/20. Initiatives commenced under Confidence and Supply funding were evaluated towards the end of 2019/20. Following a prioritisation exercise in 2020/21, a number of projects were continued into 2021/22 with non-recurrent funding from the DoH. A small number of projects were not prioritised and have since been supported through existing recurrent funding streams. Work is ongoing to understand the potential to put sustainability plans in place for the remaining projects.

Recurrent funding has also been approved for 2021/22 for the MDT Management Team in Integrated Care to continue supporting the development and delivery of various projects.

GP Workforce

Challenges have remained in 2020/21 regarding GP recruitment and retention, intensified by changes in working practices due to Covid-19. However work has continued to address future GP workforce demand as follows:

- GP Training places have increased;
- GP Retainer Scheme;
- GP Mentoring Scheme (and a business has been developed to continue the scheme into 2021/22).

As result this risk has been removed from the HSCB Corporate Risk Register and is being managed as an Integrated Care Directorate Risk in line with the HSCB Risk Management Framework.

Neurology Services Review

In December 2020, the Health Minister announced that the Independent Neurology Inquiry would be converted to a statutory Public Inquiry under the Inquiries Act 2005.

In April 2021, the Department of Health published the 'Neurology Recall: Cohort 2 Activity and Outcomes Report'. The patient group concerned comprised of two subgroups. The first includes patients in high-risk groups who had been seen by the consultant between 2012 and 2017 but who were discharged back to the care of their GP. That group included patients who had been prescribed anti-epileptic drugs, immunosuppressants and disease-modifying therapies used to treat epilepsy and MS. The second group included patients of the consultant who had been referred back to the neurology service for review by their GP.

In addition, the Minister also announced the recall of a third cohort of Neurology patients in Belfast Trust and two Independent Sector Providers was announced on 20 April 2021 by the Minister for Health.

The Neurology Recall Regional Co-ordination Group, which is co-chaired by the HSBC Director of Commissioning and the Director of Public Health, will continue to have oversight of this work in line with previous cohorts to ensure that a consistent approach is taken during the recall. The Group will provide fortnightly updates on the recall work to DoH and will further provide support to the DoH on the reporting of outcomes for cohort 3.

Muckamore Abbey Hospital

A number of Serious Adverse Incident (SAI) reports raising concerns about the care and treatment of adult inpatients 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 the appropriate relevant professional/registering bodies by the employing Trust. It was also announced by Public Prosecution Service recently that a number of staff will face prosecution for alleged offences. On 8th September 2020 the Minister announced his intention to call a Public Inquiry into allegations and gave his commitment to consult fully with families, patients and former patients.

The Muckamore Action Plan is reviewed for progress on a monthly basis by the Department of Health who have convened and manage a Muckamore Abbey Departmental Assurance Group (MDAG). The MDAG group is responsible for the oversight of the action plan arising from the SAIs and the Leadership and Governance Review. Separately the HSCB has convened the Regional Learning Disability Operational Delivery Group monthly meetings with SEHSCT, BHSCT and NHSCT to monitor the availability of inpatient beds, scope possible solutions and monitor resettlement and discharge arrangements.

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.

Cyber Security

The Business Services Organisation (BSO) Information Technology Service (ITS) are responsible for the provision of IT services, including Cyber security environments, to the HSCB.

BSO participate along with all other HSC organisations in the HSC Cyber Security Programme which was established in 2018/19. Outputs from the Cyber Security Programme have included the launch of a shared Cyber Security Incident Response

Action Plan in March 2020. The action plan provides a protocol for collective HSC organisations to follow in the event of a Cyber Security related incident and has already been used on a number of occasions. A further output during 2020/21 has been the launch of mandatory Cyber Security Awareness online training which all HSCB staff are asked to complete.

The Cyber Security Programme Board works closely with the National Cyber Security Centre (NCSC), and the NI Cyber Security Centre to enhance cyber security and compliance with the Network Information Systems Regulations across the HSC.

Recent revision of the Digital Health and Care NI (DHCNI) Governance Framework has been approved and implementation commenced. This includes an Enterprise Architecture Board as part of DHCNI Governance Framework and the delivery of a Cyber Security Strategy.

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

Financial Performance (previously included in Governance Statement as '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.

The budget for Health and Social Care in Northern Ireland continues to be challenging and set in the context of managing significant additional financial pressures relating to the response to the Covid-19 pandemic. To ensure that resources are used to their maximum benefit to deliver HSC services for the population of NI, the HSCB continues to work closely and proactively with the DoH, Trusts and our Independent Sector partners in order to address the difficulties faced. This collaborative approach enabled the HSC system to achieve financial breakeven for the 2020/21 year. However, looking ahead to 2021/22 the budget settlement, financial pressures and uncertainties in view of the ongoing Covid-19 response will require ongoing prioritisation and careful financial management.

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

Western Trust Financial Support

Since 2018/19 the Western HSC Trust has experienced significant financial difficulties, resulting in a significant deficit position being reported. Despite significant additional non-recurrent financial support in-year, the DoH (who have overall strategic financial responsibility for the HSC) approved a control total of (£12m) in 2020/21 with the consequence that financial balance was not achieved by the Trust for 2020/21. The HSCB has held a compensating amount of £12m to ensure the HSC as a whole reported a breakeven position.

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

HSCB will continue to work with the Western 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.

Programme of work to transition the HSCB to the DoH

There is a risk that failure to manage the transition of the HSCB to the DoH could have a serious impact on our ability to plan and manage HSC services. In order to ensure an effective transition the following controls have been put in place:

- Appointment of Chief Executive on 28 September 2020, who will be responsible for the Group's activities as Head of Operations. This will provide continuity of leadership through transition to the new operating model.
- The establishment of a Project Governance Structure with membership agreed including strands, checkpoint, Governance Steering Group and Oversight Board.
- Plans are being developed to capture all necessary activities and associated timeframes for actions to be taken to ensure continuity of service for all business areas post migration.
- Ongoing communications, involvement and engagement with staff and staff-side forum in relation to Migration Project.
- Roll-out of Ambition Programme.

Prescribing Efficiency Targets

Through successive years, significant attention has been paid to the costs of medicines supplied in primary care and below is a summary of the efficiencies that have been released to the wider system through rational cost-effective and efficient prescribing:

2016/17	£23m
2017/18	£17m
2018/19	£32m
2019/20	£12m

The overall prescribing efficiency target for the HSCB in 2020/21 was £14.6m. A plan was developed encompassing 49 projects to deliver efficiencies in primary care drug costs. The delivery of the plan was curtailed due to the pandemic response and £7m of efficiencies are expected to be delivered.

The HSCB continues to work closely with the DoH, Trusts and other key stakeholders to make the most effective use of the available budget without impacting patient care. However, the general pharmaceutical spend for 2020/21 resulted in an overspend of £12.5m.

Insufficient Placements

Foster Care: At 30 September 2020 there were 3,469 children looked after, the highest number since the introduction of the Children's Order (NI) 1995. This represents a 47% increase since March 2007 and this upward trajectory is continuing, placing significant demand on placement availability.

Funding was provided as part of the transformation process for the increased recruitment of foster carers. A regional fostering recruitment strategy is being progressed and, with approval of the Children and Services Improvement Board, a further focus on developing a regionally agreed foster care fee structure is being taken forward.

Set against ongoing recruitment challenges there is, however, a need for sustained increased investment to ensure sufficiency of supply to meet demands for placements. The HSCB is awaiting decision from the DoH in respect of the inescapable pressures funding bid that was submitted.

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 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 to progress a draft framework for disability services.

Residential Children's Homes: The substantial reduction in Children's homes has given rise to increased occupancy in some existing children's homes, and/or the establishment of additional bespoke individual placements within homes, to respond to particularly complex needs of some children requiring a care placement.

The introduction of an Edge of Care/Intensive Family Support Service in each HSC Trust, through part-year funding secured in 2020/21, is in early stage development, following confirmation of recurrent funding.

Novel Coronavirus – Covid-19

The Coronavirus pandemic has had an extensive impact on the health of the population and in the provision of health care services. It has required a number of measures to urgently repurpose and temporarily reconfigure the provision of services, and to identify

additional capacity. Financial measures were put in place at the start of the pandemic by the NI Executive to tackle the response to Covid-19 and the HSC has obtained essential financial support from this package of measures to assist in the ongoing fight against Covid-19. Although the approved initiatives in-year are not recurrently funded, it is expected that they will carry forward into 2021/22 to address the pandemic while DoH seeks long term financial support from the Executive. For further information see the Performance Report.

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

Failure to secure additional elective capacity

Failure to secure additional elective capacity will have a detrimental impact on waiting times for assessment and treatment leading potentially to sub-optimal outcomes for patients.

The length of time patients in NI are waiting for assessment, diagnosis and treatment is totally unacceptable. For further information see the Performance Report.

Insufficient skilled staff deployed in the right areas to deliver organisational objectives

The HSCB recognise the importance of having an available and engaged workforce with the right skills to deliver the strategic objectives of the organisation. As the organisation moves forward to the migration of staff to BSO on 1 April 2022, the HSCB are currently engaged in reviewing its workforce to ensure all posts are filled and the correct skill sets are recruited.

In addition, the HSCB wishes to ensure staff are engaged with the organisation and are clear about what is expected of them in their roles. To this end, the HSCB have implemented a new 'People Strategy' to support the organisation as it transitions into the Group in April 2022. This is underpinned by the roll-out of a refreshed appraisal process in 2021/22 which will ensure all staff have clear work related objectives in line with strategic objectives. The appraisal system also considers how staff demonstrate HSC values in achieving their objectives, their health and wellbeing and their personal development.

The health and wellbeing of staff will be a strategic priority for HSC. Staff have been delivering services throughout the Covid pandemic and Senior Management believe it is essential to support good physical and mental health amongst staff.

Failure to have in place an effective system for the management of Serious Adverse Incidents (SAIs) may result in a delay in issuing learning to the HSC system

2020/21 has seen an increase in the number of SAI review reports not being submitted within adequate timescales to the HSCB from HSC Trusts. Also, internally within the HSCB and PHA there has been a significant delay in HSCB and PHA professional

officers reviewing reports already submitted. These issues could lead to recurrence of SAIs due to the delay in issuing regional learning. The required response to the Covid-19 pandemic has further exacerbated this position. Whilst this remains a very challenging time for all involved it does not negate the need, when things go wrong, to have in place robust mechanisms to identify and share learning in a timely manner. This issue was referred to DoH Top Management Group in January 2021.

HSCB Senior Management Team approved a Safety and Quality Improvement Plan in January 2021. This not only addresses the internal backlog but also puts in place a performance management framework to manage SAIs and Safety and Quality Alerts moving forward.

To date significant progress has been made internally within the HSCB/PHA with a considerable reduction in the number of SAI review reports remaining open and in cases where learning has since been identified, this has either been issued or due for issue in the near future.

Relevant HSCB/PHA Directors and senior staff have met with senior HSC Trust officials and are working with them to put in place realistic time bound Trust SAI Improvement Plans which will not only address the backlog of SAI review reports being completed, but also ensure the process is more effective in the future by putting in place a comprehensive performance management system.

12. 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 2020/21.

REMUNERATION AND STAFF REPORT

Remuneration Report

A Committee of Non-Executive Board members exists to advise the full Board on the remuneration and terms and conditions of service for Senior Executives employed by the 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, 2019/20 and 2020/21 Senior Executive pay awards had not been received by 31 March 2021 and related payments have not been made to Executive Directors. As DoH advised that the 2016/17 and 2017/18 Circulars were imminent the Remuneration and Terms of Service Committee met on 25 March 2021 with a recommendation on assessment of Senior Executives performance to the confidential Board Meeting on 8 April 2021.

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 2020/21. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore, there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts of those appointed in 2020 and the extant Non Executive Director is until 31 March 2022, in line with the date of HSCB closure.

Executive Directors are employed on a permanent contact unless otherwise stated in the following remuneration tables.

Early Retirement and Other Compensation Schemes

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

Membership of the Remuneration and Terms of Service Committee:

Mr Leslie Drew - Chair
Mrs Catherine McCallum – Non-Executive Director
Mr Norman McKinley – Non-Executive Director

The Committee is supported by the Interim 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 shown in the following tables (it should be noted that there were no bonuses paid to any Director during 2020/21 or 2019/20).

Non Executive Members (Table Audited)

	2020/21				2019/20			
Name	**Salary £000s**	**Benefits in Kind (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*) (Leaver 31st Mar 2020)	-	-	-	-	35-40	100	-	35-40
Mr Leslie Drew *(Chair)* (Starter 1st Apr 2020)	35-40	-	-	35-40	-	-	-	-
Mr Stephen Leach (Leaver 31st Aug 2020)	0-5	-	-	0-5	5-10	100	-	5-10
Dr Melissa McCullough (Leaver 31st Aug 2020)	0-5	-	-	0-5	5-10	-	-	5-10
Mr Robert Gilmore (Leaver 31st Mar 2020)	-	-	-	-	5-10	100	-	5-10
Mr Brendan McKeever (Leaver 31st Mar 2020)	-	-	-	-	5-10	100	-	5-10
Mr John Mone (Leaver 31st Aug 2020)	0-5	100	-	0-5	5-10	100	-	5-10
Dr Thomas Moore (Starter 1st Sep 2020)	5-10	-	-	5-10	-	-	-	-
Mr Norman McKinley (Starter 1st Aug 2020)	5-10	-	-	5-10	-	-	-	-
Dr Theresa Donaldson (Starter 1st Aug 2020)	5-10	-	-	5-10	-	-	-	-
Dr Nazia Latif (Starter 1st Sep 2020)	5-10	-	-	5-10	-	-	-	-
Mrs Catherine McCallum (Starter 1st Aug 2020)	5-10	-	-	5-10	-	-	-	-
Mrs Stephanie Lowry	5-10	-	-	5-10	5-10	-	-	5-10

Notes

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

Executive Members (Table Audited)

	2020/21				2019/20			
Name	**Salary £000s**	**Benefits in Kind (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**
Ms Marie Roulston *Director of Social Care and Children* (Leaver 31st Mar 2021)	80-85	-	-	80-85	80-85	300	22,000	105-110
Mrs Tracey McCaig *Interim Director of Finance* (Starter 15th Feb 2021)	10-15 (80-85 FYE)	-	49,000	55-60	-	-	-	-
Mrs Christine Frazer *Interim Director of Finance* (Oct – Nov 2020)	10-15 (95-100 FYE)	-	19,000	30-35	-	-	-	-
Mr Lindsay Stead *Interim Director of Finance* (Dec 2020 – Jan 2021)	15-20 (95-100 FYE)	100	22,000	35-40	-	-	-	-
Mr Colin Bradley *Interim Director of Finance* (Feb – Mar 2020)	15-20 (95-100 FYE)	-	23,000	35-40	-	-	-	-
Mr Paul Cavanagh *Interim Director of Planning and Commissioning* (Starter 14th Jul 2020)	65-70 (90-95 FYE)	4,900	45,000	115-120	-	-	-	-
Mrs Lisa McWilliams *Interim Director of Performance Management & Service Improvement*	90-95	-	39,000	130-135	85-90	200	17,000	100-105
Ms Louise McMahon *Director of Integrated Care*	105-110	-	20,000	125-130	105-110	500	24,000	130-135

Executive Members continued (Table Audited)

	2020/21				2019/20			
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* (Leaver 30th Sep 2020)	75-80 (155-160 FYE)	-	-	75-80	155-160	200	-	155-160
Mr Paul Cummings *Director of Finance* (Leaver 30th Oct 2020)	50-55 (85-90 FYE)	700	-	50-55	120-125	6,700	(9,000)	115-120
Dr Sloan Harper *Director of Integrated Care* (Leaver 30th Sep 2020)	65-70 (130-135 FYE)	-	-	65-70	130-135	2,700	-	130-135
Dr Miriam McCarthy *Director of Commissioning* (Leaver 31st May 2020)	20-25 (105-110 FYE)	100	-	20-25	115-120	100	14,000	130-135

Notes

Mrs Sharon Gallagher was appointed as Chief Executive HSCB in September 2020. All remuneration relating to this post has been reported within the Department of Health's Annual Report and Accounts for the financial year ended 31st March 2021.

FYE – Full Year Equivalent

Pensions of Senior Management – Executive Members (Table Audited)

	2020/21				
Name	**Real increase in pension and related lump sum at age 60**	**Total accrued pension at age 60 and related lump sum**	**CETV at 31/03/20**	**CETV at 31/03/21**	**Real increase in CETV**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Mrs Tracey McCaig *Interim Director of Finance*	2.5-5 pension 0-2.5 lump sum	30-35 pension 60-65 lump sum	471	529	54
Mrs Christine Frazer *Interim Director of Finance*	0-2.5 pension 2.5-5 lump sum	25-30 pension 85-90 lump sum	656	716	33
Mr Lindsay Stead *Interim Director of Finance*	0-2.5 pension 2.5-5 lump sum	30-35 pension 90-95 lump sum	729	743	15
Mr Colin Bradley *Interim Director of Finance*	0-2.5 pension 2.5-5 lump sum	35-40 pension 110-115 lump sum	847	881	33
Mr Paul Cavanagh *Interim Director of Planning and Commissioning*	2.5-5 pension 2.5-5 lump sum	25-30 pension 50-55 lump sum	437	503	47
Mrs Lisa McWilliams *Interim Director of Performance Management & Service Improvement*	0-2.5 pension 0-2.5 lump sum	20-25 pension 40-45 lump sum	304	350	33
Ms Louise McMahon *Director of Integrated Care*	0-2.5 pension	20-25 pension	284	322	24

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 does not include the increase in 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 2019/20.

	2021	2020
Band of Highest Paid Director's Remuneration (band in £000s)	155-160	155-160
Median Total Remuneration (£)	38,890	37,570
Ratio	3.99	4.13

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):

	2021			2020
	Permanently employed staff	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	23,421	1,563	24,984	23,649
Social security costs	2,428	162	2,590	2,472
Other pension costs	4,623	309	4,932	4,518
Total staff costs reported in Statement of Comprehensive Expenditure	**30,472**	**2,034**	**32,506**	**30,639**
Less recoveries in respect of outward secondments			(593)	(562)
Total net costs			**31,913**	**30,077**

The HSCB participates in 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.

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

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

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

Average Number of Persons Employed (Table Audited)

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

	2021			2020
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	474	39	**513**	**499**
Less average staff number relating to capitalised staff costs	-	-	**-**	**-**
Less average staff number in respect of outward secondments	(11)	-	**(11)**	**(8)**
Total net average number of persons employed	**463**	**39**	**502**	**491**

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**	
	2021	**2020**	**2021**	**2020**	**2021**	**2020**
£200,001 - £250,000	0	0	1	0	1	0
Total number of exit packages by type	**0**	**0**	**0**	**0**	**0**	**0**
Total resource cost £000s	**£0**	**£0**	**£0***	**£0**	**£0**	**£0**

**The process for the one post holder shown above commenced in March 2019 and was accrued accordingly; however, the official process was not completed until April 2020.*

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 2020/21 or 2019/20.

HSCB Management Costs

	2021	2020
	£000s	£000s
HSCB management costs	36,163	34,443
Income:		
RRL	6,405,256	5,552,620
Less non cash RRL excluding element to cover clinical negligence provision	(9,071)	(6,611)
Income per Note 4	39,550	56,853
Less interest receivable	(22)	(14)
Total Income	**6,435,713**	**5,602,848**
% of total income	**0.56%**	**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 2020/21 there was one early retirement from the HSCB agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement is £3K. These costs are borne by the HSC Pension Scheme.

Staff Composition

At 31 March 2021 the HSCB's headcount is 506 employees which equates to 462.2 WTE. Of this figure, 455 are permanent staff members with 51 temporary staff. The ratio of female to male employees is 369 women to 137 men.

There were 74 senior staff who earn over £67k or would earn over £67k if they were 1.00 WTE, of these 35 are women and 39 men.

Sickness Absence Data

The corporate cumulative annual absence level for the HSCB for the period from 1 April 2020 – 31 March 2021 is 3.41% (2019/20 3.17%).

There were 30,444 hours lost due to sickness absence (2019/20 28,033 hours), or the equivalent of 60 hours (2019/20 56 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 8.0 days (2019/20 7.5 days) per employee.

Staff Turnover Percentage

For a given period, the total turnover figure is calculated as the number of leavers within that period divided by the average employee headcount over the period. Voluntary turnover includes leavers classified under the categories of resignation, retirement or ill-health retirement. Involuntary turnover includes leavers classified under the categories of dismissal, end of fixed term contract or ill-health termination. This information has been included for the 2020/21 financial year for the first time and comparators are not currently available.

Staff Turnover %	2021
Total Staff Turnover	9.18%
Split between:	
Voluntary Turnover	7.98%
Involuntary Turnover	1.20%

Staff Engagement Scores

HSC organisations do not monitor Employee Engagement on an annual basis, but there is a Regional Staff Survey conducted every 3 years. The HSCB employee engagement score from the most recent staff survey (2019) was 3.55 out of a possible 5. The response rate was 50%.

In addition to the regional survey, the HSCB conducted a Cultural Assessment survey which measured the culture within the organisation across 8 dimensions. Each of the 8 dimensions was scored out of 5 and the table below shows the scoring against each dimension within HSCB. The response rate for this survey was 42.8%.

Dimension	Score
Values	3.25
Vision	2.33
Goals & Performance	3.48
Quality & Innovation	2.87
Team Working	3.57
Compassionate Care	3.92
Compassionate Leadership	3.41
Collective Leadership	3.12

Due to Covid-19, the way HSCB staff work changed dramatically in 2020 with many staff working remotely from home. This was a new way of working and the organisation recognised that some staff may have found this shift challenging. In order to help address this two “Working from Home” surveys were conducted, one in the summer and one in winter, to get feedback from staff about how they are managing while working from home during the pandemic. The response rate was 48%. Some high level findings are noted below.


HSCB Results
72%
Employees feel satisfied with working from home
Down 16% since May 2020
97%
Employees would like HSCB to consider working from home post COVID-19
73%
Employees were able to deliver all of their job roles to the standard they could if they were based in the workplace
Up 4% since May 2020
88%
Managers said they hadn't seen any drop in productivity or performance
Down 5% since May 2020
57%
Employees said they exercise at least one time each day
Down 19% since May 2020
70%
Staff still feel connected to their colleagues
Down 3% since May 2020
67%
Employees believe they have a good work-life balance
Down 8% since May 2020
63%
Managers communicate daily with their wider team
Down7% since May 2020

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.

Employment and Occupation

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 expenditure of £99K on an external consultancy project relating to the Encompass Programme during 2020/21 (nil in 2019/20).

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 which cost more than £245 per day and lasted longer than 6 months during the financial year, which were not paid through the HSCB Payroll. In 2020/21 there were no such ‘off-payroll’ engagements (2019/20 – none).

ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

Funding Report

Regularity of Expenditure (audited information)

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 2020/21 there has been no evidence of irregular expenditure.

Losses and Special Payments (Tables Audited)

Losses Statement	2020/21	2019/20
Total number of losses	1	3
Total value of losses (£)	£3,354	£9,286

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

Special Payments	2020/21	2019/20
Total number of special payments	4	8
Total value of special payments (£)	£130,300	£407,167

There were no individual special payments over £250K in the 2020/21 financial year (nil in 2019/20).

Special Payments

There were no other special payments or gifts made during the year (2019/20 – none).

Other Payments and Estimates

There were no other payments made during the year (2019/20 – 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 the HSC Board, handles payments to contractors providing family practitioner services. Probity Services which is part of the Counter Fraud and Probity Service within the BSO is 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 Work 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 case management system (EPES). 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. These 'Loss' estimates are typically based on 100 cases sampled each month between September and August. However, due to the closure and gradual re-opening of dental and ophthalmic services because of the Covid-19 pandemic, larger samples of 150 were taken during the months of September 2019 to March 2020 and 100 for August 2020. The annual potential fraud/error rates are based on data that straddles two financial years so that the time delay naturally in the system has time to work its way through the data, i.e. the time period for the data is chosen so that the Counter Fraud and Probity Services (CFPS) investigations have been finalised or are at as advanced a stage as possible.

5. The methodology was revised for 2020/21 so that the potential fraud/error rates (calculated from activity between the period September 2019 and August 2020) are now applied to the payment activity in that financial year, i.e. April 2020 to March 2021, instead of the payment activity between September 2019 and August 2020. Ideally the potential fraud/error rates and activity data to which they are applied would completely align. However, it is not practically possible to do this for the current activity year due to the survey constraints highlighted above. It is considered a more accurate estimate of the monetary value of estimated loss in a given financial year to apply slightly lagged (by 7 months) potential fraud/error rates to the activity data in the year in question than to also lag the activity data for consistency purposes.

The benefit of using this revised methodology is clearly illustrated during the current Covid-19 pandemic. Both dental, and to a lesser extent ophthalmic, activity have been markedly depressed during this period. Whilst top-up payments have continued to be made to contractors during the pandemic via the financial support schemes (FSS), these also covered patient contributions so there was no scope for fraud/error with these payments. The only element of the payment still susceptible to fraud/error was in respect of the actual activity that took place when services began to be re-established – this will clearly be much lower than in a normal year. It follows, therefore, that if we were to base the annual loss estimate on activity that included a 7 month period preceding the pandemic and introduction of the FSS, it would significantly overestimate the level of loss for 2020/21 year. The revised methodology avoids this issue.

In a further enhancement, post-stratification weighting was applied to the cases sampled to ensure the estimate of loss took account of differences between the composition of the survey sample and the exemption category profile of cases in 2020/21. Importantly, this does not change the central loss estimates themselves compared to the previous method, but rather reduces the error attached to them by narrowing the confidence intervals.

6. 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. As a result it is not possible to assess the validity of the claim under exemption rules. There were twenty cases excluded for 2020/21; nine in dental and eleven in ophthalmic. In 2019/20 there were three exclusions in dental and eleven in ophthalmic, with a further twenty-one cases excluded last year due to technical issues.

Based on the revised methodology, the estimated loss due to patient exemption error/potential fraud for 2020/21 is £1.8m (£1.1m Dental, £0.7m Ophthalmic). Estimates calculated using the previous methodology have been provided purely for illustrative purposes – a total of £3.2m (£2.5m Dental, £0.7m Ophthalmic).

The central estimate figure for dental using the revised methodology outlined above is over 50% less than when the original methodology is applied, reflecting the impact that the Covid-19 pandemic has had on activity levels. The central estimate for ophthalmic has remained stable at £0.7m, showing the pandemic had less of an impact on ophthalmic services once these resumed in June 2020.

The central estimate figures formally reported last year (2019/20) for dental and ophthalmic were £2.9m and £1.0m respectively (the combined estimate was £3.9m), largely reflecting the higher level of activity in this pre-pandemic year. These estimates would have reduced a little to £2.8m and £0.9m, or £3.7m in total, if we were to apply the revised methodology outlined above.

In order to standardise for differential activity levels between years, however, the 2019/20 estimated potential fraud/error rates were applied to 2020/21 activity. This yielded dental and ophthalmic loss estimates of £0.8m and £0.7m respectively (with a

combined figure of £1.5m). These can then be compared, on a like-for-like basis, with this year's estimates based on the revised methodology, i.e. £1.1m Dental, £0.7m Ophthalmic and £1.8m combined.

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 19 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 2021, the HSCB is not aware of any remote contingent liabilities.

Mrs Sharon Gallagher

Chief Executive

Date: 10th June 2021

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

Opinion on financial statements

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

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

In my opinion the financial statements:

- give a true and fair view of the state of Health and Social Care Board's affairs as at 31 March 2021 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 for opinions

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

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

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

Conclusions relating to going concern

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

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

The going concern basis of accounting for the Health and Social Care Board is adopted in consideration of the requirements set out in the Government Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

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

Other Information

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

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

I have nothing to report in this regard.

Opinion on other matters

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

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

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

Matters on which I report by exception

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

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

Responsibilities of the Board and Accounting Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

My procedures included:

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

- making enquires of management and those charged with governance Health and Social Care Board's compliance with laws and regulations;

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

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

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

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

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

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

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

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

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

Report

I have no observations to make on these financial statements.

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

Date 30 June 2021

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2021

FOREWORD

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

Health and Social Care Board

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the Year Ended 31 March 2021

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

		2021	2020
Income	**NOTE**	**£000**	**£000**
Revenue from contracts with customers (excluding interest)	4.1	37,383	54,978
Other operating income	4.2	2,144	1,861
Total operating income		39,527	56,839
Expenditure			
Staff costs	3	(32,506)	(30,639)
Purchase of goods and services	3	(1,183,227)	(1,064,367)
Depreciation, amortisation and impairment charges	3	(3,408)	(2,939)
Provision expense	3	(5,610)	(3,599)
Other operating expenditure	3	(21,077)	(21,211)
Total operating expenditure		(1,245,827)	(1,122,755)
Net operating Expenditure		**(1,206,300)**	**(1,065,916)**
Finance income	4.1	13	14
Finance expense	3	0	0
Net expenditure for the year		(1,206,288)	(1,065,902)
Revenue Resource Limits (RRLs) and capital grants issued (to)			
Belfast Health & Social Care Trust		(1,669,205)	(1,482,817)
South Eastern Health & Social Care Trust		(848,719)	(701,086)
Southern Health & Social Care Trust		(840,923)	(714,732)
Northern Health & Social Care Trust		(905,932)	(788,843)
Western Health & Social Care Trust		(804,315)	(687,506)
NIAS Health & Social Care Trust		(115,336)	(87,578)
NI Medical & Dental Training Agency		(1,767)	(1,866)
PCC		(15)	(5)
Total RRL issued		(5,186,212)	(4,464,433)
Total Commissioner resources utilised		(6,392,500)	(5,530,335)
Revenue Resource Limit (RRL) received from DoH	23.1	6,405,154	5,552,620
Surplus / (Deficit) against RRL		**12,655**	**22,285**

OTHER COMPREHENSIVE EXPENDITURE	**NOTE**	**2021 £000**	**2020 £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	132	3,607
Net gain/(loss) on revaluation of intangibles	6.1//6.2/8	(9)	0
TOTAL COMPREHENSIVE EXPENDITURE for the period ended 31 March		**(1,206,166)**	**(1,062,295)**

The notes on pages 112 to 141 form part of these accounts.

The surplus held by HSCB offsets the £12m control total for the Western Health and Social Care Trust, which has been authorised by the Department of Health in 2020/21. 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 for the Year Ended 31 March 2021

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	2021 £000	£000	2020 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	20,334		20,441	
Intangible assets	6.1/6.2	6,794		2,354	
Financial assets	7	213		644	
Total Non Current Assets			27,342		23,439
Current Assets					
Trade and other receivables	12	14,308		4,207	
Other current assets	12	49		19	
Financial assets	7	494		117	
Cash and cash equivalents	11	921		1,243	
Total Current Assets			15,772		5,586
Total Assets			**43,113**		**29,025**
Current Liabilities					
Trade and other payables	13	(167,701)		(173,397)	
Provisions	14	(3,847)		(2,714)	
Total Current Liabilities			(171,547)		(176,111)
Total assets less current liabilities			**(128,434)**		**(147,086)**
Non Current Liabilities					
Provisions	14	(33,035)		(31,000)	
Total Non Current Liabilities			(33,035)		(31,000)
Total assets less total liabilities			**(161,470)**		**(178,086)**
Taxpayers' Equity and other reserves					
Revaluation reserve		12,537		12,416	
SoCNE reserve		(174,007)		(190,502)	
Total equity			**(161,470)**		**(178,086)**

The financial statements on pages 108 to 141 were approved by the Board on 10th June 2021 and were signed on its behalf by:

Signed  (Chairman) Date 10th June 2021

Signed  (Chief Executive) Date 10th June 2021

The notes on pages 112 to 139 form part of these accounts.

Health and Social Care Board

STATEMENT of CASH FLOWS for the Year Ended 31 March 2021

The Statement of Cash Flows shows the changes in cash and cash equivalents of the 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	2021 £000	2020 £000
Cash flows from operating activities			
Net surplus after interest/Net operating expenditure	SoCNE	(1,206,288)	(1,065,902)
Adjustments for non cash transactions	3	9,087	6,611
(Increase)/decrease in trade and other receivables	12	(10,133)	758
Increase/(decrease) in trade payables	13	(5,696)	6,051
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	(333)	702
Movements in payables relating to the purchase of intangibles	13	(2,028)	48
Use of provisions	14	(2,443)	(2,447)
Net cash inflow /(outflow) from operating activities		(1,217,834)	(1,054,179)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(2,083)	(3,629)
(Purchase of intangible assets)	6	(3,257)	(742)
(FTC loans issued to GPs)	7	0	(43)
Proceeds on disposal of intangibles		0	
FTC loans returned by GPs	7	121	118
Net cash outflow from investing activities		(5,218)	(4,296)
Cash flows from financing activities			
Grant in aid		1,222,728	1,058,969
Cap element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net financing		1,222,728	1,058,969
Net increase (decrease) in cash & cash equivalents in the period		(322)	494
Cash & cash equivalents at the beginning of the period	11	1,243	749
Cash & cash equivalents at the end of the period	11	**921**	**1,243**

The notes on pages 112 to 141 form part of these accounts.

Health and Social Care Board

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the Year Ended 31 March 2021

This statement shows the movement in the year on the different reserves held by 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 2019		**(183,622)**	**8,809**	**(174,813)**
Changes in Taxpayers' Equity 2019/20				
Grant from DoH		1,058,969	0	1,058,969
Other reserves movements including transfers		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)**
Changes in Taxpayers' Equity 2020/21				
Grant from DoH		1,222,728	0	1,222,728
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(1,206,287)	121	(1,206,166)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	54	0	54
Balance at 31 March 2021		**(174,007)**	**12,537**	**(161,470)**

The notes on pages 112 to 141 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 2020/21 or 2019/20.

1.9 Inventories

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

1.10 Income

Income is classified between Revenue from Contracts and Other Operating Income as assessed necessary in line with organisational activity, under the requirements of IFRS 15 and as applicable to the public sector. Judgement is exercised in order to determine whether the five essential criteria within the scope of IFRS 15 are met in order to define income as a contract.

Income relates directly to the activities of the 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.

Income is stated net of VAT.

Grant in aid

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

1.11 Investments

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

1.12 Research and Development expenditure

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

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

1.13 Other expenses

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

1.14 Cash and cash equivalents

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

1.15 Leases

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

The HSCB as lessee

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

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

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

The HSCB as lessor

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

1.16 Private Finance Initiative (PFI) transactions

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

1.17 Financial instruments

- Financial assets

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

Financial assets are initially recognised at fair value. IFRS 9 requires consideration of the expected credit loss model on financial assets. The measurement of the loss allowance depends upon the 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, where judged necessary.

Financial assets are classified into the following categories:

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

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.

- Financial liabilities

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

- Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with the DoH, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the 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 2021, using the discount rates issued by the Department of Finance (DoF) below.

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

Note that 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) 40-2020.

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

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 2021. 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 with sufficient regularity that the amounts recognised in the financial statements do not differ materially from those determined at the reporting period date. This has been interpreted in the FReM to mean that the period between formal actuarial valuations shall be four years. However, it has been noted in HM Treasury guidance that the validation and processing of some of the Schemes' data may not be finalised until after the 2020/21 accounts are laid. Schemes are not automatically required to reflect 2020 scheme valuation data in the 2020/21 accounts. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension scheme updated to reflect current financial conditions and a change in financial assumption methodology will be used in 2020/21 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

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

Revaluation Reserve

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

1.22 Value Added Tax (VAT)

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

1.23 Third party assets

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

1.24 Government Grants

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

1.25 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the 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 requirements of the FReM, IFRS 16 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2022.

IFRS 17 *Insurance Contracts* will replace IFRS 4 *Insurance Contracts* and is effective for accounting periods beginning on or after 1 January 2023. In line with the requirements of the

FReM, IFRS 17 will be implemented, as interpreted and adapted for the public sector, with effect from 1 April 2023.

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

1.27 Changes in accounting policies/Prior year restatement

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

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

The 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	2021 £000	2020 £000
Commissioning	2.1	5,279,425	4,547,145
FHS	2.2	1,052,515	926,494
Board Administration	2.3	60,560	56,696
Total Commissioner Resources utilised		**6,392,500**	**5,530,335**

2.1 Commissioning

Expenditure	NOTE	2021 £000	2020 £000
Belfast Health & Social Care Trust	SoCNE	1,669,205	1,482,817
South Eastern Health & Social Care Trust	SoCNE	848,719	701,086
Southern Health & Social Care Trust	SoCNE	840,923	714,732
Northern Health & Social Care Trust	SoCNE	905,932	788,843
Western Health & Social Care Trust	SoCNE	804,315	687,506
NIAS Health & Social Care Trust	SoCNE	115,336	87,578
NI Medical & Dental Training Agency	SoCNE	1,767	1,866
Patient and Client Council	SoCNE	15	5
Other Providers	3.1	121,093	109,262
		5,307,305	4,573,695
Income			
Revenue from contracts with customers exc FHS	4.1	27,880	26,550
Commissioning Net Expenditure		**5,279,425**	**4,547,145**

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

Expenditure	NOTE	2021 £000	2020 £000
General Medical Services	3.1	349,037	307,600
General Dental Services	3.1	138,011	131,598
General Pharmaceutical Services	3.1	548,648	492,866
General Ophthalmic Services	3.1	26,310	22,844
		1,062,006	954,908
Income			
Revenue from contracts with customers FHS	4.1	9,491	28,414
FHS Net Expenditure		**1,052,515**	**926,494**

2.3 Board Administration

Expenditure	NOTE	2021 £000	2020 £000
Salaries and wages	3.2	32,506	30,639
Operating expenditure	3.2	21,135	21,335
Non-cash costs	3.3	5,613	3,652
Depreciation	3.3	3,475	2,959
		62,729	58,585
Revenue from contracts with customers			
FTC interest	4.1	13	14
Other Operating Income			
Staff secondment recoveries	4.2	592	563
Canteen	4.2	32	161
Other income	4.2	1,532	1,151
		2,156	1,875
Board Administration Net Expenditure		**60,560**	**56,696**

NOTE 3 - EXPENDITURE

3.1 Commissioning:	2021 £000	2020 £000
General Medical Services	349,037	307,600
General Dental Services	138,011	131,598
General Pharmaceutical Services	548,648	492,866
General Ophthalmic Services	26,310	22,844
NHS Trusts	31,946	46,569
Other providers of healthcare and personal social services	89,147	62,693
Total Commissioning	1,183,099	1,064,170

3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	24,984	23,649
Social security costs	2,589	2,472
Other pension costs	4,932	4,518
Supplies and services - general	129	197
Establishment	19,682	19,698
Transport	3	12
Premises	1,317	1,318
Bad debts	3	9
Rentals under operating leases	0	101
Interest charges	2	0
Total Operating Expenses	53,641	51,974

3.3 Non cash items:		
Depreciation	2,641	2,308
Amortisation	834	651
Impairments relating to FTC	(67)	(19)
Loss on disposal of property, plant & equipment (including land)	15	19
Increase / Decrease in provisions (provision provided for in year less any release)	5,853	3,842
Cost of borrowing of provisions (unwinding of discount on provisions)	(243)	(243)
Auditors remuneration	54	53
Total non cash items	9,087	6,611
Total	**1,245,827**	**1,122,755**

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

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

During the year the HSCB paid its share of regional audit services (£1,244) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and this amount is included in operating costs above.

NOTE 4 - INCOME

4.1 Revenue from Contracts with Customers	2021 £000	2020 £000
Income from Department of Education	26,940	25,598
CAWT	336	349
Family Health Services Receipts	6,508	26,053
Family Health Services Receipts (PHA GMS)	2,983	2,361
FTC interest receivable	13	14
Accommodation	603	603
Total	**37,383**	**54,978**

4.2 Other Operating Income	2021 £000	2020 £000
Canteen	32	161
Seconded Staff	592	563
Other income - Home Office	1,446	980
Other income - MacMillan	24	132
Other income - Other	62	39
Total	**2,156**	**1,875**

TOTAL INCOME	**39,539**	**56,853**

NOTE 5.1 - PROPERTY, PLANT & EQUIPMENT (Year Ended 31 March 2021)

	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 2020	4,050	9,537	6	19,602	164	33,359
Indexation	0	0	0	(1)	0	(1)
Additions	0	324	0	2,094	0	2,418
Transfers	0	0	0	136	0	136
Disposals	0	0	0	(1,995)	0	(1,995)
At 31 March 2021	**4,050**	**9,861**	**6**	**19,836**	**164**	**33,917**
Depreciation						
At 1 April 2020	0	73	6	12,676	164	12,919
Indexation	0	0	0	(1)	0	(1)
Transfers	0	0	0	4	0	4
Disposals	0	0	0	(1,980)	0	(1,980)
Provided during the year	0	450	0	2,191	0	2,641
At 31 March 2021	**0**	**523**	**6**	**12,890**	**164**	**13,583**
Carrying Amount						
At 31 March 2021	**4,050**	**9,337**	**0**	**6,946**	**0**	**20,334**
At 31 March 2020	**4,050**	**9,464**	**0**	**6,926**	**0**	**20,440**
Asset financing						
Owned	4,050	9,337	(0)	6,946	0	20,334
Carrying Amount						
At 31 March 2021	**4,050**	**9,337**	**0**	**6,946**	**0**	**20,334**

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

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

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

RICS, IFRS, IVS & HM Treasury compliant asset revaluation of land and buildings for financial reporting purposes are undertaken by Land and Property Services (LPS) at least once in every five year period. Figures are then restated annually, between revaluations, using indices provided by LPS. The last asset revaluation was carried out on 31 January 2020. LPS have confirmed that, provided the relevant Indexation Categories supplied for the Effective Period 1 April 2020 to 31 March 2021 have been appropriately applied to the corresponding relevant asset classifications, as at 31 March 2021, then the restated 31 January 2020 land and building valuation figures remain appropriate at 31 March 2021.

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 subjectivity in terms of informing opinions of value. For the avoidance of doubt, this does not mean that figures cannot be relied upon, rather, the declaration of material uncertainty ensures transparency and provides further insight as to the market context under which valuation opinion has been prepared. 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 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
Transfers	0	0	0	0	0	0
Revaluation	0	(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 1 April 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**
Asset financing						
Owned	3,584	6,522	0	6,279	0	16,385
Carrying Amount						
At 1 April 2019	**3,584**	**6,522**	**0**	**6,279**	**0**	**16,385**

NOTE 6.1 - INTANGIBLE ASSETS (Year Ended 31 March 2021)

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under Construction £000	Total £000
Cost or Valuation				
At 1 April 2020	2,517	5,530	614	8,661
Indexation	0	0	0	0
Additions	169	4,654	462	5,285
Transfers	0	60	(70)	(10)
Disposals	0	0	0	0
At 31 March 2021	**2,686**	**10,244**	**1,006**	**13,937**
Amortisation				
At 1 April 2020	1,597	4,710	0	6,307
Indexation	0	0	0	0
Transfers	0	0	0	0
Disposals	0	0	0	0
Provided during the year	347	488	0	835
At 31 March 2021	**1,944**	**5,198**	**0**	**7,142**
Carrying Amount				
At 31 March 2021	**742**	**5,046**	**1,006**	**6,794**
At 31 March 2020	**920**	**820**	**614**	**2,354**
Asset financing				
Owned	742	5,046	1,006	6,794
Carrying Amount				
At 31 March 2021	**742**	**5,046**	**1,006**	**6,794**

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

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

NOTE 6.2 - INTANGIBLE ASSETS (Year ended 31 March 2020)

	Software Licenses £000	Information Technology £000	Payments on Account & Assets under £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 1 April 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**
Asset financing				
Owned	966	1,145	49	2,160
Carrying Amount				
At 1 April 2019	**966**	**1,145**	**49**	**2,160**

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. Three loans were in place at the start of 2020/21 - one GP practice paid their loan back fully within the year, leaving two active loan agreements currently in place.

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

	2021 Assets £000	2020 Assets £000
Balance at 1 April	761	816
Additions	0	43
Settlement	(121)	(118)
Impairments	(62)	(128)
Reversal of impairments	128	148
Disposal	0	0
Balance at 31 March	**707**	**761**

Analysis of expected timing of discounted flows

	2021 Assets £000	2020 Assets £000
Not later than one year	494	117
Later than one year and not later than five years	135	335
Later than five years	78	309
	707	**761**

NOTE 8 - IMPAIRMENTS

	2021 Financial Assets £000	2020 Financial Assets £000
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	(67)	(19)
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0
Total value of impairments for the period	**(67)**	**(19)**

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 2020/21 or 2019/20.

NOTE 10 - INVENTORIES

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

NOTE 11 - CASH AND CASH EQUIVALENTS

	2021 £000	2020 £000
Balance at 1st April	1,243	749
Net change in cash and cash equivalents	(322)	494
Balance at 31st March	**921**	**1,243**

The following balances at 31 March were held at	2021 £000	2020 £000
Commercial banks and cash in hand	921	1,243
Balance at 31st March	**921**	**1,243**

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2021 £000	2020 £000
Amounts falling due within one year		
Trade receivables	11,618	2,965
VAT receivable	1,247	468
Other receivables - not relating to fixed assets	1,443	171
Other receivables - relating to property plant and equipment	0	603
Other receivables - relating to intangibles	0	0
Trade and other receivables	**14,308**	**4,207**
Prepayments and accrued income	49	19
Other current assets	**49**	**19**
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	**14,308**	**4,207**
TOTAL OTHER CURRENT ASSETS	**49**	**19**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**14,357**	**4,226**

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

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2021 £000	2020 £000
Amounts falling due within one year		
Other taxation and social security	640	852
Trade capital payables - property, plant and equipment	365	32
Trade capital payables - intangibles	2,590	562
Trade revenue payables	63,114	61,069
Payroll payables	3,681	2,215
Clinical negligence payables	15	463
VER payables	0	0
BSO payables	3,649	6,494
Other payables	6,274	2,656
Accruals	86,880	99,028
Deferred income	492	26
Trade and other payables	**167,701**	**173,397**
Total payables falling due within one year	**167,701**	**173,397**
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**167,701**	**173,397**

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2021

	Pensions relating to other staff £000	Clinical negligence £000	Other £000	2021 £000
Balance at 1 April 2020	0	21,711	12,003	33,714
Provided in year	956	2,768	2,345	6,069
(Provisions not required written back)	0	(65)	(150)	(215)
(Provisions utilised in the year)	(956)	(935)	(552)	(2,443)
Cost of borrowing (unwinding of discount)	0	(300)	57	(243)
At 31 March 2021	**0**	**23,179**	**13,703**	**36,882**

Comprehensive Net Expenditure Account charges	2021 £000	2020 £000
Arising during the year	6,069	4,307
Reversed unused	(215)	(466)
Cost of borrowing (unwinding of discount)	(243)	(242)
Total charge within Operating expenses	**5,611**	**3,599**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000	Clinical negligence £000	Other £000	2021 £000
Not later than one year	0	2,457	1,390	3,847
Later than one year and not later than five years	0	3,976	2,002	5,978
Later than five years	0	16,746	10,311	27,057
At 31 March 2021	**0**	**23,179**	**13,703**	**36,882**

Provisions have been made for the following 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. In 2020/21, historical dental pension provision information was provided by BSO which was discharged at year end.

NOTE 14 - PROVISIONS FOR LIABILITIES AND CHARGES 2020

	Clinical negligence £000s	Other £000s	2020 £000s
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**

Analysis of expected timing of discounted flows

	Clinical negligence £000s	Other £000s	2020 £000s
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**

NOTE 15 - CAPITAL AND OTHER COMMITMENTS

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

NOTE 16 - COMMITMENTS UNDER LEASES

16.1 Finance Leases

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

16.2 Operating Leases

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

Obligations under operating leases comprise	2021 £000	2020 £000
Buildings		
Not later than 1 year	101	51
Later than 1 year and not later than 5 years	152	0
Later than 5 years	0	0
	253	**51**

16.3 Commitments under Lessor Agreements

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

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

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

NOTE 18 - OTHER FINANCIAL COMMITMENTS

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

NOTE 19 - CONTINGENT LIABILITIES

Clinical negligence

The HSCB has contingent liabilities of £253k.

	2021 £000	2020 £000
Total estimate of contingent clinical negligence liabilities	242	222
Amount recoverable through non cash RRL	(242)	(222)
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:

	2021 £000	2020 £000
Employers' liability	11	24
Amount recoverable through non cash RRL	(11)	(24)
Total	**0**	**0**

A discount rate is applied by courts to a lump-sum award of damages for future financial loss in a personal injury case, to take account of the return that can be earned from investment. Currently the rate in Northern Ireland has to be set in accordance with principles set out by the House of Lords in Wells v Wells. The Department of Justice made a statutory rule on 29 April 2021 changing the rate, under the Wells v Wells framework, (from 2.5%) to -1.75%, with effect from 31 May 2021. The Department has also brought forward a Bill to change how the rate is set. The Damages (Return on Investment) Bill was introduced to the Assembly on 1 March 2021 and is currently at Committee Stage. Subject to the legislative process, it is anticipated that the Bill will be enacted early next year and the rate would then be reviewed under the new framework.

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

NOTE 20 - 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.

Dr Theresa Donaldson (Non-Executive Director) is a Board Member of the Centre for Effective Services; Dr Mark Timoney (Chair of South Eastern Local Commissioning Group) is a pharmacy supplies and pharmacy owner; and Dr Gerry Millar (Chair, Southern Local Commissioning Group) is a Trustee of the NI Hospice and Facilitator in Cancer and Palliative Care, NI Children's Hospice, and Southern HSC Trust.

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 21 - THIRD PARTY ASSETS

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

NOTE 22 - FINANCIAL PERFORMANCE TARGETS

22.1 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:

	2021 Total £000	2020 Total £000
DoH (excludes non cash)	6,393,376	5,541,776
Non cash RRL (from DoH)	9,087	6,611
Adjustment for CRL grants received	2,691	4,233
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**6,405,154**	**5,552,620**

22.2 Capital Resource Limit

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

	2021 Total £000	2020 Total £000
Gross capital expenditure by HSCB	7,701	3,620
FTC issued to third parties	0	43
(FTC received from third parties)	(121)	(118)
Net capital expenditure	7,580	3,545
Capital Resource Limit	10,497	8,148
Adjustment for CRL grants received	(2,691)	(4,233)
Net CRL	7,806	3,915
Overspend/(Underspend) against CRL	**(226)**	**(370)**

22.3 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.

	2020/21 £000	2019/20 £000
Net Expenditure	(6,392,500)	(5,530,335)
RRL	6,405,154	5,552,620
Surplus / (Deficit) against RRL	12,655	22,285
Break Even cumulative position(opening)	57,685	35,400
Break Even cumulative position (closing)	**70,340**	**57,685**

Materiality Test:	2020/21 %	2019/20 %
Break Even in year position as % of RRL	0.20%	0.40%
Break Even cumulative position as % of RRL	1.10%	1.04%

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.

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

NOTE 23 - EVENTS AFTER THE REPORTING PERIOD

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

DATE OF AUTHORISATION FOR ISSUE

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