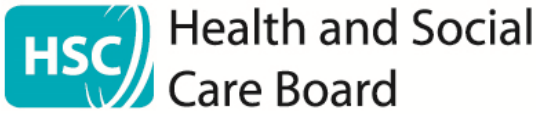

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2018

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2018

Laid before the Northern Ireland Assembly under Schedule 1, Para 17(5) of the Reform Act for the Regional Board, by the Department of Health.

On 22 June 2018

Any enquiries regarding this document should be sent to us at:

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This publication is also available for download from our website at:
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ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2018

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For an alternative format, please contact: Communications Department, Tel: 028 9536 3020

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

PERFORMANCE REPORT

Welcome to the Health and Social Care Board's Annual Report covering the financial year 2017/18.

About the Health and Social Care Board

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

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

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

3. To effectively deploy and manage its annual funding from the Northern Ireland Executive, which is currently around £4.5 billion, and to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

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

The work of the HSCB has the potential to reach everyone at some point in their lives. Its expenditure amounts to around £10 million on every single day of the year as it strives to ensure that services provided daily, to people in their homes, by their GP, in hospital or in the community, deliver what is expected of them.

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

The HSCB and PHA take forward the regional commissioning agenda through a series of integrated service teams. The HSCB's commissioning processes are currently underpinned by the five Local Commissioning Groups (LCGs) which are Committees of the HSCB Board, and are responsible for ensuring that the health and social care needs of local populations across Northern Ireland are addressed. The groups are geographically coterminous with each of the five Health and Social Care Trusts that directly provide services to the community.

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

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

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

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

Corporate Objectives for 2017/18

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

The five themes are:

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

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

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

Theme 4: Effectively engage with key stakeholders in an open and transparent manner, particularly service users and carers, benefiting from their personal experiences.

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.

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

Overview from Chief Executive and Chair of Board

The Health and Social Care Board (HSCB) continued to face changes and challenges in 2017/18.

The HSCB worked with the Department of Health (DoH) in relation to the pending closure of the organisation and welcomed the clarity that has been reached in relation to the direction of travel. This will see the majority of functions transferring to the DoH, effected through a host organisation arrangement with the Business Services Organisation (BSO), and the functions and staff of the Social Care and Children Directorate transferring to the Public Health Agency (PHA).

An Oversight Board, chaired by the Richard Pengelly, Permanent Secretary at the DoH, has been set up to provide direction and leadership on the closure of the HSCB and the successful transition to the new arrangements.

Work to identify relevant team structures, new ways of working, and to plan for the transfer of functions will continue in 2018/19. We are also working very closely with the DoH to review the risks associated with the closure, particularly in relation to business continuity, and will take all necessary steps to ensure that our key areas of responsibility are delivered.

On a wider note, the Health and Social Care (HSC) system continues to be under considerable strain, particularly in relation to pressures in primary care, the social care sector and on waiting times for both planned and unplanned care.

The constrained financial environment, which all Departments and public sector organisations are facing, combined with the current political uncertainty, is also impacting on these challenges.

A combination of factors, including a growing older population, an increased demand for services, and new specialist treatments means there simply isn't either the money, or required staffing levels, to sustain the current model of care.

While additional investment, if available, would allow us to tackle short term pressures, the only long term answer is to continue to transform services.

And, as highlighted in the performance analysis section of the report, the HSCB, DoH and wider HSC system, have continued to take forward innovative reforms at both a strategic and grass roots level. For example, these include the development of elective care centres which will see many procedures being delivered in a small number of regional centres located across Northern Ireland. It is hoped new centres will be up and running by December 2020. Also, Integrated Care Partnerships and GP Federations, in partnership with Elective Care Leads from both the HSCB and PHA, have been instrumental in designing primary care alternatives to hospital referrals. These new services will enable patients to receive high quality assessment and treatment more quickly, and will also help to free up appointments and treatment for urgent and complex cases in secondary care.

With widely reported pressures on adult social care services, including domiciliary, nursing and residential care, the HSCB continues to work with DoH in considering how best to take forward the recommendations of the final report of the Expert Advisory Panel, on Adult Care and Support – 'Power to People'. This will help ensure Northern Ireland's future care and support system is sustainable and focused on outcomes.

The HSCB welcomed publication of the Report of the Inquiry into Hyponatraemia-related deaths in January 2018, and will work with the DoH and rest of the HSC to ensure the effective implementation of its recommendations. Since the incidents leading to the deaths from hyponatraemia, a number of significant changes have taken place within the wider health and social care system. Considerable work has gone into ensuring that when things do go wrong, incidents are reported, robust action is taken, families are engaged, and relevant learning is shared and disseminated across the wider HSC. The HSCB is firmly committed to continuing this work, alongside the wider HSC, to minimise the risk of such tragic events occurring again. We are confident that the recommendations in the report will play a key role in further embedding and enhancing learning across the whole system.

In response to the challenges facing GP recruitment and retention, due to an ageing workforce and increasing pressures, additional investment in GP training, secured by the HSCB, facilitated the increase in GP training numbers. We also worked this year in supporting GP practices with recruitment challenges, encouraging more partnership working with other neighbouring practices, to ensure everyone in Northern Ireland had access to a GP.

No doubt the new financial year will bring many more challenges, however, with challenge comes opportunity, and we have a real opportunity to reshape and sustain health and social care services now and into the future.

This will require funding support and we welcome the confirmation from the DoH that around £70m will be put towards a wide range of transformational projects in 2018/19.

It is vitally important we build on all of this innovative work with our partners at a local level in primary care, in the community and voluntary sector and right across secondary care and social care.

The following report aims to highlight the breadth of some of this work and also acknowledges the challenges and opportunities that lie ahead.

Overview of Organisational Performance

Corporate Objectives

Our Corporate Objectives are grouped under five key themes set out within the overview. The HSCB Corporate Plan for 2017/18 was approved by the Board of the HSCB at its meeting on 9 February 2017 and subsequently approved by the DoH.

Financial Management

The HSCB received an opening allocation for 2017/18 of £4.6bn from the DoH to commission health and social care services for the population of Northern Ireland. During the year this funding was supplemented by £183m of non-recurrent allocations, comprising funding for general HSC pressures (£76m), Education & Training (£40m), Pay Review (£26m), Winter Pressures (£9m), Elective Care (£7m), and various other allocations.

In addition to this, the HSCB received £55m of income from other sources, which primarily consisted of £25m from the Department for Education for the delivery of Early Years Children's Services (SureStart) and £27m of Family Health Service receipts, mainly relating to dental and medical services.

At the end of 2017/18 the HSCB achieved a financial position of £0.3m surplus against its Revenue Resource Limit (RRL) of £4.8bn. This was comfortably within the HSCB's statutory breakeven threshold of 0.25% of Revenue Resource Limit.

Developing Services

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

Key Issues and Risks

During 2017/18, we have continued to drive forward improved outcomes for patients and service users in line with Departmental direction. We remain committed to creating a modern 'patient centred' system that is able to respond to increasing demand, whilst ensuring the best and most effective use of resources for the population. A number of risks have been highlighted below. See Section 10b of the Governance Statement for full details of issues and risks.

Financial Position

The current financial climate significantly limits additional resources for health and social care developments and requires Trusts and the wider system to deliver very challenging financial savings targets. In addition, political uncertainties and the resulting impact on budgetary certainty are adding further pressure to the pace of reform within the sector. We remain concerned that this will impact on the quality and safety of health and social care services. Along with our HSC partners, we continue to try to mitigate the impact of this as set out in Section 3 of the Performance Analysis and within Section 10B of the Governance Statement.

Waiting Times

Waiting times across Northern Ireland for outpatient, diagnostic, inpatient and day cases remain challenging without the certainty of a budget available for planned recurrent and non-recurrent funding. Continued pressures in unscheduled care (unplanned hospital admissions) also impact on waiting times and the Trusts' ability to deliver the volumes required to reduce these. Subject to the availability of funding, we plan to further invest in core service and initiatives to manage demand consistent with the Minister's Elective Care Reform Plan published in February 2017. The Plan sets out the long term service redesign and modernisation required to deliver substantial improvement. See Section 1.2 of Performance Analysis for further details.

General Practice (GP)

A shortage of GPs as well as an ageing GP workforce, with a number of imminent retirements in the coming years, has had considerable impact on service delivery including difficulty in recruiting GPs and getting adequate locum cover, particularly in rural areas.

Northern Ireland has the lowest number of GPs per population in the UK. Data indicates that this situation is compounded by the fact that the GP workforce in NI is older in profile than elsewhere in the UK. Although an investment plan is in place for additional GP training places and a GP retainer scheme, in the short term there remains a considerable risk to the ongoing continuity of general medical services provision to patients, particularly in smaller practices in isolated locations and out of hours services.

Some GP Out of Hours (OOH) providers have not been able to meet their target triage times. This is exacerbated by insufficient numbers of GPs who are not contractually required to work for OOH providers and has resulted in occasional base closures when staff have not been available.

The HSCB provides additional funding to support some GP practices which have experienced staffing issues and introduced the GP Induction and Refresher Scheme to support those intending to return to a GP career. We also supported remote practices by encouraging them to form mergers or partnerships to increase their capacity and ability to provide a broader range of services and cover. Further detail of this risk is provided in section 1.4 of the performance analysis and within section 10B the Governance Statement.

Business Continuity

The proposed closure of the HSCB and the uncertainty over the timing of the closure of the HSCB means that the transition of its functions to other organisations is, and will continue to have, a significant impact on business continuity, and the ongoing movement and changes in workforce. This has an impact on business delivery and the ability to design and implement longer term plans, including recruitment to LCGs. We will continue to prioritise our resources accordingly to ensure the core work and statutory functions are delivered. Further detail of this risk is provided within section 10B of the Governance Statement.

Social Care

- **Children's Services (Unallocated Cases)**

  The issue of unallocated cases has been a consistent challenge. Unallocated cases are defined as child protection, family support and disability services cases that are not allocated to a social worker within the regionally agreed time frames. In 2016/17 a project approach was developed to understand the relationship between demand, complexity and funding, and, to test the robustness of the threshold criteria for unallocated cases.

  This work has since been completed and an action plan devised to address the findings. Whilst implementation of this action plan has started, there continues to be an issue in relation to creating sufficient capacity within the system to resolve the pressures resulting in unallocated cases.

- **Review of Regional Facilities (Looked After Children)**

  As part of the reform and modernisation of Looked After Children's Services, an independent Review of Regional Facilities has been conducted to help inform the development of future services. A series of regional events are progressing to review and address service priority areas and pressures in fostering, edge of care, children with disabilities and residential childcare. It is anticipated that the outcome of these workshops will shape the development of agreed, time bound service improvement plans.

- **Domiciliary Care/Independent Home Care**

  Achieving sufficient capacity in workforce levels and volumes of domiciliary care service delivery remains extremely challenging. This is most evident at times of seasonal pressures on the HSC system and in localised service delivery problems of a more episodic nature. The potential impact of Trust procurement processes on the

future redesign and delivery of the service will require monitoring in 2018/19. The HSCB is in the process of developing a domiciliary care model that will meet broader strategic objectives and ensure sustainability into the future.

The Review of Adult Social Care and Support has been completed and the final report of the Expert Advisory Panel, 'Power to People: proposals to reboot adult care and support in NI' (December 2017), has been submitted to DoH. The HSCB is participating in a project to assess the viability and achievability of the report's recommendations.

Further detail of this risk is provided within section 10B of the Governance Statement.

Performance Analysis

The performance analysis has been carried out under the five corporate objectives which are in line with the 2017/18 Corporate Plan and the 2017/18 Commissioning Plan.

Theme 1 – Providing high quality, safe and accessible care

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

1.1 Enhancing Unscheduled Care

Pressures on our emergency services continue across Northern Ireland, which is a similar picture to other regions of the UK and Ireland. Rising demand from an ageing population and pressure on general practice all contribute to increasing attendances at Emergency Departments and ambulance service call outs. Just over 794,000 patients attended Emergency Departments (ED) in 2017/18, an increase of 3.1% on the level of attendances in the previous year.

During 2017/18, there was a significant rise in the number of 12 hour breaches and performance against the 4-hour target remained below the level required (the standard being that 95% of patients attending an ED are either treated and discharged home, or admitted, within four hours of their arrival; and no patient should wait longer than 12 hours).

In the last five years, the overall number of ED attendances in Northern Ireland has increased by 24%. Significantly, in this same period, there has also been an increase in the most seriously ill patients attending EDs.

These are often frail and elderly patients, who can require longer in-patient stays and then more complex social care packages when they are ready to leave hospital. These increases are on top of an already very busy system, and responding to spikes in pressures is increasingly more difficult.

Improving unscheduled care performance remains a priority for the HSC. The whole system is working very closely together and we are investing in a range of innovative services which will help prevent some people from attending EDs in the first place, improve the patient journey, and provide better support for patients when they leave hospital.

During 2017/18 the HSCB and PHA, through the regional unscheduled care structures, continued to work with Trusts to support the more effective delivery of unscheduled care services across Northern Ireland.

Considerable efforts continued to be made across the HSC to plan for the winter period with preparatory work commencing much earlier than in previous years. This was

supported again this year by the 'Stay Well This Winter' public information campaign, which encouraged people to take positive steps to prevent illness, to seek advice from pharmacists when appropriate and to use services responsibly.

Despite significant efforts across the region to ensure effective arrangements were in place to manage winter pressures demand, all Trusts experienced increased pressures over the Christmas and New Year period with an average increase of 4% compared to the same period last year and a 14% increase from 2015/16 in attendances across the nine larger EDs.

In the autumn of 2017, a workshop was held to bring key stakeholders together to consider potential ambulatory developments across medicine, surgery, paediatrics and frail elderly care. A number of work streams have been established to develop plans under the direction of the Local Network Groups for Unscheduled Care, a joint forum bringing together service users, primary care, secondary care, community care and commissioners.

The HSCB Senior Nurse Review Team continued with their rolling programme of delayed discharge audits to identify the main reasons for delays in patient pathways, and to support Trusts with service improvements. The Team also undertook bespoke audits of Acute/Enhanced Care at Home Services, which informed a regional learning event to share best practice in summer 2017.

In 2017 the region was supported in participating in a National Audit of Intermediate Care, consistent with the National Institute for Health and Care Excellence (NICE) guideline definition, across all Trusts. This provided a comprehensive overview of Intermediate Care Services in Northern Ireland. The regional overview has been shared with all participants, and a schedule of meetings to discuss local results with Unscheduled Care Locality Network Groups and Local Commissioning Groups arranged. Audit findings will inform service developments for Intermediate Care in 2018/19.

We have also secured external support to introduce predictive analysis in all Trusts. This analysis provides a robust indicator of future demand and identifies peaks in activity to enable Trusts to put appropriate operational plans in place to address pressures. Trusts receive data on a daily basis, based on historical urgent and emergency care data, combined with known pressure points to support a proactive system of year round operational resilience, using the principles of intelligent data use.

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

The increase in elective waiting times over the last year is not unexpected and is primarily as a result of the scale of the gap between funded health service capacity and patient demand and the impact of the wider financial position.

In order to minimise the increase in waiting times during 2017/18, the HSCB allocated the limited amount of non-recurrent funding that was available for elective care to Trusts to undertake additional outpatient and inpatient/day case activity, primarily in-house. The funding was targeted at those patients with the highest clinical need as well as those who had been waiting the longest.

In order to maximise the delivery of funded core elective capacity and, consistent with the approach set out in the DoH's draft Performance Management Framework, Trusts submitted performance improvement trajectories for a range of elective specialties, detailing the expected delivery of commissioned volumes of core capacity for 2017/18. In the majority of cases, Trusts' plans forecasted a deterioration on 2016/17 primarily as a result of financial and workforce pressures. The HSCB monitored Trusts' performance against these plans on a regular basis. Where the plans did not deliver the planned outcomes, Trusts have reported that this was largely as a result of unplanned staff absences (e.g. sickness absence), recruitment difficulties and elective cancellations as a result of unscheduled care pressures. The HSCB is continuing to work with Trusts to ensure that the delivery of funded core elective capacity is maximised particularly in the context of ongoing challenges.

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, recurrent funding was allocated to Trusts in 2017/18 to expand health service capacity. Recognising the timescales associated with recruiting new staff to deliver the increased activity associated with the investment, Trusts have been utilising the funding during 2017/18 to undertake additional activity.

The increasing waiting times trend over recent years demonstrates that the current model of delivering elective care services is not sustainable given the continued increased demand. While non-recurrent funding to enable Trusts to undertake additional activity benefits large numbers of patients and reduces waiting lists in the short term, this approach does not provide a sustainable, long-term solution.

The long term solution is to reform elective care services to meet current and future demand through the transformation of secondary, primary and community care services as set out in the DoH's Elective Care Plan published in February 2017. Since its publication, despite the challenging financial environment, a number of initiatives have been taken forward consistent with the direction of travel set out in the Plan as outlined in DoH's one-year Elective Care Progress Report published on 22 February 2018.

This provides a strong foundation for further reform and transformation including, for example, the planned development of new Elective Care Centres. It is anticipated that these stand-alone units will deliver large volumes of assessments and non-complex routine surgery in a small number of regional centres located across Northern Ireland. While some patients will be asked to travel further for treatment, the patient population overall should benefit by receiving more rapid assessment, more timely care and enhanced outcomes. It is intended to have new centres up and running by December 2020.

It is recognised that long term sustainability will be achieved only through change, supported by investment. In this context, the HSCB/PHA will continue to work with Trusts, Integrated Care Partnerships (ICPs) and GP Federations to further develop plans to reform and modernise elective care services consistent with the commitments set out in the Elective Care Plan.

Such initiatives can enable patients to receive high quality assessment and treatment more quickly in their local GP surgery. This will also help to free up appointments and treatment for urgent and complex cases in secondary care.

By the end of March 2018, for example, a GP-led vasectomy service will be in place in at least one Trust area for roll out to other areas during 2018/19. Another developing initiative involves Dermatology Photo-Triage where, when a patient sees the GP about a suspicious lesion, a photograph can be reviewed by a consultant to determine the best course of treatment.

1.3 Local Commissioning Groups (LCGs)

The HSCB's commissioning processes are underpinned by the five Local Commissioning Groups (LCGs). LCGs are responsible for ensuring that the health and social care needs of local populations across Northern Ireland are addressed. A number of examples of their work during 2017/18 are detailed below:

Belfast LCG

In 2017/18 the Belfast LCG, PHA and Integrated Care Partnerships (ICPs) launched a comprehensive pathway for people at risk of or who have Type 2 Diabetes. This included prevention and early identification of the disease; supported self-management and structured patient education to assist patients in preventing their symptoms from becoming worse; enhanced primary care management with a specialist team providing support to GPs; and a foot protection scheme which reduces the risk of loss of limbs. The pathway requires integrated working of all professions facilitated by telemedical links through which GPs can seek advice in dealing with complex cases. There is a key role for local communities in supporting healthy lifestyles and self-management, including tailored physical activity linked to the Walking Away from Diabetes programme.

The LCG, PHA and ICPs also launched a Falls service for frail older people who fall at home but have not had a fracture and do not need to attend an Emergency Department. Paramedics from the NI Ambulance Service carry out an initial assessment and contact the Falls team to ensure the older person can safely remain at home and receive follow up care. The older person is also offered strength and balance training within their local community to help prevent them from falling again.

Northern LCG

Similar to all Local Commissioning Groups, the Northern LCG has been working with local Councils (Mid and East Antrim, Causeway Coast and Glens, Mid Ulster, and Antrim and Newtownabbey Councils) to develop Community Plans. The Community Plans, published in 2017, were developed in partnership with other statutory agencies and the wider public and aim to change the way in which elements of public services are planned and delivered by focusing on what can be achieved by adopting a collaborative approach. The Northern LCG represents the HSCB across the four Council areas both at Strategic Partnership Board level and in the various health and wellbeing working groups. Key projects which are being developed include ageing well initiatives, a focus on health literacy, giving children the best start in life, development of volunteering, community responder schemes and community pharmacy initiatives. The Community Plans span the

period from 2017 to 2032 and include a series of short term, medium term and longer term measures. The HSCB is keen to ensure that the Community Plans align with wider HSC strategies including Making Life Better and Delivering Together.

South Eastern LCG (SE LCG)

During 2017/18 the SE LCG worked with the South Eastern Trust to support the commissioning of the new inpatient ward block at the Ulster Hospital (Phase A). The unit provides 288 single rooms all with en-suite facilities. Work continues with the Trust to complete the full Phase B of the project, which will include the completion of a second block providing a further 170 en-suite rooms and a new Emergency Department.

Following a trial in the Trust, the Virtual Fracture Clinic at the Ulster Hospital, it is now funded recurrently. The Virtual Fracture Clinic represents a new approach to outpatient care whereby skilled professionals carry out telephone reviews of patients and either discharge the patient or ask them to attend for a face-to face outpatient appointment. This has minimised the number of patient journeys to hospital, improved access for patients, reduced the demand at fracture clinics and shortened waiting times. Also in orthopaedics, there has been a significant new investment in orthopaedic Integrated Clinical Assessment and Treatment Services (ICATS) to treat patients with upper limb and lower back pain.

In community services, the LCG has been working with other HSCB colleagues as well as those in the PHA, ICP and SE Trust to improve access to Mental Health Services. One such investment has been in family support. For many individuals, their mental illness will have adverse impact on other family members. In recognition of this, the LCG has invested in community services to provide a Think Family support worker and additional pharmacy resources that will help with medication management for inpatients.

For patients with psychological trauma, specialist teams have been established across Northern Ireland and the LCG has funded additional trauma therapists for the South Eastern area as part of this network.

Prescribing savings during 2017/18 enabled pain management courses for patients to be delivered across the locality as well as additional staffing and equipment for GP practices.

Southern LCG

<u>Daisy Hill Pathfinder Project</u>

The Daisy Hill Hospital (DHH) Pathfinder Project was set up in response to ongoing difficulties with the recruitment of senior medical staff to work in the Emergency Department (ED). Following a regional summit in May 2017 involving the DoH Permanent Secretary and senior officers from Trusts, the HSCB and PHA, a short-term regional arrangement was made to ensure adequate locum consultant cover. However it was recognised that a sustainable long term solution was required and a Pathfinder project group was established to assess the unscheduled care needs of the Newry and Mourne population and to bring forward recommendations on the best way to meet those needs in the future.

A comprehensive needs assessment process, which included clinically-led audits of patient care, concluded that the continued presence of a 24/7 Level 1 ED on-site was justified and in keeping with the Southern Trust's position. However, it also demonstrated that the models of care provided both in and out of hospital have to adapt and change if they are to deliver a long term sustainable service to the local population.

The report of the Pathfinder Project Group was completed in December 2017, brought to the Transformation Improvement Group (TIG) in January 2018 and endorsed by the HSCB at its Board meeting in March 2018. The report recommends the establishment of a direct assessment unit, staffed jointly by medical, Care of the Elderly and ED staff, in close proximity to the ED, which will provide telephone advice to GPs, ambulatory assessment and diagnostics. This will link closely with the new Acute Care at Home service for elderly patients which has proven to be a success in another part of the Trust area.

Western LCG

Western ICP-led outpatient reform in the West has been progressing at a pace in the past year. With support from Western Trust and the Board's Commissioning Directorate, new pathways and services have been agreed, such as dietetics-led coeliac service, 'see and treat' in outpatients for gynaecology, urology and colorectal services and an enhanced sleep apnoea service.

The North West Cancer Centre has completed a roll out of cancer pathways for patients in Northern Ireland and Republic of Ireland. The new centre is now treating patients with a range of cancers including provision of oncology, chemotherapy and radiotherapy.

1.4 Primary Care

Whilst challenges in GP recruitment and retention continued in 2017/18, work is ongoing to address future GP workforce demands. See Section 10B of the Governance Statement for further information.

The primary care infrastructure programme continues, supporting service integration and bringing care closer to home, through the co-location of GP services with Trust, community and outpatient services, via a hub and spoke model. Two Health and Care Hub Projects in Newry and Lisburn have reached preferred bidder stage, and Omagh's Health and Care Hub is complete and operational. Investment from the programme, through the GP Loan Scheme and Improvement Grants Scheme, has delivered improvements in smaller (spoke) GP facilities.

1.5 Advances in Ehealth

In 2017/18 the scope of the award winning NI Electronic Care Record was extended with the introduction of a 'Key Information Summary'. Completed by GPs with patients who have significant care needs, this important development ensures better care decisions for the most vulnerable in hospitals and other settings. Support for improved medicines management practice, aimed at reducing medication errors in hospital settings, was also introduced over the past year. An electronic discharge summary to further improve the quality of information exchanged between primary and secondary care was introduced. In addition, the Regional Information System for Oncology and Haematology (RISOH) is

currently being rolled out across NI. This includes the introduction of electronic prescribing, supporting further improvement in the quality of care, and creating a mainly digital service. Subsequently enhancements to the quality of information exchange and analysis will enable improvements in the delivery of care into the future.

Looking to 2022 and beyond, the HSC is taking forward plans for further investment in technology to develop an integrated digital platform to support transformation in care delivery and optimum population planning and research. A program of work named 'Encompass' was established to plan this critical investment in the future of the HSC. A business case has been developed and is currently under review. Preparation for procurement is underway and, subject to the completion of the business case review, is expected to proceed in the year ahead.

Theme 2 – Improving Health and Reducing Inequalities

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

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

Major health challenges are consistent across our five localities. They include:

- A growing, ageing, population with escalating health needs. Between 2016 and 2024, the number of people aged 65+ is estimated to increase by 62,500 to 362,000 – a rise of 21%. The number of older people will represent 19% of the total population compared with 15.5% currently;

- Poor health compared to the rest of the UK. A major risk to health and wellbeing in Northern Ireland comes from lifestyle factors such as obesity, smoking and alcohol abuse;

- Excess deaths, particularly from heart disease, cancer and respiratory problems. We have increasing numbers of people living with long term conditions or multiple conditions such as COPD, diabetes, stroke, asthma and hypertension;

- An over-reliance on hospital care; and

- Health inequalities across the province.

Despite these challenges, in 2017/18 the HSCB worked with other agencies across Health and Social Care to deliver some innovative and life changing work to improve the health and wellbeing of the population, which is highlighted within the section below.

2.1 Community Planning

The HSCB continues to engage with its Community Planning partners, in fulfilment of its obligations under relevant legislation, working in partnership with the wider health and social care family, local Councils and other statutory partners to help design Community Plans. These Community Plans will provide a shared, long term vision to improving social, health, education, economic and environmental wellbeing and will help to reduce duplication of services and create new and innovative ways of working. See Section 1.3 for the Northern LCG example of partnership working.

2.2 Integrated Care Partnerships (ICPs)

In 2017/18 the collaborative work of the ICPs remained a key priority for the HSCB. These networks of care providers, bring together healthcare professionals (including

doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and community sectors; local council representatives; and service users and carers; to design and coordinate local health and social care services.

ICPs implement the service changes commissioned and funded by LCGs, with a focus on diabetes, respiratory and stroke services for frail older people. Over the past three years, nearly £13 million has been invested in services designed and implemented by ICPs, focusing on preventing illness where possible, delivering more care in the community, reducing demand on hospital services and improving patient and carer experience.

The roll out of the Nursing Home InReach service, facilitated through the ICPs in the Northern area continued this year. The initiative focuses on very frail older people living in nursing homes, who commonly experience a high level of attendance at hospital Emergency Departments. The service delivers a specialist education, training and development programme for staff working in nursing homes to enable them to provide more care for their residents in the home, rather than in hospital. A Practice Development Facilitator provides a 'case finder' function to track patients who do attend an ED to determine the appropriateness of that attendance, and then to provide follow up support to the home, such as additional staff training, to avoid a reoccurrence. The service is demonstrating a 33% reduction in ED attendances as well as:

- Improved Patient Experience
- Enhanced Knowledge & Clinical Skills of Nurses
- Fostering a Person Centred Care Culture
- Supporting more effective use of other services
- Reducing unnecessary ED Attendance and expediting patient discharge

2.3 Social Care

Dementia Services

During 2017/18, the HSCB, in collaboration with the PHA, continued to implement the Dementia Together NI initiative. Funded through The Executive Office's Delivering Social Change Programme, this 3-year project ended in March 2018. It focused on three broad themes from the regional dementia strategy, (i) awareness raising, (ii) training and (iii) support to carers. The project was awarded runner up in the prestigious NI Civil Service Excellence Awards for Customer Service. The 'Still Me' public awareness campaign and public information web resources were developed. Providing useful information about all aspects of dementia and where to seek help, this information is available at www.NIDirect.gov.uk/dementia, with a range of information guides covering the life journey of dementia, also available at www.pha.site/dementiadocs.

Building on the regional Dementia Learning and Development Framework, launched in 2016, the team designed and procured a unique training programme with 260 staff from all HSC sectors graduating as Dementia Champions. Furthermore, bespoke training packages were funded for staff from outside the HSC including the Police Service of Northern Ireland (PSNI), prison service and some university undergraduates.

A delirium assessment tool and training on delirium awareness was delivered to almost 3,000 staff. The further roll out of the delirium training programme to hospital and

community staff, is to be facilitated by the 43 staff trained as 'delirium trainers'. Apps and on-line training materials for residential, domiciliary and day care staff have been developed through collaboration with Northern Ireland Social Care Council (NISCC).

Ten Dementia Navigators (two per Trust), qualified nurses or social workers, who provide support to people with dementia and their carers were recruited. In addition Dementia Companions were recruited in hospital settings. Working closely with the person with dementia and their carers, these support staff offer reassurance and diversion ultimately enhancing the hospital experience for the patient.

The completion of the work of the Dementia Together project does not signal an end to the implementation of the "Improving Dementia Services in Northern Ireland" regional strategy published in 2011. The achievements of this phase provide the basis for a strong legacy on which to build longer term support services to people with a dementia and their carers.

Carer Support/Short Breaks

The HSCB continues to work with the DoH, Trusts, and carers in partnership with the primary care, community and voluntary sectors to improve the identification of carers with a view to offering advice and support. The development of a range of support options for carers (including short breaks) continues to be a key priority, enabling carers to continue in their caring role in a safe and supported manner.

Support to carers was a key element of the Dementia Together NI initiative and, in addition to a series of innovative non-residential short-break schemes (accessed by approximately 250 carers), a comprehensive training package covering dementia awareness, communication, finance and legal issues, managing care and palliative supports was designed and delivered to almost 2,500 informal carers.

Supporting Young Carers

In September 2017 the HSCB and Education Authority jointly launched the 'Supporting Young Carers in Schools' booklet, an important resource for primary and secondary schools. The Children and Young People's Strategic Partnership (CYPSP) Young Carers Group, comprising of the HSCB, in partnership with the Education Authority, Action for Children NI, Barnardo's NI, Gingerbread NI and Carers Trust NI, produced a resource pack for primary and secondary school staff. This aimed to better support young carers in school and to raise awareness of their needs especially among educators and teachers.

The HSCB is also engaged in a three-year Early Intervention Transformation Programme with Trusts, the Department of Education and Education Authority to improve educational outcomes for Looked After Children in primary school years.

'Signs of Safety' Framework

The adoption of the 'Signs of Safety' model, to assist social work practitioners with risk assessment and safety planning in child protection cases, continued in 2017/18. This consistent approach to practice provides the core methodology for how social workers work with families. The benefits of this preventative and person-centred framework include: improving the safety of children and families; enhancing life chances; and

building resilience through better engagement with families. Child intervention provides the catalyst for change and empowerment for families.

Self Directed Support

The Self Directed Support (SDS) initiative presents a key change in how social care is delivered reflecting the shifting expectations of people today. Service users and carers are given greater control, choice and flexibility.

The process of bedding in SDS, and establishing operational focus across the Trusts is well underway, with many key tasks identified, scheduled and accomplished. Strong linkages have been established to user outcomes using the Adult Social Care Outcomes Framework (ASCOF) and the associated Adult Social Care Outcomes Tool (ASCOT). A final regional data-set has now been agreed and collection of outcomes-based data commenced on 1 April 2018.

2.4 Primary Care

High Street Oral Surgery Pilot

A new Dental Pilot Personal Dental Service (PDS) scheme, to increase the provision of high street oral surgery was established in October 2017. The interim evaluation report indicates that the pilot is on track to meet its activity by end of the 2017/18 financial year and that Trust referrals have been reduced by 6%.

Pharmacy and Medicines Management

Work continues with primary care providers and the public to reduce medicine waste; substantial efficiencies have been achieved through optimising prescribing choice, increasing generic prescribing and the review of unnecessary medicines. In 2017/18 the prescribing efficiency programme in primary care has resulted in the reinvestment of over £18m into enhancing patient care in other health and social care services.

Although we did not meet the 2017/18 efficiency target, this is in part due to the success of the programme over the past five years and the efficiencies generated to date. Further detail is provided within section 10B of the Governance Statement.

A range of service development pilots in prescribing have contributed to more positive patient outcomes. Practice Based Pharmacists have led on enhancing prescribing quality, for example, through risk reduction in the misuse and inappropriate use of prescribed medicines. Work on improved management and use of medicines has been recognised through the following awards:

- The Controlled Drug Reconciliation Project was awarded runner-up in the NI Civil Service Awards.
- The medicines waste media campaign was a Gold Winner in the Best Low Budget Campaign in the NI Chartered Institute for Public Relations 2017 Excellence Awards.
- The involvement of patients and service users in the development of the Pain Toolkit, for the management of pain, achieved a silver award in the 2017 PrescQIPP UK Innovation Awards.

Effective stakeholder engagement, focusing on quality and service improvement in prescribing and medicines management, was central to the development of these initiatives.

The Community Pharmacy Assurance Framework, well established in 2017/18, led to improved quality of community pharmacy service provision. Variability in pharmacy services has been highlighted through the Community Pharmacy Assurance Framework. Greater collaboration with pharmacy service providers has resulted in service developments achieved through better information provision, training and revised processes.

A new Community Pharmacy Contract Framework was agreed, in preparation for negotiation of a NI Pharmacy Contract. Strategically, the role of community pharmacy has been recognised in supporting health improvement and chronic disease management. A number of community pharmacy service developments were piloted in 2017/18. These include the Alcohol MOT, emergency supply out of hours, hidden carers and pharmacy support for Belfast Acute Care at Home.

Learning from this year's pharmacy and medicines management service development pilots will continue to inform commissioning in prescribing and medicines management into 2018/19.

Building Capacity in Ophthalmology Services

The development of integrated planning and delivery of eye-care services remained a focus this year. Key to capacity building in Ophthalmology Services has been the implementation of electronic referral, via the Clinical Communications Gateway (CCG), from General Ophthalmic Services (GOS) directly to secondary care Ophthalmology Services. During 2017/18, 80% of GOS contractors have been enabled to access CCG with 81% of enabled practices actively using CCG by January 2018. Benefits realised from electronic referral include improved direct access between primary and secondary care and more rapid access for patients to secondary care Ophthalmology Services.

A pilot of GOS access to the NI Electronic Care Record, supporting effective and safe care provision, was established in 2017/18. NI Electronic Care Record access enables primary care optometrists to view important and essential information about their patients which assists in their decision making about the management of their patients. Optometrists, in collaboration with their patients, can make better informed and considered decisions about their care.

2.5 Reshaping Stroke Services

Between June and September 2017, a pre-consultation public engagement exercise was delivered in line with the 2016 Ministerial commitment outlined in "Health and Wellbeing 2026: Delivering Together". This process engaged with a broad range of stakeholders and the general public on development of proposals to modernise regional Stroke Services. The feedback from this engagement exercise has informed the establishment of a working group, committed to addressing co-production and co-design principles. Work continues to finalise options for the delivery of modernised Stroke Services.

2.6 Review of Breast Assessment Services

The HSCB and PHA are committed to ensuring that people referred to hospital with suspected cancer are seen and assessed as quickly as possible. Women with breast symptoms, are normally seen within two weeks at dedicated assessment clinics in all Trusts across Northern Ireland. Women referred from Breast Screening are seen in separate screening assessment clinics in four locations across Northern Ireland. Difficulties in recruiting and retaining specialist staff in a number of Trusts have resulted in challenges in ensuring everyone is seen and assessed within the target timescales with some people waiting longer than is acceptable.

A number of measures have helped to improve waiting times for women referred for breast assessment. However the need for a more sustainable model of care, which can provide an assessment within target timescales for all people with a suspicion of breast cancer, is widely recognised. A Project Board was established to consider options for the future configuration of the service, including the potential to consolidate services on fewer sites. The Project Board, which included service user representation, established a rigorous process for assessment of these options, including receiving feedback from a broad range of stakeholders. A public consultation is expected during 2018.

2.7 Palliative Care

Revised palliative care management arrangements are now in place with an agreed work plan focusing on identification, promotion of the key worker, improving the specialist palliative care work-force and ensuring appropriate training for all staff including those in primary care and the independent sector. The HSCB/PHA have completed a needs assessment having considered all the significant data available on end of life. This assessment has been shared with all the main stakeholders to improve patient care.

2.8 Planning for Trauma, Air Ambulance and Northern Ireland Ambulance Service (NIAS)

Working closely with NIAS, the HSCB has agreed a new Clinical Response Model (CRM) for emergency ambulance services which would place a greater emphasis on reaching life-threatened patients sooner. Following completion of a major capacity-demand review of emergency ambulance responses, it is clear that considerable additional capacity is required to deliver on response times in line with the CRM. The HSCB is working closely the DoH and NIAS to put this in place in the next five years.

The Helicopter Emergency Medical Service (HEMS) commenced operations in July 2017. In collaboration with the charity, Air Ambulance NI, NIAS has been commissioned to provide a doctor-paramedic response in daylight hours in cases where pre-hospital care would benefit patients who have experienced major trauma.

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

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

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

See section 10B of the Governance Statement for further details.

3.1 Financial Planning

The HSCB worked closely with DoH and Trusts to prepare a Financial Plan for 2017/18, taking into account the significant budgetary constraints and varied and mounting pressures across the HSC sector. This plan was supported by the development of Trust Delivery Plans (TDPs) which were scrutinised by the HSCB and DoH. All but one was supported by HSCB and subsequently approved by the Minister (see Section 10B of the Governance Statement).

Looking forward into 2018/19, the current financial context significantly limits the additional resources available for health and social care developments and requires the HSC system to deliver very challenging financial savings targets. There continues to be a risk that this will impact on the quality and safety of health and social care services which HSCB along with the sector continue to try to mitigate. In addition, the political uncertainties and the resultant impact on budgetary uncertainty add more pressure to the HSC sector.

3.2 HSC Financial Stability

The HSCB works with the DoH to ensure the overall financial stability of the Health and Social Care system within Northern Ireland including the Trusts, HSCB and the PHA. The significant and ongoing financial constraints required rigorous planning, monitoring, management and decision making with respect to the budget by the HSCB and DoH during 2017/18.

Throughout the year, the HSCB worked closely and proactively with all Trusts and the DoH in order to address the ongoing severe financial challenges faced by the HSC system. The financial position was formally monitored on a monthly basis and appropriate actions taken.

The receipt of significant in-year non recurrent funding resulted in the major and controversial savings plans proposed by Trusts not being required. By this careful management at the end of 2017/18 the wider HSC shows a breakeven position.

3.3 HSCB Breakeven Duty

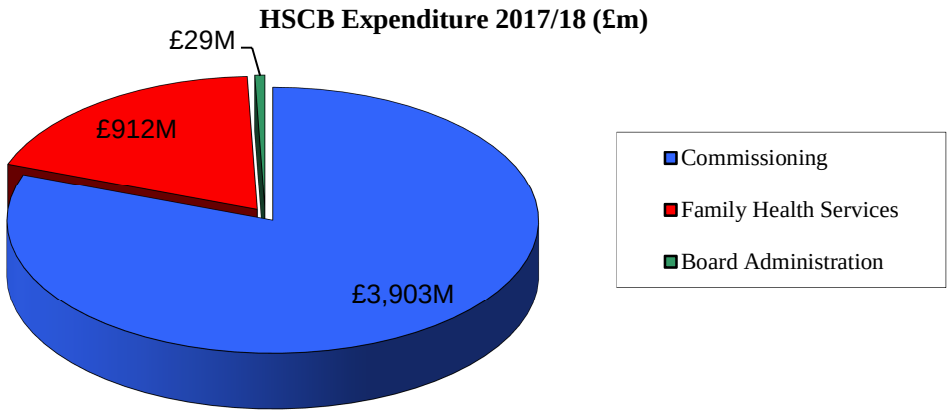
During 2017/18, the HSCB received a budget of £3m capital resource and £4,800m revenue resource from the DoH, along with income from other sources of £55m, of which the HSCB has a statutory duty to breakeven within +/-0.25% of these resources. The

financial statements presented in this Annual Report and Accounts highlight a small surplus of £0.3m.

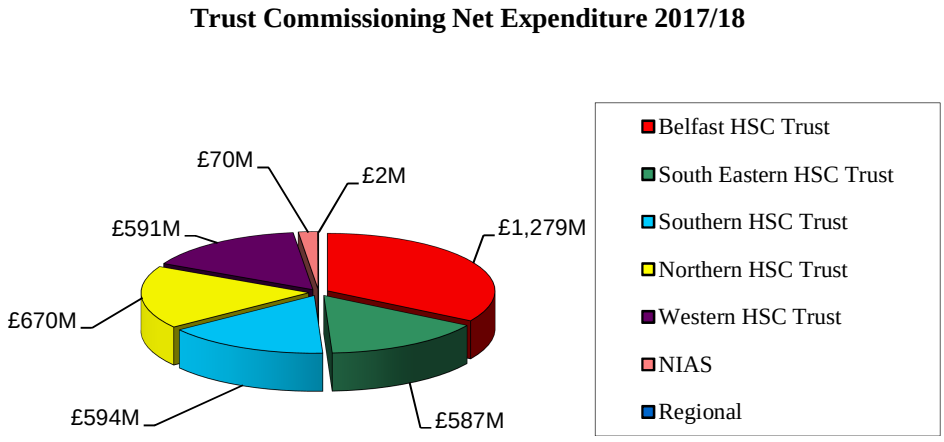
This was achieved by significant effort on the part of the Finance Directorate and all budget holders in managing the wide range of pressures and demands, and the delivery of significant efficiencies in both the FHS and Management and Administration budgets.

The following charts highlight how the HSCB's revenue funds have been utilised during 2017/18.

a. HSCB Net Revenue Expenditure 2017/18

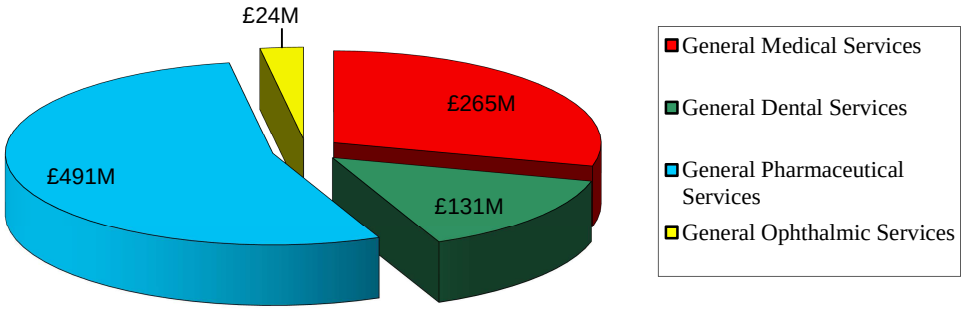


b. Commissioning Expenditure Analysis by Provider 2017/18



c. Family Health Services Expenditure 2017/18

FHS Expenditure 2017/18

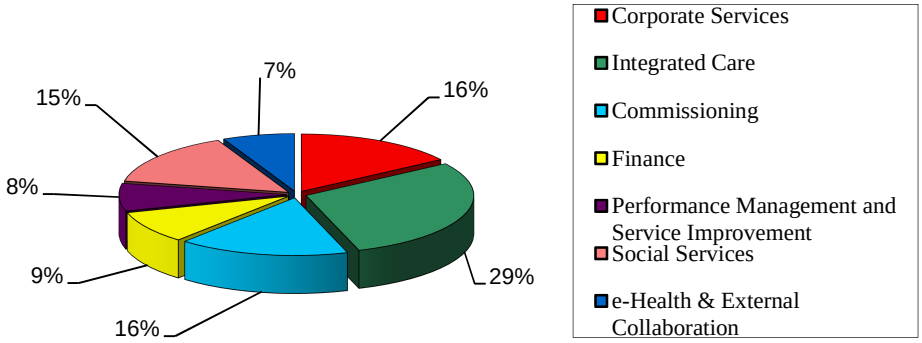


During the 2017/18 financial year, the HSCB continued with the difficult task of managing to successfully deliver its many and complex functions with a significantly reduced Management and Administration budget. Delivery of these savings, set against the backdrop of significant organisational uncertainty regarding the closure of the HSCB, has created a significant and ongoing challenge for the HSCB to ensure that core functions continue to be delivered to the standard that its stakeholders expect.

At the end of 2017/18, the HSCB has been successful in delivering a wide range of efficiencies on a recurrent basis. The outlook for 2018/19 is increasingly constrained – please refer to the Quality, Quantity and Financial Controls section in the Governance Statement for further detail.

d. HSCB Management Costs 2017/18

HSCB Management Costs 2017/18



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

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

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

Regional Learnings from Serious Adverse Incidents (SAIs)

The HSCB continue to implement the "Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs)", issued in November 2016. The procedure provides clear, consistent governance arrangements for reporting and learning from the most serious incidents. Aimed at ensuring review and learning from incidents, it improves patient safety and reduces the risk of recurrence within the reporting organisation and across the wider HSC system. Measures are also in place to ensure that effective engagement with service users, family and carers is undertaken in an open, informed and timely manner; this continues to be monitored by the HSCB.

The HSCB and PHA are jointly responsible for identifying and disseminating regional learning from SAIs, and during 2017/18 issued a number of alerts in the form of reminders of best practice and professional letters, which were issued across the HSC and to primary care practitioners. Learning from SAIs that fell within specialist areas, was shared with relevant networks and fora and two Bi-annual SAI learning reports were issued relating to the following reporting periods: 1 October 2016 – 31 March 2017 (Edition 12) and 1 April – 30 September 2017 (Edition 13).

During 2017/18, a scoping exercise was undertaken which reviewed SAIs involving a delayed diagnosis of cancer over a period of six years. The aim of the review is to highlight common failures and to identify possible preventative measures which can be shared across the service.

The third Annual Regional SAI Learning Event was held on 23 May 2017. This event provided an opportunity to share and learn from SAIs in health and social care and progress a regional approach to reviews and learning.

There was a parallel workshop approach, at the event, relating to the following work streams: Acute Services, Maternity Services, Mental Health and Social Care, Primary and Community Care and on issues with a high regional profile such as severe sepsis, unrecognised deterioration, anticoagulant and antiplatelet management and poor communication and teamwork.

Annual Learning Event – Complaints

The HSCB has oversight of all Health and Social Care complaints, including those regarding Family Practitioner Services, and has responsibility for regionally disseminating learning from complaints. The HSCB monitors and reviews the complaints

to establish if there are patterns, trends or areas of concern. The HSCB Annual Complaints Report 2017/18 can be viewed online at www.hscboard.hscni.net/publications/complaints-publications.

This year's Annual Learning from Complaints event, the fourth of its kind, focused through a number of speakers, on complaints regarding patients in receipt of palliative care, including the co-ordination of discharge arrangements. In particular, how the information received from complaints had influenced the development of the Regional Palliative Care Programme was highlighted. Using extracts and sentiments from real complainants' stories, the audience heard how these experiences informed improvements in practice, including the allocation of a key worker to each person identified as possibly being in the last year of life. This enables the person to have the opportunity to discuss and record their advance care planning decisions and to be supported by having access to appropriate generalist and specialist palliative care services. This ensures that there is an ongoing process of discussion between the person, those close to them and their health professionals, focusing on their wishes and preferences as they approach the end of their life.

In addition, the perspectives of relatives, and nurses and doctors who had provided palliative care within the Belfast Trust's intensive care unit was reflected. The importance of relaying information to patients and their families in a sensitive, appropriate manner and ensuring that the family is involved in each stage of the decision making process was also acknowledged.

The event was attended by staff from HSC organisations, including Family Practitioner Services, the Regulation and Quality Improvement Authority (RQIA) and the Patient and Client Council.

4.2 HSC Online

The HSCB in partnership with the DoH, PHA, Patient Client Council, patients and service users and other key partners, have continued to develop HSC Online, establishing an easily accessible, high quality, trusted health and care information source, accredited by the HSC. During 2017/18, the HSCB has continued to work with NI Direct to extend the range of information on health and care conditions for citizens. Linking the NI Direct resources to public health campaigns enables citizens to easily access the advice and support they need to make the best choices for their health and wellbeing.

In addition, the number of GP practices involved in providing online services has risen from 58 per cent in April 2016 to 75 per cent in January 2018.

The number of online appointments in 2016 was 140,011 rising to 165,542 in 2017. The total number of repeat prescriptions online in January 2016 was 47,701 rising to 88,985 in January 2017.

4.3 Communications, Engagement and Digital Channels

Communications and engagement is vital in ensuring that the HSCB staff, stakeholders and wider public are informed about key health and social care developments and changes to services.

Working with the DoH, PHA, Trusts and a wide range of other partners, HSCB Communications continued to provide a professional service across the wide range of areas including, media engagement, stakeholder engagement, internal communications, projects and partnerships, campaigns and digital media, providing co-ordination to the wider HSC on key proactive and reactive issues.

The HSCB continued to develop its digital channels and also best practice in this area in creating a range of creative content (videos, animations, infographics) to enhance engagement with stakeholders.

This work was recognised at Chartered Institute of PR Excellence Awards in September 2017 at which the HSCB won 'the best low budget campaign' for 'a powerful campaign with inspired content'. The campaign helped re-educate people in the way they access health and pharmacy services; played a role in influencing healthcare policy; and also assisted with the drive to achieve significant savings for the healthcare budget.

The HSCB also supported a major engagement process to ensure the fullest range of stakeholders could have a say in reshaping stroke services in Northern Ireland (see Section 2.5 of the Performance Analysis). This involved: running five stroke survivor workshops, attended by around 150 people and facilitated by NI Chest Heart and Stroke; 12 public meetings; seven staff engagement events; and producing a wide range of materials, including videos featuring stroke survivors, an animation, infographics and leaflets.

4.4 Support Working with Key Stakeholders on the Planning and Co-ordination of Service Delivery

During 2017/18 the HSCB has demonstrated its commitment to co-production which is the collaboration of people who commission and manage services with people who have lived experience of using these services. The following examples illustrate the HSCB's undertaking to meaningfully engage and involve patients and their families, working with key stakeholders to plan and design services.

The valuable contribution of people living with dementia, their families and carers was recognised at a regional event 'Moving Forward Together: Planning for the Future in Dementia Care' in November 2017. This event celebrated the partnership working ethos underpinning the work of the Dementia Together partnership (see section 2.3 of the Performance Analysis for further details). Co-production in service planning and design, taking forward this work in partnership with the Alzheimer's Society and with service user support from Dementia NI, facilitated the implementation of a range of initiatives developed to raise awareness and address the stigma surrounding dementia. Furthermore, the HSCB recognises that engaging with people with a dementia about their experiences is essential when determining service need and helping shape future dementia services in NI.

During summer 2017 the HSCB and PHA engaged with a range of key stakeholders to hear their views on the regional Review of Breast Assessment Services (see Section 2.6 of the Performance Analysis). The purpose of this pre-consultation engagement exercise was to shape the consultation proposals for service reconfiguration and to inform the development of the criteria to be used in the assessment of the various options. Patient

focus groups were held in each Trust area and initial engagement took place with key voluntary organisations. Wider public engagement took place through public meetings organised by the five Local Commissioning Groups.

In March 2018 the HSCB, in partnership with the PHA, launched 'Working Together: A Pathway for Children and Young People through CAMHS' and a Welcome Guide for children and young people coming in to Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland. The HSCB facilitated collaborative working, through engaging young people who have personal experience of using CAMHS and their families, working alongside health and social care professionals in the production and design of these CAMHS resources. By supporting the involvement of young people from the outset, in all decisions about their care and treatment, CAMHS users are enabled to make informed choices, from referral through to moving on and recovery. In line with service reform and modernisation principles, the pathway provides a person-centred, evidence based framework, supporting better integrated working and seamless care based on individual need. It demonstrates the HSCB's commitment to ensuring CAMHS services in Northern Ireland provide children and young people with the best opportunity for recovery.

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

5.1 Valuing Staff: Ensuring Effective Transitional Arrangements during the Change Process

The HSCB is firmly committed to ensuring that robust systems and processes are in place to maximise the potential of its staff by ensuring that they are skilled, motivated and valued.

Regarding the future closure of the HSCB, the Chief Executive, the Chair and Senior Management Team continue to engage with staff and Trade Unions to ensure they are fully informed and involved in the change process. During 2018/19 there will be continued input from Human Resources (HR) provided by the Business Services Organisation (BSO) to ensure staff are supported through this time of change and that any impact is minimised.

In 2017/18 HR colleagues at BSO led on a number of work areas including pay and conditions, employee relations (both improvement of working relationships and resolution of individual cases) and retained recruitment (i.e. quality assurance role in respect of posts advertised and job evaluations). This involved working with managers, staff and Trade Union organisations. A number of new and amended policies have been rolled out within HSCB with associated planned training.

5.2 Preparing for Change: Organisational and Workforce Design

The Recruitment Scrutiny Group involving senior management and HR continues to meet regularly to manage the recruitment process taking into account the need for organisation reshaping, Voluntary Exit Scheme and the provision of business continuity, whilst awaiting the development and implementation of future models of care.

The HSCB has also embarked on developing a Coaching Culture throughout the organisation to ensure managers are properly equipped with the skills, knowledge and ethical understanding they need to provide effective support for the development of others and improved performance

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

During 2017/18 HSCB staff have had the opportunity to participate for a second year in the Global Corporate Challenge to improve their health, wellbeing and performance by walking 10,000 steps daily. HSCB staff also have access to workplace wellbeing services such as mental health support, counselling and other therapeutic interventions through partnership working with Inspire. Following workshops involving staff, the HSCB are

also working with Inspire to finalise the development of a number of initiatives and programmes for managers and staff to provide support during the period of change.

Equality, Human Rights and Diversity

During 2017/18, the HSCB placed particular emphasis on reinvigorating engagement of staff, across all parts of the organisation, on equality and disability responsibilities. To this end, all staff have been required to attend face-to-face training. This training raises awareness of the needs and experiences of equality target groups and to provide a summary of equality legislation, its key concepts and requirements.

The HSCB continued to facilitate and support Tapestry, the Disability Staff Network for the 11 regional Health and Social Care organisations. Work progressed to develop a stand-alone website for the network and to develop recommendations for a new streamlined process for making reasonable adjustments. Together with regional HSC partners, the HSCB also engaged with Carers NI to learn more about good practice in supporting staff who provide care for family members.

The BSO Equality Unit, on behalf of HSCB and in partnership with Trusts, finalised the new Gender Identity Employment Policy following review of the outcome of its consultation. The policy was approved by the HSCB Senior Management Team in October 2017.

5.3 Emergency Preparedness

In light of the increasing number of terror related attacks in Europe including in the UK, the HSCB and PHA have been working collaboratively with Trusts, other Arm's Length Bodies and multi-agency partners on the development of a regional health operational plan for a mass casualty incident. Significant progress has been made on identifying casualty capability across the five Trusts, and, in enhancing their major incident plans to deal with incidents of this nature. These arrangements were tested at a regional desktop exercise during December 2017. It is anticipated that the learning from this event will be incorporated into a final NI Regional Mass Casualty Plan early next year. This plan will be subject to continued review, testing and reviewing.

5.4 Departmental/Private Office and Freedom of Information Requests

During 2017/18, 88 FOI Requests were received with 67% being answered within 20 working days. Five Subject Access Requests were received, with 80% answered within 40 calendar days. No serious personal data related incidents occurred in 2017/18.

Sustainability

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

The HSCB has continued to implement a number of energy saving initiatives which support the policies on environmental and waste management. During 2017/18, existing light fittings in two HSCB offices were replaced with Light Emitting Diodes (LED) to reduce energy consumption and costs which, in turn, will deliver Carbon Emission savings and provide better lighting conditions.

The roll out of a new Multi-Functional device fleet took place during the year and continues to produce significant savings of up to 30% on printing costs through a reduction in paper requirements, more efficient use of fewer machines and a reduction in energy consumption as printers automatically switch to standby mode.

The HSCB continued to encourage staff initiatives in an effort to reduce its carbon footprint. The use of tele-conferencing and video-conferencing facilities in each of the four HSCB offices has reduced the need to travel for business purposes.

The Sustrans workplace initiative "Leading the Way with Active Travel" encourages more sustainable travel by staff within Belfast and a further 6 staff availed of the Cycle to Work Scheme, which also promoted a healthier lifestyle. The Business Rail Translink Scheme encourages staff to make use of public transport to help reduce environmental pollution.

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

Mrs Valerie Watts

Chief Executive

Date: 14 June 2018

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2018

ACCOUNTABILITY REPORT – GOVERNANCE REPORT

Directors' Report

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

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

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

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

Non-Executive Directors are appointed by the Health Minister in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The Non-Executive Directors are independent and reflect wider outside and community interests in the decision making of the Board. There is currently a Non-Executive Director vacancy following the resignation of a Non-Executive Director in September 2017.

This year saw some changes to the membership of the Board. During 1 April 2017 and 31 March 2018 the Board membership comprised the following Directors:

Non-Executive Directors

Dr Ian Clements
Chairman

Mr Robert Gilmore

Mr Stephen Leach

Dr Melissa McCullough

Mr Brendan McKeever

Mr John Mone

Dr Robert Thompson[1]

Mrs Stephanie Lowry

[1] Dr Thompson resigned as Non-Executive Director on 30 September 2017

Executive Directors

Mrs Valerie Watts
Chief Executive

Mr Michael Bloomfield[2]
Director of Performance and Corporate Services/Deputy Chief Executive

Mr Dean Sullivan[3]
Director of Commissioning

Mrs Fionnuala McAndrew[4]
Director of Social Care and Children

Mr Paul Cummings
Director of Finance

Dr Miriam McCarthy
Director of Commissioning[5]

Mr Cecil Worthington
Acting Director of Social Care and Children

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

- Dr Sloan Harper, Director of Integrated Care, Health and Social Care Board;
- Mr Sean Donaghy, Director of eHealth and External Collaboration, Health and Social Care Board;
- Dr Carolyn Harper, Executive Medical Director/Director of Public Health, Public Health Agency; and
- Mrs Mary Hinds, Director of Nursing and Allied Health Professionals, Public Health Agency
- Ms Louise McMahon, Director.

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

[2] Mr Bloomfield left his post as Director of Performance & Corporate Services/Deputy Chief Executive on 31 March 2018
[3] Mr Sullivan left his post as Director of Commissioning in July 2017
[4] Mrs McAndrew was absent from September 2017
[5] Dr McCarthy took up post as Director of Commissioning on 11 December 2017

Board of Directors

Dr Ian Clements, Chairman

Dr Clements has been Chair of the Health and Social Care Board since its formation in 2009. Dr Clements lives in Newtownards, where he had practised as a GP for 27 years. Throughout his GP career, Dr Clements has continually sought to improve health and care services for patients through his involvement in the commissioning process. He also contributed his expertise as a doctor over many years to a wide array of leading health and care organisations.

Mrs Valerie Watts, Chief Executive

Mrs Watts took up post as Chief Executive of the Health and Social Care Board in July 2014. Mrs Watts has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital where she oversaw competitive tendering for ancillary support services. Most recently, Mrs Watts was Chief Executive of Aberdeen City Council (2011-2014) and formerly Town Clerk and Chief Executive of Derry City Council (2009-2011) where she was instrumental in securing the UK City of Culture for 2013 and developing a strategic economic master plan for the North West. Since October 2016, Mrs Watts also holds the post of Interim Chief Executive of the Public Health Agency.

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

Mr Gilmore lives in Co. Down and is a Public Sector Advisor and former Local Authority Chief Executive. He has been a Non-Executive Director of the Health and Social Care Board since April 2009 and was previously a lay member of the Southern Local Commissioning Group (Health and Social Services). He is an Independent Member of the Audit and Risk Assurance Committee in the Department for Infrastructure. He was formerly a Director in a Local Enterprise Agency, a Governor in a Further and Higher Education Institute and a Commissioner in the Local Government Staff Commission.

Mr Stephen Leach CB, Non-Executive Director

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

Mrs Stephanie Lowry, Non-Executive Director

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

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

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

Mr Brendan McKeever MSc, PGCE, Non-Executive Director

Mr McKeever is a User Consultant at Queen's University and the Ulster University and has undertaken work to support projects to improve the care of people with disabilities. He has written widely on these matters and continues to assist organisations that provide and develop services for users and carers.

Mr John Mone MSc, BA, Non-Executive Director

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

Dr Robert Thompson MB, BCh, FRCGP, Non-Executive Director (until 30 September 2017)

Dr Thompson lives near Craigavon and has been a Non-Executive Director of the Health and Social Care Board since 2009. After qualifying in medicine at Queen's University Belfast, he worked for some 20 years as a GP in Lurgan, Co Armagh. He later served the former Southern Health and Social Services Board in a senior capacity where he assisted with the development of many services provided to patients by GPs. Mr Thompson resigned from his position as Non-Executive Director on 30 September 2017.

Mr Paul Cummings, Director of Finance

Paul Cummings is Director of Finance, HSCB, having taken up the position when the Board was established in 2009. He has previously been a Director of Finance in the South Eastern, Mater and Ulster Community and Hospitals Trusts with over 25 years' experience in health and social care and was the national chair of the Healthcare Financial Management Association in 2002/03, continuing to be an active member.

Mrs Fionnuala McAndrew OBE, Director of Social Care and Children

Mrs McAndrew was appointed to her post when the Health and Social Care Board was established in April 2009, and previously trained and practised as a social worker. She led the management and development of many aspects of social care in Northern Ireland. She is a Board Member of the charity Children in Northern Ireland (CiNI) and Northern Ireland Trustee for the Social Care Institute for Excellence (SCIE).

Mr Cecil Worthington, Acting Director of Social Care and Children (interim arrangement)

Mr Worthington qualified as a Social Worker from Ulster University, Jordanstown, in 1978 with a BA (Hons) in Social Work. Cecil has worked during his career with the full range of client groups; older people, family and child care, mental health and disability services. He was Director of Social Services/Executive Director of Social Work in Ulster Community Hospital Trust from 2001 to 2007 covering child care, disability and older peoples' services. He was Director of Children's Services/Executive Director of Social Work in the Northern Trust, from May 2009 to August 2012. Mr Worthington's operational responsibilities included family and child care services, child health, paediatric services, child and adolescent mental health services and children with a disability. Cecil commenced work in the Belfast Trust in September 2012 as Director of Children's Community Services/Executive Director of Social Work. He is formerly a Trustee with the National Children's Bureau. He retired from the Belfast Trust in September 2017 and took up the position of Acting Director of Social Care and Children's Services in December 2017 on a part-time basis.

Mr Dean Sullivan, Director of Commissioning (until 31 July 2017)

Mr Sullivan trained as an accountant with the National Audit Office in London. He later worked as a management consultant with PwC and PA Consulting Group. In 2003 he joined the former Department of Health, Social Services and Public Safety, initially as Director of Secondary Care and then Director of Performance and Planning. He joined the Health and Social Care Board in 2010.

Dr Miriam McCarthy, Director of Commissioning (from 11 December 2017)

Miriam McCarthy is the Director of Commissioning at the Health and Social Care Board, having taken up post in December 2017. Miriam is a medical doctor trained in both general practice and public health. While she has spent most of her career working in Northern Ireland, she has also worked and studied for many years in the USA. Miriam has extensive experience in policy and strategy development. As a senior civil servant during the period 1998-2011 she led many high profile service reviews which have shaped the direction of acute and specialist hospital services in Northern Ireland. She subsequently took up a position as consultant in public health, based at the Public Health Agency where she worked in partnership with commissioners in shaping and developing hospital services across NI, with particular focus on specialist services, cancer and medicines management. Miriam has also been closely involved with the work of the National Institute for Health and Care Excellence (NICE) and was a member of a Technology Appraisal Committee between 2013 and 2017. In her role as Director of Commissioning Miriam provides leadership to improve patient care, ensure sustainable services and transform the delivery of care.

Mr Michael Bloomfield, Director of Performance and Corporate Services/Deputy Chief Executive (until 31 March 2018)

Mr Bloomfield joined the Health and Social Care Board when it was established in April 2009 as Assistant Director of Performance Management, following over 20 years in the Northern Ireland Civil Service. From 1998 to 2009 he held a number of posts in the Department of Health, Social Services and Public Safety, latterly as Head of Performance Management in the Service Delivery Unit. Mr Bloomfield was appointed Head of Corporate Services at the Board in March 2011. In November 2012 he also took on the role of Acting Director of Performance Management and Service Improvement. In November 2016, he was appointed HSCB Deputy Chief Executive.

Related Parties Transactions

The HSCB is an arm's length body of the DoH 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 HSC Trusts.

Mrs Fionnuala McAndrew (Director of Social Care and Children) is a member of the Board of Directors of the registered charity Children in Northern Ireland (CiNI), which may be likely to do business with the HSCB in future.

Mr Danny Power (Interim Chair of Belfast Local Commissioning Group) is a member of the Board of Directors of Clan Mor Surestart and the West Belfast Partnership Board, which may be likely to do business with the HSCB in future.

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

Register of Directors' Interests

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

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

Audit Services

The Health and Social Care Board's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office and the notional charge for the year ended 31 March 2018 was £52,000.

Audit Disclosure

All Directors can confirm that they are not aware of any relevant audit information of which the external auditors are unaware. The Accounting Officer has taken all necessary steps to ensure that all relevant audit information which she is aware of has been passed to the external auditors.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

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

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

- Observe the HSC Manual of Accounts issued by DoH including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the HSCB will continue in operation.*
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the HSCB.
- Pursue and demonstrate value for money in the services the HSCB provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the DoH, as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland, has designated Mrs Valerie Watts as the Accounting Officer for the HSCB. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the HSCB's assets, are set out in the Accountable Officer Memorandum, issued by DoH.

*It should be noted that the then Minister for Health announced in November 2015, confirmed by the subsequent Minister, the intention to close the HSCB and realign its activities across the wider HSC system. However, no formal timeframe for closure has been advised and HSCB is expected to continue as constituted for the 2018/19 financial year. The financial statements, therefore, have been prepared on a going concern basis.

Governance Statement

1. Introduction/Scope of Responsibility

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

Processes in place by which the HSCB works with partner organisations

- Public Health Agency (PHA)

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

- Business Services Organisation (BSO)

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

- Health and Social Care Trusts

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

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

Inter-relationship with DoH and HSCB

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

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

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

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

2. Compliance with Corporate Governance Best Practice

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

Standing Orders

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

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

During the period there were no conflicts of interests declared at Board meetings. There were abstentions or dissentions from voting on a number of occasions and these are recorded in the public Board minutes.

Register of Interests

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

Gifts and Hospitality Policy

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

Performance Appraisal System

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

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

Training

"Essential Skills" refresher training was last undertaken in 2013 and was valid for three years. Further training was provided during the period under review, and consideration is being given to organising further training.

Self-Assessment

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

- A Board Governance Self-Assessment Tool covering the period 2017/18 is currently being progressed and will be approved by the Board at its meeting in June 2018. ALBs are required to provide assurance through their mid-year assurance statement that: the tool is being completed; actions are being addressed and any exception issues will be raised with the Department.

- The intention of the Board Governance Self-Assessment evaluation is to improve the effectiveness of the Board and provide Board members with the assurance that business is conducted in accordance with best practice.

3. Governance Framework

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

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

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

The current Governance Framework was revised and approved by the Governance Committee at its meeting in January 2015 and is principally concerned with ensuring the HSCB has the basic building blocks in place for good governance through the development and implementation of a sound system of internal control, which will assist the Board of the HSCB, through the Chief Executive, to sign the annual Governance and Mid-Year Assurance Statements.

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

The Board

The Board of Directors is comprised of a Non-Executive Chair, seven Non-Executive Directors, the Chief Executive and four Executive Directors – the Director of Finance, Director of Commissioning, Director of Social Care and Children and Director of Performance and Corporate Services/Deputy Chief Executive. From 1 October 2017 there has been one Non-Executive Director vacancy. There has been no governance risk associated with this vacancy and this will continue to be assessed.

A number of Directors from the HSCB's Senior Management Team also attend Board meetings including the Director of Integrated Care, the Director of eHealth and External Collaboration, the Director, responsible for Community Planning, the Executive Medical Director/Director of Public Health (PHA), and the Director of Nursing and Allied Health Professionals (PHA).

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

During the period 1 April 2017 – 31 March 2018, the Board met on ten occasions and was quorate on each occasion. There was one special Board meeting held during this period.

Name	Title	Meetings attended	Meetings contracted to attend
Dr Ian Clements	Chair	10	10
Mr Robert Gilmore	Non Executive Director	10	10
Mr Stephen Leach	Non Executive Director	10	10
Mrs Stephanie Lowry	Non Executive Director	10	10
Mr John Mone	Non Executive Director	9	10
Mr Brendan McKeever	Non Executive Director	9	10
Dr Melissa McCullough	Non Executive Director	9	10
Dr Robert Thompson	Non Executive Director (until 30/09/17)	3	4
Mrs Valerie Watts	Chief Executive	10	10
Mr Michael Bloomfield	Director of Performance & Corporate Services / Deputy Chief Executive(until 31/03/18)	10	10
Mr Paul Cummings	Director of Finance	10	10
Mr Dean Sullivan	Director of Commissioning (until 31/07/17)	2	2
Dr Miriam McCarthy	Director of Commissioning (from 11/12/17)	2	3
Mrs Fionnuala McAndrew	Director of Social Care & Children	2	10
Mr Cecil Worthington	Acting Director of Social Care & Children (from 11/12/17)	2	3

Role of the Audit Committee

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

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

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

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

During the 2017/18 financial year six meetings of the Audit Committee were held (96% attendance), along with a joint meeting with the Governance Committee to consider the mid-year Assurance Statement.

The Audit Committee assessed itself against the five good practice principles published in the Audit and Risk Assurance Committee Handbook (NI) and can demonstrate adherence to these principles covering:

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

Role of the Governance Committee

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

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

In the 2017/18 year, the Governance Committee met on four occasions with 100% attendance at three meetings and 75% attendance at one meeting.

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

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

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

4. Business Planning and Risk Management

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

Business Planning

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

Commissioning Plan

In line with the above statute, the HSCB is required to prepare and publish an annual Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery. The preparation of the Commissioning Plan is done in partnership with the PHA and is implemented through a series of integrated service teams. It takes full account of the financial parameters set by the DoH and is consistent with the direction and priorities, as set out in the Commissioning Plan Direction. It incorporates the system transformation agenda, to ensure that the HSCB, as the commissioner of health and social care services, is able to make the best use of the resources available to support the continued reform and modernisation of HSC services.

Corporate Plan

Many of the HSCB's objectives and responsibilities for the year 2017/18 are reflected in the Commissioning Plan. The Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

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

The key objectives for the focal year 2017/18 have been subject to bi-annual review. The first of these reviews was carried out as at 30 September 2017 and was approved by the Governance Committee at its meeting on 1 February 2018. The year-end review was carried out as at 31 March 2018 and will be approved by SMT prior to being approved by the Governance Committee at its meeting in June 2018.

Planning for 2018/19 Corporate Plan

The 2018/19 plan was approved by the Governance Committee at is meeting on 29 March 2018 prior to being noted by the Board in April 2018 and subsequently approved by the Department of Health.

Business Continuity Plan

The Board Corporate Business Continuity Management System (Policy and Plan) is aligned to the requirements of the International Standards Organisation (ISO) 22301. The Plan identifies the HSCB functions deemed as 'critical', which must continue to be delivered during an interruption to normal business. Each Directorate undertook a risk analysis and developed strategies and tactics to detail how the critical functions would be delivered during an interruption. The Plan is available on the HSCB intranet site, along with guidance for staff.

Risk Management

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

The purpose of risk management is not to remove all risk, but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss. The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004 standard (adopted by DoH) which ensures there is a systematic and unified process for the management of risks across all areas of the Board's activity. The process for the management of Board-wide risk is part of the HSCB's overarching Governance Framework which was revised in January 2015. It includes a step by step process from the initial identification of a risk, risk grading (using the regional risk matrix), how the risk should be managed and escalation/de-escalation of grading to and from Directorate to Corporate Risk Registers. The implementation of this process has led to a fully functioning Risk Register at both directorate and corporate levels.

Risk Management Leadership

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

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

The adoption of an overarching Governance Framework, which was revised in January 2015, ensures the HSCB has the basic building blocks in place for good governance; to lead, direct and control its functions in order to achieve organisational objectives and by which it relates to its partners and the wider community. The Framework highlights the key components that underpin a sound system of governance and internal control, and embraces the structure and process for managing and leading risk throughout the organisation.

An e-learning risk management awareness programme has been developed within the HSCB and is mandatory for all HSCB staff. Completion rates are actively monitored and verified as part of the Controls Assurance Standards programme. Training in risk management is also incorporated in the overarching corporate induction programme.

Categorisation of Risk

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

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

The HSC Regional Risk Matrix, adopted by the HSCB with effect from April 2013, updated June 2016, is included as an appendix to the Governance Framework and is consistent with DoH mandatory guidance 'An Assurance Framework: A Practical Guide for Boards of DoH Arm's Length Bodies'. This matrix which is used to categorise potential risks, incidents, complaints and claims, facilitates the prioritisation of risk in terms of likelihood and impact (consequence). In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

- Risk Appetite

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

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

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

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

- Embedding of Risk

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

The substantive review as at 31 March 2018, involved the Governance Team meeting with Directors and their senior staff to review both Directorate and corporate risks and making the necessary additions/amendments in respect of:

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

The Governance Committee is currently in the process of approving the substantive review as at 31 March 2018 for onward referral to the Board for noting at its meeting in June 2018.

<u>Stakeholder Risk</u>

- Serious Adverse Incidents (SAIs)

The HSCB continues to implement the Procedure for the reporting and follow up of SAIs, which was revised and issued to the HSC in October 2016 (see Section 4.1 of the Performance Analysis section of the Annual Report).

- Complaints

The HSCB has oversight of all HSC complaints and is responsible for the monitoring of complaints and processes and for the identification and dissemination of learning from complaints (see Section 4.1 of the Performance Analysis section of the Annual Report).

- Emergency Preparedness

The HSCB adheres to the DoH Emergency Planning Controls Assurance Standards which state "all Health and Social Care organisations should have detailed emergency preparedness plans in place, which are reviewed annually and which are part of an annual programme for testing and validating plans." A joint PHA/HSCB/BSO Emergency Response Plan has been developed since 2009/10. The Plan is reviewed and updated following each activation or test.

An Annual Report which provides an overview of HSC Emergency Preparedness is prepared by the PHA/HSCB and BSO and submitted to the DoH each year.

The Board, PHA and BSO work collaboratively to continually review and enhance emergency preparedness arrangements. The Emergency Planning Programme Board, chaired jointly by the Director of Public Health, PHA and the Director of Performance and Corporate Services, HSCB oversees the wider Health and Social Care emergency preparedness and the coordination of planning for major events and preparation for adverse events (see Section 5.3 of the Performance Analysis section of the Annual Report).

Fraud

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

5. Information Risk

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

Structures include the roles of Senior Information Risk Owner, Personal Data Guardian, Information Asset Owners and Administrators all of which are supported by an Information Governance Team. Escalation is facilitated via a range of fora across all levels of the organisation. Examples include the Records Management Working Group, Information Governance Steering Group, Senior Management Team and the Board's Governance Committee.

2017/18 saw continued maintenance and update of the Board's Information Asset Register. Data flow analysis and risk assessments were completed and reviewed as necessary for all information assets. Treatment plans were produced to highlight and address any identified risks. Identified actions were agreed with Information Asset Owners who in turn provided assurance to the Senior Information Risk Owner on progress. During 2017/18 preparations commenced for the introduction of the new General Data Protection Regulations (GDPR) effective from 25 May 2018; an action plan has been developed and HSCB staff are participating both internally and regionally in a range of working groups to address those actions.

The HSCB deploys a number of mandatory Information Governance e-learning training programmes to staff. The programmes, developed regionally by HSC staff, are formally updated every three years with less formal awareness updates issued annually. Completion rates are actively monitored and reported to the Board's Senior Management Team and Governance Committee as Key Performance Indicators (KPI's).

The Accounting Officer and Board received assurances on information risk via formal reporting mechanisms. The Information Governance Steering Group, chaired by the Senior Information Risk Owner, met quarterly with updates provided as necessary at each meeting. Reports to the HSCB Governance Committee were provided from the Senior Information Risk Owner who attends both groups. Further assurances were sought via Internal Audit with an Information Management audit being completed in February 2018 showing a Satisfactory level of assurance.

6. Public Stakeholder Involvement

The HSCB, working collaboratively with the PHA, recognises that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of HSC services. PPI is the active and meaningful involvement of service users, carers and the public in those processes. All commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work, ensuring that the input of service users and carers underpins the identification of commissioning priorities and in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements (see Section 4.4 of the Performance Analysis report). Some examples of good practice include:

- 40 service users or carers have been recruited onto the 17 Integrated Care Partnerships.
- HSCB continues to commission PPI training for both staff and service users and carers. 20 additional HSC, Voluntary and Community staff successfully completed ILM level5 training; 10 Service user and carers successfully completed ILM level 3.
- Local engagement events discussing issue specific topics in all Local Commissioning Group areas.
- Service user and carers actively involved in the implementation of Physical Disability and Sensory Strategy, Social Work and Social Research Strategies, implementation of the Stroke Strategy, and the regional Carers Strategy;
- Development of HSC online.
- Service users actively involved in the design, implementation and roll out of both EHCR and NI direct web portal.
- We continue to work with our staff, service users and carers to take forward a diverse and challenging work programme in regards to involvement and co-production.

7. Assurance

Assurance Framework

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

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

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

Quality of Board Papers

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

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

Delegated Statutory Functions

Trusts submit an annual monitoring report on the delivery of statutory functions with a mid-year return on Corporate Parenting. This is analysed by HSCB and an overview report on findings was considered by the Board at its meeting on 14 September 2017 and submitted to DoH. Trusts have developed action plans where remedial action was required. The quality of supporting data has continued to improve and together with regular monitoring meetings, ensures that this area is kept under constant review.

Controls Assurance Standards

The HSCB assessed its compliance with the applicable Controls Assurance Standards which were defined by the DoH and against which a degree of progress was expected in 2017/18.

The HSCB achieved the following levels of compliance for 2017/18.

Standard	**DoH Expected Level of Compliance**	**HSCB Level of Compliance**	**Audited by Internal Audit**
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	83%	-
Decontamination of medical devices	75% - 99% (Substantive)	Not Applicable	-
Emergency Planning	75% - 99% (Substantive)	91%	-
Environmental Cleanliness	75% - 99% (Substantive)	Not Applicable	-
Environment Management	75% - 99% (Substantive)	82%	-
Financial Management *(Core Standard)*	75% - 99% (Substantive)	88%	BSO IA
Fire Safety	75% - 99% (Substantive)	90%	BSO IA
Fleet and Transport Management	75% - 99% (Substantive)	Not Applicable	-
Food Hygiene	75% - 99% (Substantive)	Not Applicable	-
Governance *(Core Standard)*	75% - 99% (Substantive)	93%	BSO IA
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	84%	-
Infection Control	75% - 99% (Substantive)	Not Applicable	-
Information Communication Technology	75% - 99% (Substantive)	89%	-
Management of Purchasing	75% - 99% (Substantive)	84%	-
Medical Devices and Equipment Management	75% - 99% (Substantive)	Not Applicable	-
Medicines Management	75% - 99% (Substantive)	Not Applicable	-
Information Management	75% - 99% (Substantive)	82%	-
Research Governance	75% - 99% (Substantive)	Not Applicable	-
Risk Management *(Core Standard)*	75% - 99% (Substantive)	93%	BSO IA
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	87%	-

8. Sources of Independent Assurance

The HSCB obtains independent assurance from the following sources:

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

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

Internal Audit

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

In 2017/18 Internal Audit performed the following audit assignments, with overall levels of assurance given as shown:

- Management of Sure Starts (Satisfactory) and Bright Starts (Limited), including visits to organisations (Limited for Clan Mor Sure Start only)
- Financial Review - Satisfactory
- Acute Specialist Drugs Budgets - Satisfactory
- General Dental Services – Satisfactory for Management of Fraud/Error and Use of Year End Slippage, Limited for FPPS System and Prior Approvals Process
- General Medical Services – Satisfactory for Management of Quality Outcomes Framework (QOF) Funding, Use of Slippage Monies and BSO Assurances, Limited for Management of KPIs in relation to GP Out of Hours Services
- Data Quality - Limited
- Cooperation and Working Together (CAWT) - Satisfactory
- Risk Management - Satisfactory
- Information Management - Satisfactory
- ICT Governance - Limited
- Incident Management - Satisfactory.

In the Annual Report, the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the HSCB's objectives. However, the following Priority 1 findings or recommendations were identified during 2017/18:

- Management of Sure Starts and Bright Starts

This recommendation related to the sustainability of Bright Start schemes. For the majority of schemes achieving sustainability has not been possible to date, which has led to an extension of funding. It was recommended that HSCB consider the lessons learnt from the current model of operating Bright Starts and take forward any actions which may be applicable to the HSCB, including sharing their views with the Department of Education on the potential options for future funding/structure of Bright Starts.

Management accepted this recommendation and the year-end follow up report from Internal Audit confirmed that it has been implemented.

- General Dental Services

At the time of audit, the FPPS Dental Payments System was not able to calculate the dental payments; this function was being performed by BSO Information Unit with data being extracted from the system and the calculation performed on a secondary software system. A number of technical system issues were highlighted, resulting in a Priority 1 recommendation that the HSCB should continue to work with BSO to establish and address the number and value of errors in payments. A project plan was developed to both address and ensure a timely approach to the required IT and data fixes, and was regularly monitored by HSCB and Family Practitioner Services. Management accepted this recommendation and the year-end follow up report from Internal Audit confirmed that it has been implemented.

- General Medical Services

The findings in this report related to GP Out of Hours (OOH) performance monitoring, and resulted in two Priority 1 recommendations. The first recommendation is based on the risk that HSCB cannot clearly demonstrate adherence to procurement regulations and therefore, value for money. This is an ongoing issue and the Directorate of Integrated Care accept this repeated recommendation. A review was previously carried out and it was agreed by key stakeholders that due to the level of instability within OOH services in Northern Ireland, it would not be appropriate to enter into a regional competition or full scale restructure at this time, as this could further adversely impact the stability of the service. Management will address the current procurement risk once the OOH service stabilises.

The second recommendation states that HSCB should continue the work within the confines of its responsibility, and in conjunction with DoH and Trusts to progress actions set out in the GP-led Primary Care review to ensure performance of the Out of Hours Service is improved. This should include a review of key performance indicators to ensure they allow for effective monitoring of the Out of Hours Service by HSCB. The HSCB Board should also be provided with regular formal updates on the status of implementation of the action plan. Internal Audit have recognised that HSCB requires input from other organisations to ensure full implementation.

- ICT Governance

This recommendation stated that HSCB should take a lead role in clarifying and strengthening regional cyber security governance and leadership, including a cyber security strategy and a regional ICT incident management protocol that is regionally tested. The recommendation is currently categorised as partially implemented with the following management responses to the year-end follow up by Internal Audit:

  - eHealth will commission a cyber-security programme from BSO ITS, to include a strategy and business case for investment. See section 10C of the Governance statement for further details.

- The 'Roles and Responsibilities' document published by DoH sets out organisational responsibility in the event of a cyberattack, and clarifies the lead role of BSO in the provision of advice and guidance to ALBs.
- HSC ALBs have drawn up a directory of staff responsible for managing cyber security, alongside contact details in and out of hours in the event of an incident.
- Further work is required to agree an investment programme to increase out-of-hours response capacity in BSO and ALBs. A project has been established to take this work forward. This is required in order to provide appropriate and timely response services in the event of an incident. This process has commenced with the establishment of a '24/7' project, with phase 1 expected to generate additional costs of c £300k per annum.
- Existing business continuity plans make clear the decision making process in the event of an incident, including escalation from business continuity to emergency planning. Details of the process for reporting incidents to BSO are available to all other HSC ALBs, and there are clear escalation arrangements in place within BSO.

Management regularly review and are working towards the implementation of all recommendations made by Internal Audit.

Regulation Quality Improvement Authority (RQIA)

The HSCB/PHA introduced a system via the Safety and Quality Alerts Team (SQAT) during 2013/14 to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented.

This system of assurance takes the form of a six monthly report which details the progress on implementation of RQIA recommendations. The report for the period ending 31 March 2017 was approved by SMT on 18 September 2017 and noted at Governance Committee on 5 October 2017.

Due to timings of the separate report to the DoH Top Management (TMG), the reporting period to the HSCB Governance Committee has changed to the end of June and December each year. The most recent six monthly report on progress for the period ending 30 December 2017 was approved by the Governance Committee on 29 March 2018.

National Confidential Enquiry into Patient Outcome and Death Reports

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

This system of assurance takes the form of a six monthly report which details the progress on implementation of NCEPOD recommendations. The report on progress for the period ending 30 June 2017 was approved by SMT on 18 September 2017 and noted at the Governance Committee at its meeting on 5 October 2017.

To accommodate revised reporting arrangements for RQIA progress reports, the reporting period of the progress reports has changed to the end of March and September each year. The report for the period ending 31 March 2018 will be considered at the Governance Committee in June 2018.

External Audit

For the year ended 31 March 2017, the Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the HSCB's accounts. A Report to Those Charged with Governance on additional matters did not identify any priority 1 or 2 issues.

9. Review of Effectiveness of the System of Internal Governance

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

10. Internal Governance Divergences

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

Business Services Transformation Project/Shared Services (Recruitment)

The audit assignment carried out during 2016/17 for Recruitment Shared Services resulted in a limited level of assurance being received from the Internal Auditor. For the 2017/18 audit of Recruitment Shared Services, Internal Audit has provided satisfactory assurance over the system of control with no significant issues to report.

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

Quality, Quantity and Financial Controls 2017/18

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

Health and Social Care (HSC) in Northern Ireland continued to face very significant financial challenges during 2017/18. The HSCB worked closely and proactively with all Trusts and the DoH throughout the year in order to address the difficulties faced. This collaborative approach enabled the HSC system to achieve financial breakeven for the 2017/18 year.

The Northern Ireland Assembly was dissolved from 26 January 2017 with an election taking place on 2 March 2017, on which date Ministers ceased to hold office. An Executive was not formed following the 2 March 2017 election. As a consequence, the Northern Ireland Budget Act 2017 was progressed through Westminster, receiving Royal Assent on 16 November 2017, followed by the Northern Ireland Budget (Anticipation and Adjustments) Act 2018 which received Royal Assent on 28 March 2018. The authorisations, appropriations and limits in these Acts provide the authority for the 2017/18 financial year and a vote on account for the early months of the 2018/19 financial year as if they were Acts of the Northern Ireland Assembly.

While overall a breakeven financial position in the year to 31 March 2018 was achieved, the HSCB is aware of the underlying recurrent deficit position which, coupled with further in-year emergent pressures, ensure that the significant budgetary challenges continue into 2018/19.

The outlook for 2018/19 is indicating the financial year's resources will also be increasingly constrained, both from a capital and revenue perspective. Planning for the 2018/19 year has been on-going for several months at Departmental, HSCB and Trust level and in December 2017 the Department of Finance published a briefing document on the Northern Ireland Budgetary Outlook illustrating the choices that might need to be made to set a budget, and steps that may need to be taken to address the pressures in public services, particularly Health and Education. On 8 March 2018, the Secretary of State for Northern Ireland announced a budget for Northern Ireland.

Given the level of significant and ongoing financial challenges currently faced across HSC, extensive budget planning work is therefore on-going between the Trusts, HSCB and DoH in order to achieve a 2018/19 financial plan. It is anticipated that when the overall financial position is brought together there will remain a significant recurrent and in-year 2018/19 deficit, however the HSCB remains committed to working with the DoH and Trusts in seeking to find solutions to enable it to live within its budget.

Western Trust Financial Support

During 2017/18 financial difficulties within the Western Health and Social Care Trust, seen in previous years, continued. The Trust's final 2017/18 position of financial balance was only achieved through the provision of significant additional non-recurrent financial support. Whilst a number of HSC Trusts have required significant interventions and additional assistance in 2017/18, the level provided to the Western Trust for the fourth consecutive year remains above that provided to other Trusts. The HSCB will continue to work with the Trust and DoH in relation to improving the Trust's financial position and performance.

Business Services Transformation Project/Shared Services (Payroll)

The audit assignment carried out during 2016/17 for 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 limited impact on the HSCB, it was of some concern that progress on issues identified in prior years had not been made. As a result of the 2016/17 Payroll audit, an action plan was developed by BSO to attempt to address the control and system stability issues identified. Internal Audit have provided limited assurance for the 2017/18 audit of Payroll Shared Services. A number of key functions have not yet stabilised and significant control issues remain, including the resolution of known system issues.

Health Visiting

The DoH Healthy Child, Healthy Future (2010-2015) 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, 30% of the CHPP in 2014 were not being delivered. Decrease in CHPP delivery creates risk to children and families from a prevention and early intervention perspective, as well as placing undue pressure on other services such as Primary Care Teams, Paediatrics, Emergency Departments, Allied Health Professionals and Social Services.

Investment has resulted in the regional health visiting workforce increasing from 362.2 WTE to 397.5 WTE resulting in an average WTE caseload of 250 preschool children. The PHA continues to work closely with DoH, HSCB and Trusts to increase health visiting capacity and compliance with the child health promotion programme. Phase 4 Delivery Care (health visiting) has been completed and the proposed workforce model accepted by DoH. Further investment is required.

Regular workforce updates from Trusts continue to be analysed. The funded vacancy rate at 31 January 2018 is 22.28 WTE. All student health visitors graduating at November 2017, available for recruitment, have been provided with permanent contracts. A further 44 students are expected to graduate in October 2017. Due to nursing workforce pressures and demands on the nursing education commissioning budget the number of student health visitors available is less than is needed.

Compliance with the Child Health Programme per Trust and regionally continues to be measured on a three monthly basis using regionally agreed Indicator of Performance tolerances. Improvements have been made in compliance with the earlier contacts (ante-natal to 1 year old) but there remains significant under compliance with the older contacts (2-4 years) with a number of children missing out on consecutive contacts. The PHA continues to work with DoH and Trusts to support compliance with the delivery of the Child Health Promotion Programme.

GP Out of Hours (OOH) Services

The urgent Primary Care service continues to face considerable challenge due to increasing demand. Not all GP Out of Hours (OOH) providers are meeting the Key Performance Indicator (KPI) standards set out in the Service Specification. Concerns

relate to the 20 minute and 1 hour triage targets, particularly during busy times such as weekends and public holidays.

From 1 January 2017 – 31 December 2017, 90% of urgent calls have been responded to within 20 minutes and 75% of routine calls have been responded to within 1 hour. Patient satisfaction remains high.

However, the OOH service remains under considerable strain due to increasing demand and difficulty in filling GP shifts. There is also a general shortage of GPs in Northern Ireland leading to medical workforce recruitment and retention issues.

In addition, HMRC has recently reviewed the employment status of sessional GPs working in OOH and determined that these GPs should be treated as employees and not as self-employed. This determination will impose additional pressures on OOH Providers in terms of retaining the current workforce. There is a risk that some GPs may leave the OOH service, potentially impacting on other unscheduled care services, including NIAS and Emergency Departments. HMRC has given GP OOH Providers a deadline of 1 April 2018 to move their sessional GPs onto the payroll. OOH providers are currently working to put the necessary steps in place to facilitate the transfer of sessional GPs onto the payroll before the 1 April deadline and to minimise, in so far as possible, any knock on effect to other unscheduled care services.

The situation is exacerbated by increasing demands and insufficient numbers of GPs, together with the fact that GPs are not contractually required to work in the OOH service. On occasion OOH bases must be closed when insufficient staff are available. The high demand for the service at peak times, such as weekends and public holidays, coupled with the lack of medical capacity has led to significant delays in some services thereby increasing clinical risk.

A range of actions required to improve the situation has been identified. There is a need to update and agree a regional GP pay structure for OOH provision. A draft Business Case was prepared and submitted to DoH for uplift to the recommended Regional GP OOH rates. The draft Business Case is being revised whilst awaiting the impact of the HMRC determination on the OOH Providers.

Similarly to 2016/17, the HSCB made available a sum of £1.7million in 2017/18 to OOH Providers to enable them to pay an incentive to GPs. The aim was to cover the additional costs associated with working in OOH including indemnity, working unsocial hours and to encourage those GPs working a small number of hours to undertake more OOH hours. Feedback from providers, together with a review of data received to date, suggests that the localised scheme model has been effective.

In 2017/18, the HSCB again made available £500k to fund OOH Local Enhanced Services (LESs) which are currently running in the Western, South Eastern, Southern and Belfast LCG areas. The LES in the Western area continues with 12 practices contracted to provide a total of 250 evening surgeries in the Altnagelvin OOH Centre. A similar scheme is continuing in Limavady until the end of March 2018. Out of Hours LESs are currently running in the Southern, South Eastern and Belfast areas with a view to increasing the level of GP engagement in OOH. Fifteen GPs have signed up to this LES

in the Southern area, whilst 16 GPs and 10 GPs have signed up in the South Eastern and Belfast LCG areas respectively. These enhanced services will be evaluated in terms of numbers of additional GP hours or sessions secured at the end of March 2018 and revised on the basis of outcomes.

A Pharmacy Prescriber Scheme runs in the Southern area and is designed to assist skill mix. This will continue to run in 2018/19.

Finally, the HSCB participated in the review of GP OOH Provision Working Group which was established by the then DHSSPS with a view to examining the current delivery of GP OOH service across Northern Ireland and to identify good practice and opportunities to improve service provision within existing resources. The Working Group launched its report in March 2016 and made 11 recommendations to provide an effective OOH service. The HSCB is working with the DoH Primary Care Directorate on reviewing and updating the recommendations and current timescales. A new timescale is expected to be agreed by 30 June 2018. See also Section 1.2 (Risks) and Section 2.4 (Performance Analysis) of the Annual Report for further information on primary care.

Service and Budget Agreements

Service and Budget Agreements (SBAs) are being prepared for issue to all Trusts in February 2018.

GP Workforce

A shortage of GPs has continued to impact on service delivery including the level of supply of sessional doctors available to provide day time locum sessions in practices and on some practices experiencing difficulties recruiting new partners. GP Out of Hours OOH providers have also reported difficulty filling shifts. There is a considerable risk to ongoing continuity of general medical services provision to patients, particularly in relation to sustaining smaller practices in more isolated locations.

GP training places are funded by DoH through the Northern Ireland Medical and Dental Training Agency (NIMDTA). In response to workforce capacity concerns, the number of WTE training places has been increased from 65 which had been the intake for several years until 2015/16 to 85 in 2016/17, 95 in 2017/18 and with plans to further increase to 111 per year from 2018/19. To date 86 of these posts have been filled and it is anticipated that an additional two recruitment rounds will ensure the full cohort of trainees begin the NI General Practice Specialty Training Programme in February 2019.

To ensure that all residents in Northern Ireland have access to a GP, we worked this year in supporting GP practices with recruitment challenges and encouraged more partnership working with other neighbouring practices. In a move to support retention of qualified GPs, there are 25 GPs included on a 2-year retainer scheme covering 2016/17 and 2017/18. A new cohort of retainer places will be available starting in 2018/19. These GPs are attached to a practice and also commit to a number of Out of Hours sessions.

The HSCB has also sought to mitigate the GP workforce issue at operational level by providing additional funding to general practices to increase staff capacity, such as the

continuing roll out of practice based pharmacist posts. A review of General Practice nursing is ongoing.

Child Sexual Exploitation (CSE)

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

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

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

The HSCB and the PSNI continue to monitor and refine the missing person's guidance and convened a workshop in 2017 as part of the review and learning from existing processes. Data collection systems assist in promoting our understanding and identifying emerging trends and issues.

Voice of Young People in Care (VOYPIC) also continues to engage young people directly to ensure that their views are considered and taken into account.

The DoH has stood down the response team which reviewed the Marshall Action Plan as most of the actions have now been addressed and associated costings where available have been identified. The only outstanding action for HSC is recommendation S6 and draft guidance on Protecting Looked after Children has been forwarded to DoH for approval. The recommendation also requires comment on protecting children with a disability which is being addressed and both elements will be completed by April 2018.

The Safeguarding Board for Northern Ireland (SBNI) reported on its Thematic Review in December 2015 and the HSCB/ Trusts completed a follow up audit in November 2016. The SBNI reviewed both the PSNI and HSC reports and compiled a composite report for consideration by the DoH.

Domiciliary Care/Independent Home Care

Achieving sufficient capacity in terms of workforce levels and volumes of domiciliary care service delivery remains extremely challenging. This is most acutely evidenced at times of seasonal pressures on the health and social care system, in addition to those localised service delivery problems of a more episodic nature.

Trust procurements are likely to have a major impact on the future redesign and delivery of the service. This will need to be monitored during the coming period. The Board is also in the process of developing a future model for domiciliary care that will be sustainable and meet wider strategic objectives.

In order to minimise the risk of non-compliance with the Public Contract Regulations 2015, all DoH ALBs are extending CoPE cover for social and health care services in the Light Touch Regime. This is being taken forward by the ALBs via a formally constituted project, reported to Regional Procurement Board.
The ongoing registration of the social care workforce by the Northern Ireland Social Care Council (NISCC) alongside the Departmental led Domiciliary Care Workforce Review, is aimed at improving the status and support of domiciliary care staff. Providers continue to make representations for enhancements to the hourly rate paid for care with Living Wage considerations and other inflationary cost pressures being to the fore in these discussions. Sector stability is monitored via regular dialogue with Trusts, Providers and via the Community Services workstream of the Regional Reform of Adult Social Care Project. The issue remains on the Corporate Risk Register.

HSCB Business Continuity

In light of the Ministerial announcement to close the HSCB in November 2015, there continues to be a risk to the HSCB's ability to deliver its statutory, mandatory and business planning requirements. A direction of travel has been agreed to give operational effect to the mandate set out by two previous Ministers, and HSCB staff are actively involved in the detailed design and implementation planning of the future operating model, with a focus on ensuring the smooth transition of HSCB functions. See the Chief Executive and Chair's overview and Section 2 (Risks) of the Annual report for further details.

Alongside this, the DoH has commissioned, in line with Orange Book guidance, a *Transition to Closure Risk Assessment* which seeks to identify and assess the potential risks arising from the transition period. HSCB staff are feeding into this assessment, and the outcomes and associated actions arising will require careful consideration.

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

- Chief Executive participation in the Oversight Group set up to provide direction and leadership in relation to the closure of the HSCB.
- HSCB staff participation in development and design of new arrangements.
- Active and ongoing consideration of business priorities within SMT, and with DoH colleagues as issues arise.
- Regular updates to staff when information is available.
- Regular review of key duties as staff leave the HSCB.
- A corporate approach to recruitment, retention and VES.

Other associated issues which have been identified and will require careful management include the potential loss of the HSCB's corporate memory and knowledge during the period of transition. To ensure this risk is appropriately addressed, a number of actions have been identified and included in the Information Governance Action Plan for 2017/18 and are expected to carry forward into the 2018/19 Action Plan.

Prescribing efficiency targets

In 2016/17, a £30m efficiency target was set with £23m to be delivered through primary care. The Primary Care efficiency target was not achieved, resulting in an £11m overspend. Further to the shortfall in delivery of prescribing efficiencies in 2016/17, the target for this area of work increased from £30m to £38m to be delivered across the HSC.

Primary Care prescribing savings were set at £29.5m and plans were developed in order to achieve this ambitious target.

Management within the HSCB worked proactively with the DoH, Trusts and other key stakeholders throughout the year to deliver the challenging target which unfortunately was not delivered in full.

Primary Care prescribing efficiencies of £17m have been delivered, resulting in a shortfall of £12.5m for the year.

Furthermore, in 2017/18 the unprecedented impact of Concessionary Prices on primary care medicine costs has been significant with approximately £18.5m of additional unavoidable costs being incurred by HSC during 2017/18.

Looking ahead to 2018/19, the continuing constraints on the financial resources for Health and Social Care will require further substantial efficiency savings to be delivered from prescribing budgets regionally.

The HSCB will continue to work closely with the DoH, Trusts and other key stakeholders in order to make the most effective use of the available budget without impacting patient care.

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 has removed all supported housing schemes for HSC client groups from their capital development plans for 2017/18 and beyond, unless they already have committed funding. This will limit the capacity of HSC organisations to develop appropriate housing options for vulnerable client groups. It is likely to impact negatively on the ability to discharge people with additional needs from hospital to appropriate community settings, and avoid inappropriate admissions to hospital.

The funding pressures within NIHE and the HSC requirements to adhere to a wider application of formal procurement processes in relation to social care services has potentially detrimental consequences to a number (seven) of schemes previously approved by the Supporting People Commissioning Body. This has required robust discussions involving DoH and Department for Communities (DfC) representatives, legal and procurement advisers as well as HSCB and Trust staff to determine which schemes can be delivered. A number of these are associated with Transforming Your Care strategic change proposals. The impact of not delivering on these objectives has the potential for significant media/public reaction and adverse reputational impact.

In December 2016 FOLD Housing Association successfully sought Judicial Review of the incremental withdrawal of Special Needs Management Allowance (SNMA) by the Department for Communities (DfC) from a number of schemes for frail older people, people with learning disabilities, physical disabilities and mental illness. DfC has indicated that it will embark on an individually targeted review of each facility reducing SNMA as recommended in the Judicial Review determination. This has the potential to create funding pressures and potential sector instability which will need to be jointly managed.

Whilst HSCB has no direct responsibility for commissioning or delivery of supported housing, any destabilisation to current services are likely to impact significantly on vulnerable HSC Programme of Care (PoC) groups who use the services, and HSC Trusts who have a duty of care for them. HSCB will therefore continue to provide support and guidance to NIHE and DfC to implement their reform of the Supporting People Programme and review of their SNMA funding stream, and will continue to support the Trusts in sustaining partnership working with NIHE and planning to mitigate the risks to HSC service users arising from NIHE / DfC actions.

Acute Service Continuity

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

In the development of a proposed model to meet the unscheduled care needs of the Newry and Mourne area the Daisy Hill Pathfinder Group has completed a population health needs assessment for the area. The DoH Transformation Implementation Group (TIG) has subsequently indicated its intention to take forward completion of population health needs assessments across the region as part of the broader considerations on the future of urgent and emergency care.

Lakewood Secure Care Centre

Lakewood had been experiencing challenges in service delivery due to reductions in staff available to fill rotas, largely due to levels of sickness in the core team. The increased reliance on agency staff is not conducive to continuity of care. The HSCB and Trusts worked together to support the facility and recently opened a third unit within Lakewood as part of the planned approach to service development. Staffing within Lakewood has also been addressed and the system is now stabilised. Lakewood also forms part of a review of regional facilities which reported its findings in March 2018. This report has been forwarded to DoH for consideration.

Leases

A business case for the renewal of a lease for office accommodation in County Hall, Ballymena for the period 1 October 2017 to 30 September 2020 was submitted for consideration by the DoH on 20 June 2017. HSCB continued to work with DoH and the Business Case was recommended to the Department of Finance (DoF) for consideration and approval on 7 September 2017. The Departmental Solicitor's Office, advised that

DoF was not prepared to accept the inclusion of a break clause after 2 years as it took the view that, as a 3 year short term letting, a break clause would not be appropriate in this case. DoF approved a holdover of the HSCB lease from 1 October - 31 December 2017 to allow for further negotiations with the landlord in respect of a potential lease forward which included provision for a reduced occupancy with associated costs. The HSCB obtained the agreement of the landlord to reduce occupancy and associated costs from 1 January 2018 and DoF extended the holdover period approval to 28 February 2018 to allow for the resolution of any outstanding issues. The holdover approval for the period 1 October 2017 - 28 February 2018 ensured irregular spend was not incurred whilst the Business Case remained under consideration. On 1 March 2018, DoH advised that DoF had offered an assurance that the Business Case was not considered to be irregular and on 26 March 2018 further confirmation was received that DoF was not seeking an additional request for a holdover. As at mid-May 2018, the Business Case remains under consideration by DoF and DoH is awaiting further advice from DoF in respect of a holdover period.

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

Cyber-security

The eHealth programme, through the HSC Information Security Forum, had commissioned BSO to undertake a cybersecurity scoping review prior to the attack in the NHS (see Section 8 of the Governance Statement for further details). In light of that attack, DoH requested that BSO identify immediate action required, in addition to developing a medium and long term plan for review by the eHealth programme. A Capital Resource Limit of £950,000 was provided in 2017/18 to the BSO to implement urgent actions to mitigate the risk of cyber security threats impacting on HSC services. A risk has been added and updated on the HSCB corporate risk register outlining the response to the threat of cyber-attacks on the HSC network leading to potential loss of access to systems for a sustained period and/or the potential loss of data. A review of existing business continuity plans is underway to ensure they reflect the nature of the potential threat. This includes the review of incident management processes, and the development of additional guidance to ensure clarity on the operation of existing business continuity arrangements in the event of a cyber-attack with potential or actual impact on the HSC.

In January 2018, the Information Security Forum requested that all Trusts and BSO provide an update summarising recently completed and imminently planned cyber security work, with an emphasis on the identification of threats and corresponding action required. Returns received will inform and shape ongoing work for the HSC Cyber Security Programme. Key areas of further work highlighted by Trusts and BSO focus on:

1. Resource and time required to plan for a regional cyber security business continuity exercise.
2. How to address the limited technical ICT staff resources required to address areas of gap/threats identified and deploy Emergency OBC financed products.

3. Requirements and potential costs for a managed Security Information and Event Management (SIEM) service for the entire HSC.
4. Requirements for 24/7 Out of Hours IT support.
5. User awareness and education requirements for cyber security threats.

Integrated Care Partnerships (ICPs)

Work has continued to support Integrated Care Partnerships in 2017/18. The extension of funding for ICP clinical and business support teams and ICP infrastructure has been confirmed until end June 2018. This short term approach and the lack of clarity on available resources has had an impact on the service change transformation which was delivered through ICPs in 2017/18. A revised governance structure continues to be discussed with DoH in light of the planned closure of the HSCB and a proposal paper on the future direction for ICPs was presented to the Transformation Implementation Group (TIG) in January 2018 which continues to be considered.

In the interim, the Director of Integrated Care has continued to provide assurance to SMT on the operation of ICPs. Local Commissioning Groups (LCGs) have continued to hold ICPs to account for any services commissioned in line with the Local Accountability Agreement and quarterly monitoring reports which are submitted to each LCG. The Director of Integrated Care provided an update to the HSCB Audit Committee in January 2018 on progress against the internal audit findings for ICPs. There is no confirmation of resources beyond June 2018.

Instability in Independent Care Home Market

All Nursing Homes and most residential homes are owned and managed by independent providers.

A small but significant number of small businesses are closing due to retirement of the owner/manager. Larger companies continue to seek cost efficiencies and the reduction of costs through consolidation of their estate and withdrawing from areas where profits are deemed to be low or reducing.

Nursing homes in particular are finding it difficult to recruit and retain appropriately qualified staff to deliver the required level of care and leadership within homes. There is an emerging trend of home owners seeking to change their registration status from nursing to residential care in an effort to manage this challenge.

The HSCB continues to:

- Host regular meetings with HSC Trusts to share information and access the state of provision on a regional basis;
- Support HSC Trusts where local contingency plans have to implemented on the occasion of the re-registration or closure of a home and make sure any regional learning is identified and shared;
- Develop a regional process to provide regular updates on bed availability. This includes the testing of a “real time” system to access information from the HSC Trusts; and

- Meet regularly with the independent sector to better understand the pressure affecting the market that could impact on market instability, including sector cost pressures; and
- Monitor any relevant Failure to Comply Notices issued by the regulator, to identify trends and manage risks.

In addition, the PHA has recently commenced a review of nursing levels within independent care homes.

EU Exit

The impact of any changes to regulations as a result of the planned EU exit is not yet known. A key potential negative impact is on the recruitment and retention of staff for whom there is uncertainty regarding their post EU exit legal status pending agreement of EU exit arrangements.

HSCB will work closely with DoH and other HSC bodies to determine potential impacts and to agree requirements for strengthening of business continuity arrangements.
In particular, the HSCB is actively scoping the potential impact of a "no deal" outcome from the UK-EU negotiations on the services it provides, in line with the information provided by the Department. The process will continue to be refined as more clarity emerges on the detail of the final agreement.

Neurology Call Back

Due to concerns being raised in relation to the practice of a consultant neurologist at the Belfast Trust including work he undertook on behalf of other Trusts and in relation to his private practice, the HSCB and PHA have, at the direction of the DoH, established a regional Coordination Group (to include representatives for each of the five Trusts) to co-ordinate the work necessary to complete a call-back review. The HSCB will work closely with the Trusts and independent providers to clarify their assessments of the numbers of past and present patients who may be affected, ensuring that a consistent approach is taken both during the review and reporting of outcomes to enable patients to be assessed and receive appropriate treatment and care where it is required.

The DoH has established an independent inquiry panel to examine how concerns about the clinician were communicated and responded to. The DoH has also directed RQIA to undertake an expert review of the records of deceased patients of the clinician who have died over the past ten years and to include patients who died before this if there is a concern.

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

The call back exercise should be completed by the end of July 2018. The Governance Review and Independent Inquiry are not planned to commence fully until the call back exercise is completed in order to avoid diverting resources away from ensuring the needs of patients are addressed.

11. Conclusion

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

Further to considering the accountability framework within the Body and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the HSCB has operated a sound system of internal governance during the year 2017/18.

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

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

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the HSCB received any other bonus or performance related pay in 2017/18. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

Non-Executive Directors are appointed by the DoH under the Public Appointments process and the duration of such contracts is normally for a term of 4 years initially with a possibility of extension.

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

Early Retirement and Other Compensation Schemes

There was 1 early retirement agreed relating to current or past Senior Executives during 2017/18.

Membership of the Remuneration and Terms of Service Committee:

Dr Ian Clements - Chair
Dr Melissa McCullough – Non-Executive Director
Mr Brendan McKeever – Non-Executive Director (to 31st January 2018)

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

Median Salary (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 2016/17.

	2018	2017
Highest Earner's Total Remuneration (band in £000s)	155-160	155-160
Median Salary (£)	35,224	34,875
Median Total Remuneration Ratio	**4.4**	**4.4**

Senior Employee's Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows (it should be noted that there were no bonuses paid to any Director during 2017/18 or 2016/17):

Non Executive Members (Table Audited)

	2017/18				2016/17			
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*)	30-35	200	-	30-35	30-35	100	-	30-35
Mr Stephen Leach	5-10	-	-	5-10	5-10	-	-	5-10
Dr Melissa McCullough	5-10	-	-	5-10	5-10	-	-	5-10
Mr Robert Gilmore	5-10	100	-	5-10	5-10	-	-	5-10
Mr Brendan McKeever	5-10	100	-	5-10	5-10	-	-	5-10
Mr John Mone	5-10	200	-	5-10	5-10	200	-	5-10
Dr Robert Thompson (Leaver 30/09/17)	0-5	-	-	5-10	5-10	-	-	5-10
Mrs Stephanie Lowry	5-10	-	-	5-10	5-10	-	-	5-10

Note: 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)

	2017/18				2016/17			
Name	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £000s**
Mrs Valerie Watts *Chief Executive*	155-160	100	41,000	195-200	155-160	200	36,000	190-195
Mrs Fionnuala McAndrew *Director of Social Care and Children* *	90-95	200	7,000	95-100	85-90	200	10,000	95-100
Mr Cecil Worthington *Acting Director of Social Care and Children* (Starter 11th Dec 2017) *	25-30 (90-95 FYE)	-	-	25-30	-	-	-	-
Mr Paul Cummings *Director of Finance*	110-115	4,900	19,000	130-135	105-110	2,100	35,000	145-150
Dr Sloan Harper *Director of Integrated Care*	125-130	2,600	40,000	165-170	125-130	300	16,000	140-145
Mr Dean Sullivan *Director of Commissioning* (Leaver 31st Jul 2017) *	35-40 (105-110 FYE)	200	-	35-40	105-110	400	21,000	125-130
Dr Miriam McCarthy *Director of Commissioning* (Starter 11th Dec 2017) *	30-35 (100-105 FYE)	-	-	30-35	-	-	-	-
Mr Michael Bloomfield *Director of Performance and Corporate Services / Deputy Chief Executive*	100-105	200	81,000	180-185	90-95	200	54,000	145-150
Mr Sean Donaghy *Director of eHealth and External Collaboration*	125-130	200	7,000	130-135	125-130	200	18,000	145-150
Ms Louise McMahon *Director*	105-110	-	30,000	140-145	25-30	-	6,000	30-35

* Any absences and gaps in posts being substantively filled have been covered through internal acting arrangements.

FYE – Full Year Equivalent

Pensions of Senior Management – Executive Members (Table Audited)

	2017/18				
Name	**Real increase in pension and related lump sum at age 60 £000s**	**Total accrued pension at age 60 and related lump sum £000s**	**CETV at 31/03/17 £000s**	**CETV at 31/03/18 £000s**	**Real increase in CETV £000s**
Mrs Valerie Watts *Chief Executive* (1)+(3a)	2.5-5 pension	10-15 pension	111	162	46
Mrs Fionnuala McAndrew *Director of Social Care and Children* (2)	0-2.5 pension 2.5-5 lump sum	20-25 pension 70-75 lump sum	-	-	-
Mr Paul Cummings *Director of Finance*	0-2.5 pension 5-7.5 lump sum	45-50 pension 140-145 lump sum	915	984	35
Dr Sloan Harper *Director of Integrated Care* (3b)	2.5-5 pension 7.5-10 lump sum	55-60 pension 170-175 lump sum	1,155	1,254	56
Mr Dean Sullivan *Director of Commissioning* (Leaver 31st Jul 2017) (4)	-	-	-	-	-
Dr Miriam McCarthy *Director of Commissioning* (Starter 11th Dec 2017) (4)	-	-	-	-	-
Mr Michael Bloomfield *Director of Performance and Corporate Services* (3c)	2.5-5 pension 5-7.5 lump sum	40-45 pension 10-15 lump sum	618	707	65
Mr Sean Donaghy *Director of eHealth and External Collaboration* (3d)	0-2.5 pension 2.5-5 lump sum	50-55 pension 150-155 lump sum	1,037	1,100	25
Ms Louise McMahon *Director* (3e)	0-2.5 pension	25-30 pension 25-30 lump sum	306	407	27

Notes

(1) Since 17/10/16 the post holder has also been the Interim Chief Executive of the Public Health Agency and had dual responsibility for the HSCB and the Public Health Agency. All remuneration and pension information has been reported under the substantive post in the HSCB and referenced as such in the PHA report.

(2) CETV calculation not applicable for this post holder.

(3) CETV at 31/03/17 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:
(a) 107 to 111 (b) 1,140 to1,155 (c) 617 to 618 (d) 1,038 to 1,037
(e) 159 to 306

(4) This is an annual calculation so no figures are available for this financial year.

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 decrease due to transfer of pension rights.

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

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

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

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

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase of accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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

Staff Costs Comprise (Table Audited):

	2018			2017
	Permanently employed staff	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	19,945	622	20,567	21,558
Social security costs	2,158	67	2,225	2,292
Other pension costs	3,032	94	3,126	3,207
Total staff costs reported in Statement of Comprehensive Expenditure	**25,135**	**783**	**25,918**	**27,057**
Less recoveries in respect of outward secondments			(411)	(418)
Total net costs			**25,507**	**26,639**

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

Average Number of Persons Employed (Table Audited)

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

	2018			2017
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	466	21	**487**	**512**
Less average staff number relating to capitalised staff costs	-	-	**-**	**-**
Less average staff number in respect of outward secondments	(6)	-	**(6)**	**(7)**
Total net average number of persons employed	**460**	**21**	**481**	**505**

Staff Composition

At 31 March 2018 the HSCB's headcount is 502 employees which equates to 449.16 WTE. Of this figure, 442 are permanent staff members with 60 temporary staff. The ratio of female to male employees is 375 women to 127 men.

There were 77 senior staff who earn over £67k or would earn over £67k if they were 1.00 WTE, of these 35 are women and 42 men.

Reporting of early retirement and other compensation scheme – exit packages (Table Audited)

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2018	**2017**	**2018**	**2017**	**2018**	**2017**
<£10,000	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	1	0	1
£25,001 - £50,000	0	0	0	5	0	5
£50,001 - £100,000	0	0	0	3	0	3
£100,001 - £150,000	0	0	0	1	0	1
£150,001 - £200,000	0	0	0	0	0	0
£200,001 - £250,000	0	0	1	0	0	0
Total number of exit packages by type	**0**	**0**	**1**	**10**	**1**	**10**
Total resource cost £000s	**£0**	**£0**	**£222**	**£593**	**£222**	**£593**

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 Act 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 2017/18 or 2016/17.

HSCB Management Costs

	2018	2017
	£000s	£000s
HSCB management costs	29,481	30,815
Income:		
RRL	4,800,366	4,574,708
Less non cash RRL excluding element to cover clinical negligence provision	(10,446)	(3,059)
Income per Note 4	55,090	53,446
Less interest receivable	0	0
Total Income	**4,845,010**	**4,625,095**
% of total income	**0.61%**	**0.67%**

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 2017/18 there were no early retirements from the HSCB agreed on the grounds of ill-health.

Sickness Absence Data

The corporate cumulative annual absence level for the HSCB for the period from 1 April 2017 – 31 March 2018 is 3.67% (2016/17 3.27%).

There were 32,625 hours lost due to sickness absence (2016/17 30,872 hours), or the equivalent of 65.0 hours (2016/17 58.9 hours) lost per employee. Based on a 7.5 hour working day, this is equal to 8.67 days (2016/17 7.85 days) per employee.

Staff Policies Applied During the Financial Year

The Board is committed to promoting equality of opportunity and good relations for all groups under Section 75 of the Northern Ireland Act and Equality of Opportunity Policy. In respect of recruitment, the introduction of Shared Services enabling online recruitment continues to be embedded and the process updated as required within the HSCB and other HSC organisations. A number of HR policies have been updated and 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. It is anticipated that training in respect of updated policies and especially in respect of Attendance Management for HSCB staff will be rolled out during 2018/19. In addition, this year has

also seen the introduction of a Gender Identity Policy to support staff in the workplace. This is currently going through the required approval processes prior to implementation.

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

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

Expenditure on Consultancy

The HSCB had no expenditure on consultancy projects during 2017/18. However, notification was received that there was an external consultancy project approved by DoH at the end of 2016/17 for External Assurance of the Electronic Health and Care Record Programme which should have been classified as consultancy. The expenditure in 2016/17 was therefore £67k, rather than nil as previously reported.

Off-Payroll Engagements

The HSCB is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed with a total cost of over £58,200 during the financial year, which were not paid through the HSCB Payroll. In 2017/18 there were no such 'off-payroll' engagements (2016/17 – none).

Funding Report

Regularity of Expenditure

The Board 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 are self-assessed in controls assurance standards. During 2017/18 there has been no evidence of irregular expenditure.

Losses and Special Payments

Type of loss and special payment		2017/18		2016/17
		Number of Cases	£	£
Administrative write-offs				
	Bad Debts	-	-	139
Cash losses				
	Cash Losses – Overpayments of salaries, wages and allowances	1	284	-
Special Payments				
	Compensation payments:			
	- Clinical Negligence	10	236,750	3,113,846
	- Employers Liability	5	28,025	11,511
TOTAL		**16**	**265,059**	**3,125,496**

Special Payments

There were no other special payments or gifts made during the year (2016/17 – none).

Other Payments and Estimates

There were no other payments made during the year (2016/17 – none).

Estimate of Patient Exemption Fraud and Error

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

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

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

3. To estimate the total annual loss due to patient exemption fraud and error 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. This year a methodological change has been incorporated into the calculation: 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.

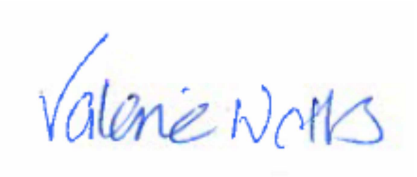
The best estimate available for patient exemption fraud in 2017/18 is £3.6m (£2.8m Dental, £0.8m Ophthalmic). The combined estimate for 2016/17 was £3.5m. However, retrospectively applying the new methodology to exclude the discontinued cases would lead to a revised combined estimate of £3.3m for 2016/17. If the revised figures for 2016/17 were then uplifted to 2017/18 activity levels, the estimated combined figure remains at £3.3m.

Losses and Special Payments over £250,000

Losses and Special Payments over £250,000	**Number of Cases**	**2017/18 £**	**2016/17 £**
Special Payments			
Prior year total (2 cases)	-	-	2,777,596
TOTAL	**-**	**-**	**2,777,596**

Remote Contingent Liabilities

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 21 of the Annual Accounts, 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 2018, the Board is not aware of any remote contingent liabilities.



Mrs Valerie Watts

Chief Executive

Date: 14 June 2018

Glossary of Terms

ALB – Arm's Length Body

BSO – Business Services Organisation

Chronic conditions – illnesses such as diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

CoPE – Centre of Procurement Expertise

DoH – Department of Health

ED – Emergency Department

E-Health and Social Care – the use of information and communication technologies (ICT) for health.

Elective Care - care that is planned, for example, when a patient has an appointment for an operation or procedure or just to see a specialist as an out-patient

Evidence based commissioning – the provision of health and social care services based upon proven evidence of their value.

GP – General Practitioner

Health inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

HRPTS – Human Resources, Payroll, Travel and Subsistence

HSC – Health and Social Care

Integrated Care Partnerships (ICPs) – collaborative network of health and social care professionals, community and voluntary sector, users and carers, working as part of a multidisciplinary team to provide and support a more complete range of services.

Local Commissioning Groups (LCGs) – Committees of the Health and Social Care Board that are comprised of GPs, professional health and social care staff such as dentists and social workers and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at a local level.

Locum doctors – doctors whose work is based upon short term or temporary contracts.

Managed clinical networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff.

National Institute for Clinical Excellence (NICE) – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

NIAS – Northern Ireland Ambulance Service

NIASP - Northern Ireland Adult Safeguarding Partnership

NISAT - Northern Ireland Single Assessment Tool

OFMDFM - Office of the First Minister and Deputy First Minister

Palliative care – services for people who are terminally ill and who suffer from conditions such as advanced cancer.

PHA – Public Health Agency

PPI – Patient and public involvement

Primary care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use health and social services.

Reablement – programme of support to assist people in getting back to independent living.

RQIA - Regulation and Quality Improvement Authority

Quality Outcomes Framework – a system under which the effectiveness of schemes and measures to improve health is measured against a set of agreed targets.

S6 – a recommendation in the Marshall Implementation Plan: Tackling Child Sexual Exploitation in Northern Ireland, for which the HSCB is responsible.

Trusts – organisations that directly provide care to patients and clients through such facilities as hospitals and social services centres.

Unscheduled Care - any unplanned contact with the health or social services such as urgent care and emergency care.

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

Opinion on financial statements

I certify that I have audited the financial statements of the Health and Social Care Board for the year ended 31 March 2018 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. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion the financial statements:

- give a true and fair view of the state of the Health and Social Care Board's affairs as at 31 March 2018 and of the Health and Social Care Board's net expenditure for the year then ended; and

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

Opinion on regularity

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

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate. My staff and I are independent of the Health and Social Care Board in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2016, and have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Other Information

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

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

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

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

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

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

I am required to obtain evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

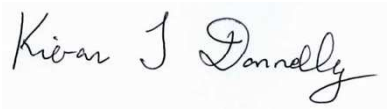
Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.



KJ Donnelly

Comptroller and Auditor General

Northern Ireland Audit Office

106 University Street

Belfast

BT7 1EU

19 June 2018

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2018

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

FOREWORD

These accounts for the year ended 31 March 2018 have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 91 to 122) which I am required to prepare on behalf of the Health and Social Care Board have been compiled from, and are in accordance with, the accounts and financial records maintained by the Health and Social Care Board and with the accounting standards and policies for HSC bodies approved by the DoH.

Paul Cummings

Director of Finance

Date 14 June 2018

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 91 to 122) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Ian Clements

Chairman

Date 14 June 2018

Valerie Watts

Chief Executive

Date 14 June 2018

HEALTH and SOCIAL CARE BOARD

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2018

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.

		2018	2017
Income	**NOTE**	**£000**	**£000**
Income from activities	4.1	53,884	52,230
Other income (excluding interest)	4.2	1,189	1,209
Deferred income	4.3	0	0
Total operating income		55,073	53,439
Expenditure			
Staff costs		(25,918)	(27,057)
Purchase of goods and services	3	(1,007,097)	(979,885)
Depreciation, amortisation and impairment charges	3	(2,345)	(2,516)
Provision expense	3	(8,035)	(360)
Other expenditures	3	(20,186)	(19,903)
Total operating expenditure		(1,063,580)	(1,029,721)
Net Expenditure		**(1,008,508)**	**(976,282)**
Finance income	4.2	17	7
Finance expense	3	0	0
Net expenditure for the year		(1,008,490)	(976,275)
Revenue Resource Limits (RRLs) and capital grants issued (to)			
Belfast Health & Social Care Trust		(1,278,726)	(1,225,599)
South Eastern Health & Social Care Trust		(586,620)	(554,899)
Southern Health & Social Care Trust		(593,818)	(561,431)
Northern Health & Social Care Trust		(669,550)	(628,827)
Western Health & Social Care Trust		(591,259)	(560,107)
NIAS Health & Social Care Trust		(69,904)	(65,891)
NI Medical & Dental Training Agency		(1,646)	(1,531)
Patient and Client Council		(5)	(5)
Total RRL issued		(3,791,528)	(3,598,290)
Total Commissioner resources utilised		(4,800,019)	(4,574,565)
Revenue Resource Limit (RRL) received from DoH	24.1	4,800,366	4,574,708
Surplus / (Deficit) against RRL		**347**	**143**

OTHER COMPREHENSIVE EXPENDITURE		2018	2017
	NOTE	**£000**	**£000**
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	225	196
Net gain/(loss) on revaluation of intangibles	6.1/8/6.2/8	8	20
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(1,008,258)**	**(976,059)**

The notes on pages 95 to 122 form part of these accounts.

HEALTH and SOCIAL CARE BOARD

STATEMENT of FINANCIAL POSITION as at 31 March 2018

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	2018 £000	£000	2017 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	14,998		14,659	
Intangible assets	6.1/6.2	1,979		1,355	
Financial assets	7	787		866	
Total Non Current Assets			17,764		16,880
Current Assets					
Trade and other receivables	12	4,993		4,454	
Other current assets	12	49		3	
Financial assets	7	111		110	
Cash and cash equivalents	11	5,479		1,041	
Total Current Assets			10,632		5,608
Total Assets			**28,396**		**22,488**
Current Liabilities					
Trade and other payables	13	(156,127)		(145,388)	
Provisions	15	(5,633)		(5,277)	
Total Current Liabilities			(161,760)		(150,665)
Total assets less current liabilities			**(133,364)**		**(128,177)**
Non Current Liabilities					
Provisions	15	(37,812)		(32,485)	
Total Non Current Liabilities			(37,812)		(32,485)
Total assets less total liabilities			**(171,176)**		**(160,662)**
Taxpayers' Equity and other reserves					
Revaluation reserve		8,606		8,373	
SoCNE reserve		(179,782)		(169,035)	
Total equity			**(171,176)**		**(160,662)**

The financial statements on pages 91 to 122 were approved by the Board on 14 June 2018 and were signed on its behalf by:

Signed  (Chairman) Date 14 June 2018

Signed  (Chief Executive) Date 14 June 2018

HEALTH and SOCIAL CARE BOARD

STATEMENT of CASH FLOWS for the year ended 31 March 2018

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	2018 £000	2017 £000
Cash flows from operating activities			
Net surplus after interest/Net operating expenditure	SoCNE	(1,008,490)	(976,275)
Adjustments for non cash transactions	3	10,446	3,059
(Increase)/decrease in trade and other receivables	12	(585)	1,686
Increase/(decrease) in trade payables	13	10,740	(17,647)
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	(259)	(71)
Movements in payables relating to the purchase of intangibles	13	102	595
Use of provisions	15	(2,352)	(4,840)
Net cash outflow from operating activities		(990,399)	(993,493)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(1,845)	(1,614)
(Purchase of intangible assets)	6	(1,123)	(767)
(FTC loans issued to GPs)	7	0	(750)
FTC loans returned by GPs	7	113	43
Net cash outflow from investing activities		(2,855)	(3,088)
Cash flows from financing activities			
Grant in aid		997,692	987,527
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net financing		997,692	987,527
Net increase (decrease) in cash & cash equivalents in the period		4,438	(9,054)
Cash & cash equivalents at the beginning of the period	11	1,041	10,095
Cash & cash equivalents at the end of the period	11	**5,479**	**1,041**

The notes on pages 95 to 122 form part of these accounts.

HEALTH and SOCIAL CARE BOARD

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2018

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) and the Revaluation Reserve (i.e. reflecting 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 2016		**(180,339)**	**8,157**	**(172,182)**
Changes in Taxpayers' Equity 2016/17				
Grant from DoH		987,527	0	987,527
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(976,275)	216	(976,059)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	52	0	52
Balance at 31 March 2017		**(169,035)**	**8,373**	**(160,662)**
Changes in Taxpayers' Equity 2017/18				
Grant from DoH		997,692	0	997,692
Other reserves movements including transfers		0	0	0
(Comprehensive expenditure for the year)		(1,008,490)	233	(1,008,258)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	52	0	52
Balance at 31 March 2018		**(179,782)**	**8,606**	**(171,176)**

The notes on pages 95 to 122 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

These accounts 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 follow International Financial Reporting Standards (IFRS) to the extent that it is meaningful and appropriate to the Health and Social Care Board (HSCB). Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the HSCB for the purpose of giving a true and fair view has been selected. The HSCB's accounting policies 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.

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 (Statement of Asset Valuation Practice) Appraisal and Valuation Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 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. The HSCB had no AUC in either 2017/18 or 2016/17.

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 2017/18 or 2016/17.

1.9 Inventories

The HSCB had no inventories as at 31 March 2018 or 31 March 2017.

1.10 Income

Operating Income relates directly to the operating activities of the HSCB and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

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 2017/18 or 2016/17.

1.12 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.

1.13 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.

1.14 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.

<u>The HSCB as lessee</u>

The HSCB held no finance or operating leases during 2017/18 or 2016/17.

<u>The HSCB as lessor</u>

The HSCB did not have any lessor agreements in either 2017/18 or 2016/17.

1.15 Private Finance Initiative (PFI) transactions

The HSCB had no PFI transactions during 2017/18 or 2016/17.

1.16 Financial instruments

- Financial assets

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

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

- Financial liabilities

The HSCB had no financial liabilities in 2017/18 or 2016/17.

- 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.

1.17 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 using Department of Finance issued discount rates of -2.42% (1-5 years), -1.85% (5-10 years), -1.56% (>10 years), or 1.37% in the case of injury benefit cases, in real terms.

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.

1.18 Contingencies

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.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 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 2018. Untaken flexi leave is estimated to be immaterial to the HSCB and has not been included.

Retirement benefit costs

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

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2016 valuation for the HSC Pension Scheme updated to reflect current financial conditions (and a change in financial assumption methodology) will be used in 2017/18 HSC Pension Scheme accounts.

1.20 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.

1.21 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.

1.22 Third party assets

The HSCB had no third party assets in 2017/18 or 2016/17.

1.23 Government Grants

The HSCB had no government grants in 2017/18 or 2016/17.

1.24 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.

1.25 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.

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.

1.26 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2018. Due to changes in the template, there have been amendments to the layout and display of some figures.

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

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**	**2018 £000**	**2017 £000**
Commissioning	2.1	3,860,234	3,660,935
FHS	2.2	884,334	864,802
Board Administration	2.3	55,451	48,828
Total Commissioner Resources utilised		**4,800,019**	**4,574,565**

2.1 Commissioning

Expenditure	**NOTE**	**2018 £000**	**2017 £000**
Belfast Health & Social Care Trust		1,278,726	1,225,599
South Eastern Health & Social Care Trust		586,620	554,899
Southern Health & Social Care Trust		593,818	561,431
Northern Health & Social Care Trust		669,550	628,827
Western Health & Social Care Trust		591,259	560,107
NIAS Health & Social Care Trust		69,904	65,891
NI Medical & Dental Training Agency		1,646	1,531
Patient and Client Council		5	5
Other Providers	3.1	95,150	88,254
		3,886,678	3,686,544
Income			
Income from activities	4.1	26,444	25,609
Commissioning Net Expenditure		**3,860,234**	**3,660,935**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

		2018	2017
Expenditure	**NOTE**	**£000**	**£000**
General Medical Services	3.1	265,356	256,653
General Dental Services	3.1	131,269	131,033
General Pharmaceutical Services	3.1	491,331	480,286
General Ophthalmic Services	3.1	23,818	23,451
		911,774	891,423
Income			
FHS receipts & recovery of charges	4.1	27,440	26,621
FHS Net Expenditure		**884,334**	**864,802**

2.3 Board Administration

		2018	2017
Expenditure	**NOTE**	**£000**	**£000**
Salaries and wages	3.2	25,717	27,057
Operating expenditure	3.2	20,228	19,928
Non-cash costs	3.3	8,065	543
Depreciation	3.3	2,381	2,516
		56,391	50,044
Income			
Staff secondment recoveries	4.2	412	418
Operating income	4.2	777	791
FTC interest	4.2	17	7
		1,206	1,216
Dementia Project (Capital Grant)			
Expenditure			
Salaries and wages	3.2	201	0
Operating expenditure	3.2	65	0
		266	0
Board Administration Net Expenditure		**55,451**	**48,828**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 3 - EXPENDITURE

3.1 Commissioning:	**2018**	**2017**
	£000	**£000**
General Medical Services	265,356	256,653
General Dental Services	131,269	131,033
General Pharmaceutical Services	491,331	480,286
General Ophthalmic Services	23,818	23,451
NHS Trusts	37,917	27,432
Other providers of healthcare and personal social services	57,233	60,348
Capital grants (Brightstart)	0	474
Total Commissioning	1,006,924	979,677
3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	20,567	21,558
Social security costs	2,225	2,292
Other pension costs	3,126	3,207
Supplies and services - general	173	208
Establishment	18,729	18,171
Transport	11	11
Premises	1,380	1,538
Bad debts	0	0
Total Operating Expenses	46,211	46,985
3.3 Non cash items:		
Depreciation	1,976	2,110
Amortisation	405	406
Impairments/reversal of impairments relating to FTC	(36)	121
(Profit) on disposal of property, plant & equipment (excluding profit on land)	0	0
Loss on disposal of property, plant & equipment (including land)	14	10
Increase / Decrease in provisions (provision provided for in year less any release)	8,740	737
Cost of borrowing of provisions (unwinding of discount on provisions)	(705)	(377)
Auditors remuneration	52	52
Total non cash items	10,446	3,059
Total	**1,063,581**	**1,029,721**

[1] Further detailed analysis of staff costs is located in the Staff Report on page 74 within the Accountability Report.

NOTE 4 - INCOME

4.1 Income from Activities	**2018**	**2017**
	£000	**£000**
Income from Department of Education	25,296	24,735
Co-operation & Working Together (CAWT)	252	294
Family Health Services Receipts	27,440	26,621
Other income	896	580
Total	**53,884**	**52,230**

4.2 Other Operating Income	**2018**	**2017**
	£000	**£000**
Accommodation	603	604
Canteen	174	187
Seconded Staff	412	418
FTC interest receivable	17	7
Total	**1,206**	**1,216**

4.3 Deferred income	**2018**	**2017**
	£000	**£000**
Income released from conditional grants	0	0
Total	**0**	**0**

TOTAL INCOME	**55,090**	**53,446**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 5.1 - Property, plant & equipment - year ended 31 March 2018

	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 2017	3,250	7,121	6	17,079	164	27,620
Indexation	163	65	0	18	0	246
Additions	0	306	0	1,798	0	2,104
Transfers	0	0	0	0	0	0
Disposals	0	0	0	(1,714)	0	(1,714)
At 31 March 2018	**3,413**	**7,492**	**6**	**17,181**	**164**	**28,256**
Depreciation						
At 1 April 2017	0	668	6	12,123	164	12,961
Indexation	0	15	0	6	0	21
Disposals	0	0	0	(1,700)	0	(1,700)
Provided during the year	0	271	0	1,705	0	1,976
At 31 March 2018	**0**	**954**	**6**	**12,134**	**164**	**13,258**
Carrying Amount						
At 31 March 2018	**3,413**	**6,538**	**0**	**5,047**	**0**	**14,998**
At 31 March 2017	**3,250**	**6,453**	**0**	**4,956**	**0**	**14,659**
Asset financing						
Owned	3,413	6,538	0	5,047	0	14,998
Carrying Amount						
At 31 March 2018	**3,413**	**6,538**	**0**	**5,047**	**0**	**14,998**

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 (2017 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2017 - £nil).

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 5.2 - Property, plant & equipment - year ended 31 March 2017

	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 2016	3,097	6,934	6	16,530	164	26,731
Indexation	153	16	0	37	0	206
Additions	0	171	0	1,514	0	1,685
Transfers	0	0	0	0	0	0
Disposals	0	0	0	(1,002)	0	(1,002)
At 31 March 2017	**3,250**	**7,121**	**6**	**17,079**	**164**	**27,620**
Depreciation						
At 1 April 2016	0	354	6	11,310	164	11,834
Indexation	0	3	0	7	0	10
Disposals	0	0	0	(993)	0	(993)
Provided during the year	0	311	0	1,799	0	2,110
At 31 March 2017	**0**	**668**	**6**	**12,123**	**164**	**12,961**
Carrying Amount						
At 31 March 2017	**3,250**	**6,453**	**0**	**4,956**	**0**	**14,659**
At 1 April 2016	**3,097**	**6,580**	**0**	**5,220**	**0**	**14,897**
Asset financing						
Owned	3,250	6,453	0	4,956	0	14,659
Carrying Amount						
At 31 March 2017	**3,250**	**6,453**	**0**	**4,956**	**0**	**14,659**
Asset financing						
Owned	3,097	6,580	0	5,220	0	14,897
Carrying Amount						
At 1 April 2016	**3,097**	**6,580**	**0**	**5,220**	**0**	**14,897**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 6.1 - Intangible assets - year ended 31 March 2018

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2017	1,584	4,932	6,516
Indexation	0	11	11
Additions	642	379	1,021
At 31 March 2018	**2,226**	**5,322**	**7,548**
Amortisation			
At 1 April 2017	1,334	3,827	5,161
Indexation	0	3	3
Provided during the year	93	312	405
At 31 March 2018	**1,427**	**4,142**	**5,569**
Carrying Amount			
At 31 March 2018	**799**	**1,180**	**1,979**
At 31 March 2017	**250**	**1,105**	**1,355**
Asset financing			
Owned	799	1,180	1,979
Carrying Amount			
At 31 March 2018	**799**	**1,180**	**1,979**

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 (2017 - £nil).

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 6.2 - Intangible assets - year ended 31 March 2017

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2016	1,428	4,893	6,321
Indexation	0	23	23
Additions	156	16	172
At 31 March 2017	**1,584**	**4,932**	**6,516**
Amortisation			
At 1 April 2016	1,233	3,519	4,752
Indexation	0	3	3
Provided during the year	101	305	406
At 31 March 2017	**1,334**	**3,827**	**5,161**
Carrying Amount			
At 31 March 2017	**250**	**1,105**	**1,355**
At 1 April 2016	**195**	**1,374**	**1,569**
Asset financing			
Owned	250	1,105	1,355
Carrying Amount			
At 31 March 2017	**250**	**1,105**	**1,355**
Asset financing			
Owned	195	1,374	1,569
Carrying Amount			
At 1 April 2016	**195**	**1,374**	**1,569**

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 then to undertake premises developments and improvements for health and social care purposes. The first two loans were issued in 2015/16, with a 3rd loan issued in 2016/17 as shown in the note below.

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

	2018 Assets £000	2017 Assets £000
Balance at 1 April	975	389
Additions	0	750
Settlement	(113)	(43)
Impairments	(181)	(121)
Reversal of impairments	217	0
Balance at 31 March	**898**	**975**

Analysis of expected timing of discounted flows

	2018 Assets £000	2017 Assets £000
Not later than one year	111	109
Later than one year and not later than five years	421	415
Later than five years	366	451
	898	**975**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 8 - IMPAIRMENTS

	2018 Financial Assets £000	2017 Financial Assets £000
Total value of impairment/reversal of impairment for the period	(36)	121
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	(36)	**121**

The HSCB had no other impairments in 2017/18 in relation to Property, Plant & Equipment or intangible assets.

NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

The HSCB did not hold any assets classified as held for sale in 2017/18 or 2016/17.

NOTE 10 - INVENTORIES

The HSCB did not hold any inventories as at 31 March 2018 or 31 March 2017.

NOTE 11 - CASH AND CASH EQUIVALENTS

	2018 £000	2017 £000
Balance at 1st April	1,041	10,095
Net change in cash and cash equivalents	4,438	(9,054)
Balance at 31st March	**5,479**	**1,041**

	2018 £000	2017 £000
The following balances at 31 March were held at		
Commercial banks and cash in hand	5,479	1,041
Balance at 31st March	**5,479**	**1,041**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2018 £000	2017 £000
Amounts falling due within one year		
Trade receivables	4,028	3,628
VAT receivable	763	646
Other receivables - not relating to fixed assets	202	180
Trade and other receivables	**4,993**	**4,454**
Prepayments	49	3
Accrued Income	0	0
Other current assets	**49**	**3**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
Prepayments and accrued income		
Other current assets falling due after more than one year	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**4,993**	**4,454**
TOTAL OTHER CURRENT ASSETS	**49**	**3**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**5,042**	**4,457**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 13 - TRADE PAYABLES, FINANCIAL AND OTHER LIABILITIES

	2018 £000	2017 £000
Amounts falling due within one year		
Trade capital payables - property, plant and equipment	671	412
Trade capital payables - intangibles	18	120
Trade revenue payables	44,507	41,167
Payroll payables	1,202	629
Clinical negligence payables	670	228
BSO payables	7,962	9,379
Other payables	3,116	2,289
Accruals	97,822	91,049
Deferred income	159	113
Trade and other payables	**156,127**	**145,386**
Total payables falling due within one year	**156,127**	**145,386**
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**156,127**	**145,386**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 14 - PROMPT PAYMENT POLICY

14.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that HSCB pay their non HSC trade creditors 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:

	2018 Number	2018 Value £000	2017 Number	2017 Value £000
Total bills paid	20,776	92,501	19,701	126,401
Total bills paid within 30 day target or under agreed payment terms	19,234	88,048	17,796	119,193
% of bills paid within 30 day target or under agreed payment terms	**92.6%**	**95.2%**	**90.3%**	**94.3%**
Total bills paid within 10 day target	15,359	76,018	14,410	107,055
% of bills paid within 10 day target	**73.9%**	**82.2%**	**73.1%**	**84.7%**

14.2 The Late Payment of Commercial Debts Regulations 2002

The HSCB did not pay any compensation or interest for payments made late to date in 2017/18 (2016/17 £nil).

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2018

	Clinical negligence £000	Other £000	2018 £000
Balance at 1 April 2017	26,451	11,311	37,762
Provided in year	8,947	342	9,289
(Provisions not required written back)	(323)	(226)	(549)
(Provisions utilised in the year)	(1,604)	(748)	(2,352)
Cost of borrowing (unwinding of discount)	(714)	9	(705)
At 31 March 2018	**32,757**	**10,688**	**43,445**

Comprehensive Net Expenditure Account charges	2018 £000	2017 £000
Arising during the year	9,289	4,833
Reversed unused	(549)	(4,096)
Cost of borrowing (unwinding of discount)	(705)	(377)
Total charge within Operating expenses	**8,035**	**360**

Analysis of expected timing of discounted flows

	Clinical negligence £000	Other £000	2018 £000
Not later than one year	4,435	1,198	5,633
Later than one year and not later than five years	4,291	2,683	6,974
Later than five years	24,031	6,807	30,838
At 31 March 2018	**32,757**	**10,688**	**43,445**

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

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2017

	Clinical negligence	Other	2017
	£000	£000	£000
Balance at 1 April 2016	32,117	10,125	42,242
Provided in year	3,211	1,622	4,833
(Provisions not required written back)	(4,032)	(64)	(4,096)
(Provisions utilised in the year)	(4,347)	(493)	(4,840)
Cost of borrowing (unwinding of discount)	(498)	121	(377)
At 31 March 2017	**26,451**	**11,311**	**37,762**

Analysis of expected timing of discounted flows

	Clinical negligence	Other	2017
	£000	£000	£000
Not later than one year	4,335	942	5,277
Later than one year and not later than five years	3,806	1,797	5,603
Later than five years	18,310	8,572	26,882
At 31 March 2017	**26,451**	**11,311**	**37,762**

NOTE 16 - CAPITAL COMMITMENTS

The HSCB did not have any capital commitments as at 31 March 2018 or 31 March 2017.

NOTE 17 - COMMITMENTS UNDER LEASES

17.1 Finance Leases

The HSCB had no finance leases in 2017/18 or 2016/17.

17.2 Operating Leases

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

	2018 £000	2017 £000
Obligations under operating leases comprise - Buildings		
Not later than 1 year	101	62
Later than 1 year and not later than 5 years	152	0
Later than 5 year	0	0
	253	62

17.3 Commitments under Lessor Agreements

The HSCB had no lessor obligations in either 2017/18 or 2016/17.

NOTE 18 - COMMITMENTS UNDER PFI CONTRACTS AND OTHER SERVICE CONCESSION ARRANGEMENTS

The HSCB had no commitments under PFI or service concession arrangements in either 2017/18 or 2016/17.

NOTE 19 - OTHER FINANCIAL COMMITMENTS

The HSCB did not have any other financial commitments at either 31 March 2018 or 31 March 2017.

NOTE 20 - FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which the HSCB is funded, financial instruments play a more limited role within the HSCB in creating risk than would apply to a non public sector body of a similar size, therefore the HSCB is not exposed to the degree of financial risk faced by business entities. The HSCB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the HSCB in undertaking activities. Therefore the HSCB is exposed to little credit, liquidity or market risk.

For disclosures relating to HSCB financial instruments in existence at 31 March 2018, please refer to Note 7.

NOTE 21 - CONTINGENT LIABILITIES

Clinical negligence

The HSCB has contingent liabilities of £159k.

	2018	2017
	£000	£000
Total estimate of contingent clinical negligence liabilities	139	348
Amount recoverable through non cash RRL	(139)	(348)
Net Contingent Liability	**0**	**0**

In addition to the above contingent liability, provision for clinical negligence is given in Note 15. 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:	2018	2017
	£000	£000
Employers' liability	20	9
Amount recoverable through non cash RRL	(20)	(9)
Total	**0**	**0**

A new discount rate which courts must consider when awarding compensation for future financial losses in the form of a lump sum in personal injury cases came into effect in England and Wales in March 2017. The Department of Justice has power to prescribe the discount rate for Northern Ireland (in consultation with the Government Actuary and Department of Finance). The discount rate has been under active consideration by the Department but any change requires secondary legislation and has not been taken forward in the absence of a Minister. As such, it has not been possible at this time to quantify the potential impact on the Health and Social Care Board of any change in the discount rate.

NOTE 22 - 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.

Mrs Fionnuala McAndrew (Director of Social Care and Children) is a member of the Board of Directors of the registered charity Children in Northern Ireland (CiNI), which may be likely to do business with the HSCB in future.

Mr Danny Power (Interim Chair of Belfast Local Commissioning Group) is a member of the Board of Directors of Clan Mor Surestart and the West Belfast Partnership Board , which may be likely to do business with the HSCB in future.

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

NOTE 23 - THIRD PARTY ASSETS

The HSCB had no third party assets in 2017/18 or 2016/17.

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 24 - FINANCIAL PERFORMANCE TARGETS

24.1 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:

	2018 Total £000	2017 Total £000
DoH (excludes non cash)	4,789,642	4,571,175
Non cash RRL (from DoH)	10,446	3,059
Adjustment for CRL grants received	278	474
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**4,800,366**	**4,574,708**

24.2 Capital Resource Limit

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

	2018 Total £000	2017 Total £000
Gross capital expenditure by HSCB	3,125	1,858
FTC issued to third parties	0	750
(FTC received from third parties)	(113)	(43)
Net capital expenditure	3,012	2,565
Capital Resource Limit	3,013	2,565
Overspend/(Underspend) against CRL	**(1)**	**0**

24.3 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.

	2017/18 £000	2016/17 £000
Net Expenditure	(4,800,019)	(4,574,565)
RRL	4,800,366	4,574,708
Surplus / (Deficit) against RRL	347	143
Break Even cumulative position(opening)	8,528	8,385
Break Even cumulative position (closing)	**8,875**	**8,528**

Materiality Test:	2017/18 %	2016/17 %
Break Even in year position as % of RRL	0.01%	0.00%
Break Even cumulative position as % of RRL	0.18%	0.19%

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.

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2018

NOTE 25 - 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 19 June 2018.