

**HEALTH AND SOCIAL CARE BOARD**

**ANNUAL REPORT & ACCOUNTS**

**FOR THE YEAR ENDED 31 MARCH 2016**

**HEALTH AND SOCIAL CARE BOARD**

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*Laid before the Northern Ireland Assembly under Schedule 1, Para 17(5) of the Reform Act for the Regional Agency, by the Department of Health, Social Services and Public Safety.*

*On 30 June 2016*

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# **HEALTH AND SOCIAL CARE BOARD**

## **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

### **Chairman's Overview**

2015/16 has seen unprecedented challenges across Health and Social Care as we continue to operate under a climate of increasing pressure on resources.

The Annual Report of the Health and Social Care Board for 2015/16 highlights key achievements and the hard work behind the scenes to progress reform across Health and Social Care in Northern Ireland despite these difficult circumstances. The Board is committed to ensuring that the patient, service user and their family are at the centre of all health care decision making.

Key highlights this year include over £10m of targeted investments by the Belfast Local Commissioning Group to support the opening of a new state of the art Emergency Department at the Royal Victoria Hospital. This investment increased the number of Emergency Department staff and incorporated a range of improvements including a minor injuries service provided by specialist nursing staff for 12 hours every day, and an acute care at home team, which enables patients to be treated at home without the need to attend hospital. The benefit of these investments was evident in the improved flow through the Royal Victoria's Emergency Department during the winter months of 2015 /16 when pressures are usually greatest.

Integrated Care Partnerships (ICPs), a Transforming Your Care initiative, implemented a range of service changes to deliver more joined up and community based care for older people and those with long term conditions. This included Acute Care at Home services in several localities across the region which provide assessment, treatment and care for frail older people in their own home without the need for admission to hospital. Work is continuing to evaluate these services and to ensure coverage across the whole of Northern Ireland.

ICPs play a pivotal role in delivering change by bringing together doctors, nurses, pharmacists, social workers, hospital specialists, paramedics, the community and voluntary sector along with local councils and service users and carers to reconfigure and co-ordinate local health and social care services to benefit patients and service users.

Within Social Care, the Reablement Service which helps to reduce hospital attendances, readmissions and to facilitate quicker discharge is now operating across all five Health and Social Care Trusts in Northern Ireland. The service has supported almost 3,800 people to live independently in their own home.

Self Directed Support, another new initiative for people who traditionally receive social care support is being rolled out across Northern Ireland. Self Directed Support promotes independence by offering more flexibility in how social care services are provided, enabling people to take more control over decisions which affect their lives.

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The Board continues to work in partnership with those who use Health and Social Care services, carers and third sector representative groups to ensure services, policies and guidelines reflect the needs of the population of Northern Ireland.

In November 2015, the Minister for Health, Social Services and Public Safety announced the outcome of a Health Review which included wide ranging reforms and the closure of the Board. It is envisaged that the design phase, planning and start of the legislative process for these reforms will take place during 2016/17, with implementation in 2017/18 and expected completion in 2018/19. I want to take this opportunity to acknowledge the hard work of the Board staff who have continued to produce their best in the face of much uncertainty and under challenging circumstances.

We look forward to being fully involved in the next steps of the review so that the essential work currently carried out by the Board in planning health and social care services for the population of Northern Ireland can continue to be delivered and developed.



**Dr Ian Clements**  
**Chairman**

Date 9 June 2016



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### **PERFORMANCE REPORT**

#### **Chief Executive's Message – Preparing for Change**

2015/16 has seen a number of major developments and improvements to support the health and wellbeing of the population of Northern Ireland. The following report gives a flavour and aims to highlight the breadth of the Board's work across primary, community and acute care, and also highlights the challenges and opportunities that lie ahead.

However, 2015/16 also signalled a new direction for both our work and our staff through a proposed restructuring of the current shape of Health and Social Care. The Board and its staff are committed to achieving a world class Health and Social Care (HSC) service with the patient and service user at its heart, and to ensuring the best possible health and social outcomes for the population of Northern Ireland. We look forward to working with the Department of Health, Social Services and Public Safety and with Health and Social Care Trusts towards designing improved arrangements building on the strengths of the current system.

2015 saw the official opening of new Health and Care Centres in Banbridge and Ballymena as part of the Board's Primary Care Infrastructure Development Programme. These new healthcare hubs are enabling diagnostic, primary and community care services to be provided in a more integrated manner, closer to home and at the heart of the community for those using these services.

We were also delighted to announce the new Health+Pharmacy accreditation. Pharmacies with the Health+Pharmacy accreditation will work with their local communities to offer advice and services on improving health and wellbeing. This can take place within and outside the pharmacy, for example in local schools and community groups, to offer advice on issues such as obesity and better nutrition or signposting those in need to local services that can provide support.

We continue to work with the Department of Health, Social Services and Public Safety and Trusts to ensure safe, appropriate and quality care across our hospital Emergency Departments and that those patients who need to use our urgent care services are seen in as timely a manner as possible. New regional and local Unscheduled Care Structures, underpinned by clinical and professional leadership, were put in place to give a renewed focus to the planning, reform and delivery of emergency care services. The Board also invested £10m to fund additional staff in the new Emergency Department at the Royal Victoria Hospital which opened in 2015.

Our Choose Well public information campaign aimed at promoting and encouraging appropriate use of urgent healthcare services continued to run during the winter months across a wide range of channels including TV, radio, press and outdoor advertising. The campaign was further strengthened with a number of new campaign materials, including, a new radio advert, animations, videos, infographics, newspaper articles and new posters.

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Increasing demand and the challenges of the wider financial position have meant that elective waiting times have continued to increase during 2015/16. The additional allocation of £40m announced by the Minister in November 2015 was therefore very welcome. The Board led the co-ordination of the use of this funding with Trusts, resulting in over 60,000 patients benefiting who would otherwise be waiting for assessment, diagnostics, treatment and other services.

The Board's Specialist Services Commissioning Team has continued to drive forward improvements in patient outcomes. The diagnosis and management of neuromuscular conditions have continued to improve, increasing life span so that patients who had previously survived only into childhood are now becoming adults. During the year, the Board identified additional resources which have been invested to ensure that care pathways are in place to support the seamless transition of young people living with neuromuscular conditions from paediatric to adult neuromuscular services.

The Board also worked with BHSCT to develop a dedicated 10 bed high dependency level unit for the management and treatment of patients with intestinal failure. This will support improvements in the patient outcomes as evidenced in national frameworks.

The rate of living donor kidney transplants in NI continues to be the highest in the UK. The transplant programme has continued to be more successful than originally anticipated.

Emotional and mental health wellbeing continues to be a key priority. During the year, the Board completed a fundamental review of the Mental Health and Wellbeing Service Framework. The Board also developed a new regional guide for the delivery of mental health psychological care and provided funding for an additional 50 staff in specialist psychological interventions; redesigned and developed a new mental health assessment and personal wellbeing pathway; as well as enabling the further roll out of psychological therapy hubs across primary care.

The Board has continued to support young people leaving care. This year showed continued growth and investment in the Going the Extra Mile (GEM) Scheme with 265 young people continuing to live in safety and with stability with their former foster carers.

The Board was also delighted to jointly commission the opening of a new project supporting vulnerable young people in Enniskillen with the NI Housing Executive. This new initiative will provide 13 bed spaces for care leavers and young people who are homeless.

During the year, we continued to see the growing use of technology to improve patient and client care. eHealth has enabled remarkable improvements in the delivery of health and social care in Northern Ireland through better integration and coordination across the health and social care system, ultimately benefitting service users and carers.

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However, the above developments have only been possible to achieve through the continued professionalism, dedication and commitment of our staff. On behalf of myself, the Chair and the Board, I would sincerely like to express our deep appreciation and gratitude to all our staff. Finally, I commend this Annual Report for 2015/16 to you.



**Valerie Watts**  
**Chief Executive**

Date 9 June 2016

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **The role of the Health and Social Care Board**

The Health and Social Care Board (Board) 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 Health and Social Care Board is broadly contained in three functions:

1. To arrange or 'commission' a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland.
2. To performance manage Health and Social Care Trusts that directly provide services to people and support service improvements in pursuit of optimal quality and value for money, in line with relevant government targets.
3. To effectively deploy and manage its annual funding from the Northern Ireland Executive – currently around £4.4 billion – to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

The Board is accountable to the Health Minister for translating his 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 Board 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, or in hospital deliver what is expected of them.

Each year the Board is required by statute to prepare and publish a Commissioning Plan setting out the range of services to be commissioned and the associated costs of delivering these. The Board prepares the annual Commissioning Plan in partnership with the Public Health Agency (PHA) and publishes it on the website [www.hscboard.hscni.net](http://www.hscboard.hscni.net).

The Board and PHA take forward the regional commissioning agenda through a series of integrated service teams. The Board's commissioning processes are underpinned by the five Local Commissioning Groups which are committees of the 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 Local Commissioning Groups 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 Board has genuine sensitivity and influence at a local level.

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All of the service teams responsible for commissioning services are comprised of Board and PHA staff, demonstrating the common agenda shared by both organisations and the close working with one another. The PHA is also represented on each of the five Local Commissioning Groups.

The Board also commissions services from voluntary and community organisations. This feeds directly into local economies and is responsive to local demands. The Board is also exploring opportunities to procure provision from Social Enterprises and to encourage and build social capital through community development opportunities. These approaches are underpinned by effective stakeholder engagement and Personal and Public Involvement. The Board is committed to embedding Personal and Public Involvement into its culture and practice. It is currently implementing a joint Health and Social Care Board and PHA Personal and Public Involvement strategy (available online at [www.hscboard.hscni.net/publications](http://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.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **OVERVIEW OF ORGANISATIONAL PERFORMANCE**

In 2015/16, the Health and Social Care Board received funding of £4.4bn from the Department of Health, Social Services and Public Safety (DHSSPS). In addition to this, the Board also received income from other sources which amounted to £52m for delivery of services such as Early Years Children's Services and Family Health Service receipts for dental and ophthalmic services.

The funds received are used by the Board to commission a wide range of health and social care services for the population of Northern Ireland from the five HSC Trusts, Family Health Service Practitioners, NI Ambulance Services (NIAS) and third sector Community and Voluntary organisations as well as the running costs of the Board.

The Board's overarching aims, as outlined in the Corporate Plan are:

- to ensure high quality, safe, accessible and integrated health and social care services, and performance manage delivery to achieve quality outcomes;
- to improve the health and social wellbeing of the population of NI with a focus on prevention and health inequalities, promoting equality, human rights and diversity in all the HSCB's functions;
- provide value for money through the effective use of resources ensuring robust financial management;
- effectively engage with key stakeholders in an open and transparent manner, particularly service users and carers, benefiting from their personal experiences; and
- maintain and develop effective internal systems and processes and maximise the potential of our staff by ensuring that they are skilled, motivated and valued.

In recent years, despite austerity and the associated financial constraints, the Health and Social Care (HSC) sector in Northern Ireland has continued to respond effectively to the challenge of an ageing population with increasingly complex health and social care needs. At the same time, new technologies, drugs and treatments have been implemented which have improved both life expectancy and quality of life for many in our local population.

Key highlights in 2015/16 for the Board include:

#### **Unscheduled Care**

- More than £10m investment by Belfast Local Commissioning Group to support the opening of the new Emergency Department at the Royal Victoria Hospital and related unscheduled care services. This increased staff by 52 nurses, 11 medical staff and included service improvements such as a Clinical Assessment Unit, an Ambulatory Care Centre and a Minor Injuries stream.
- Roll out of Acute Care at Home schemes in Belfast and Southern Trusts, providing rapid response to support GPs in managing acutely-ill frail older people at home; and either avoiding an admission to hospital or facilitating an early discharge.

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- New regional and local Unscheduled Care Structures, underpinned by clinical and professional leadership, were put in place to give a renewed focus to the planning, reform and delivery of emergency care services.
- The annual Choose Well Public Awareness Campaign to support measures in unscheduled care during the busy winter period and to raise public awareness of all available Health service touch points including pharmacies, GPs and Minor Injury Units.

#### **Elective Care**

- Strong performance against the target to deliver a minimum of 80 kidney transplants. The rate of living donor kidney transplants in Northern Ireland continues to be the highest in the United Kingdom;
- Improved performance against the Ministerial standard to ensure that 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures;
- Strong performance of 98% of patients diagnosed with cancer receiving their first definitive treatment within 31 days of a decision to treat;
- Worked with specialists in BHSCT to develop a dedicated 10 bed high dependency unit for the management and treatment of patients with Intestinal Failure;
- Established a fully representative NI Chronic Pain Forum with partners to identify priority needs for the development of pain services in NI. Key areas of focus include reducing inequities, development of flexible and responsive models of care and strengthening service user and care engagement through increased opportunities for self-management; and
- Oversight of the allocation of additional funding for elective care from November 2015 monitoring round to maximise the benefit for patients and ensure greatest impact on waiting times.

#### **Integrated Care**

- Invested an additional £4.3m to meet service pressures, greatest over public holidays, in GP Out Of Hours;
- Established pharmacists within GP practices to work alongside GP teams and support optimum care for patients;
- Received award of funding of €3m from the EU for the development of innovative solutions to support those recovering from stroke, and a programme developing additional eHealth supports for frail older people;
- Piloted an oral health improvement scheme for elderly patients living in nursing or residential homes with the Western HSC Trust Community Dental Service (CDS) team; and
- Supported the development and opening of two new health centres in Banbridge and Ballymena in 2016 through the Primary Care Infrastructure Development programme.

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#### **Social Care**

- Extended Psychological Therapy Hubs in primary care across all of the BHSCT area and piloted two sites in the other 4 Trusts;
- Commenced a fundamental review of Autism Services with a view to remodelling referral assessment, diagnostic, and intervention services;
- Undertook a review of Dementia Services and developed a new stepped care model design to enable people with dementia to live well, supported by purposeful and meaningful follow on care; and
- Established a new Gender Identity Service for Children and Young People.

#### **Financial overview**

Since its inception, the Board has sought to balance 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 financial statements presented in this Annual Report and Accounts highlight a surplus of £0.6m for the Board.

#### **Expenditure**

Total expenditure in 2015/16 was £4.4bn – an increase in cash terms of 5% over the previous financial year, 2014/15.

In 2015/16, the Board spent £0.9bn on Family Health Services to meet the health and social care needs of local populations. This covers services provided by GPs, dental, pharmaceutical and ophthalmic providers.

The Board commissions most of its services from local Trusts with a small amount being delivered by other providers. The breakdown of spending in 2015/16 with the five Health Trusts was £3.4bn and a further £0.1bn with community and voluntary agencies and other providers of health and social care services.

#### **Efficiencies Delivered**

During the financial year, the Board delivered a plan to create efficiencies of £5.4m (15%) which was retracted recurrently from the management and administration budget by the DHSSPS at the start of 2015/16. The delivery of this plan necessitated a moratorium on staffing, combined with severe controls on all aspects of our goods and services and the implementation of a Voluntary Exit Scheme.



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#### **KEY ISSUES AND RISK**

During 2015/16, the Health and Social Care Board continued to drive forward improved outcomes for patients and service users in line with Departmental direction and reflected in its Commissioning Plan 2015/16. The plan, developed in partnership with the Public Health Agency outlines the key priorities and investments for the forthcoming financial year.

The Board remains committed to driving forward reform to create a modern 'patient centred' system that is able to respond to increasing demand whilst ensuring the best and effective use of resources for the NI population, Health and Social Care in Northern Ireland continues to face significant challenges. These include:

#### **Aging demographic**

A growing and older population is a positive celebration of the success of our health and social care system. However, an ageing population with complex health and care needs brings increased demands on services and combined with advances in medicine and technology, increased expectations and finite resources, are placing significant rising demands on services and allocated resources.

Meeting the needs of a growing older population, many of whom have a number of complex and chronic conditions has been a key focus for the Board in 2015/16. This has led to increased need for personal care to support individuals when they leave hospital and to live as independent lives as possible in their own homes. It has also led to the refocus of services from acute into primary care in order to provide support in a local community setting rather than in a traditional hospital setting. The Board continues to prioritise improvements in the coordination of care between multiple providers of health and social care in the community to support older people.

#### **New drugs and technologies**

Medical advances including new drugs and treatments are transforming the lives of many people. The implementation of National Institute for Health and Care Excellence (NICE) guidance remains a priority for the Board going forward, however there is increasing pressure on the available funding for new drugs and treatments as growth in existing therapies continues to increase each year. The Board will continue to review the available funding on an on-going basis against the context of other competing financial pressures.

#### **Financial pressures**

The Board has operational responsibility to ensure the overall financial stability of the Health and Social Care (HSC) system within Northern Ireland including the Trusts and the Public Health Agency (PHA). In 2015/16 significant financial constraints required rigorous planning, monitoring, management and decision making in conjunction with the DHSSPS with respect to the budget.

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This ultimately meant the development of a revised financial plan during the year in order to maintain the quality of services required, to manage the increased demand and corresponding financial pressures being experienced by Trusts.

Throughout the year, the Board worked closely and proactively with all Health Trusts and the DHSSPS in order to address the on-going severe financial challenges faced by the system.

However, demographic changes, an increase in the number of people with long-term complex conditions and the challenging budgetary climate has highlighted capacity gaps in the system which in turn, has led to increased waiting times across a number of specialities and services in 2015/16 which will continue into 2016/17. These pressures have been identified within the 2016/17 HSC Financial Plan and will require careful financial management, including delivery of significant efficiencies in 2016/17.

#### **Reform and Business**

The DHSSPS recently completed a consultation on the future remodelling of Health and Social Care structures including the proposed closure of the Board.

A Programme Board has been set up to take forward the design, development and implementation of the best model for efficient and effective planning, commissioning and performance management of HSC services in the future. Part of this work will address how and where the current roles and functions undertaken by the Board will be discharged in future.

The Board welcomes the opportunity of working with the DHSSPS, the Public Health Agency and with Health and Social Care Trusts towards designing improved arrangements which build on the strengths of the current system.

An Expert Panel, chaired by Professor Rafael Bengoa, has also been set up to look at how health and social care services in Northern Ireland should be re-configured and develop a clinically informed model for future service delivery. The Board will be contributing to the programme of work being led by the Expert Panel.

Together, the work of the Programme Board and Expert Panel will inform the future shape of NI Health and Social Care.

#### **Voluntary Early Severance Scheme**

As part of the HSC Reforms, a Voluntary Early Severance (VES) Scheme was in place during 2015/16 and it is anticipated that there will be a further Scheme in 2016/17. This will result in a loss of skills and experience and a key challenge for the Board in the next financial year will be to refocus the organisation's priorities in order to maximise resource flexibility to deliver a robust health and care commissioning service for Northern Ireland.

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#### **Resettlement of Syrian Refugees**

The HSCB has led a group to ensure an effective response to the resettlement of refugees from Syria under the Government scheme. Two groups of refugees have arrived and all necessary arrangements were successfully put in place for them to access health and social care services, both within the Welcome Centre and in their final locality. It is evident that the health and care needs within the second group of families were more significant and it is likely that this will be the pattern in subsequent groups. As a result, individual needs will require access to a wider range of services in the longer term with increased cost and demand on these, including trauma related services which we expect to be required.

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#### **OUTLOOK FOR 2016/17**

The outlook for 2016/17 continues to be challenging with financial pressure experienced in previous years continuing to grow and outstrip additional available funding. In order to address these challenges (a growing older population, increasing demands and patient expectations, new medical advances and treatments), the Board recognises the need to reshape how health and social care services are delivered to ensure that care and support is provided for those patients and clients most in need, and are delivered efficiently and effectively in line with best available evidence.

The only way to have sustainable, safe and high quality services is to transform how we plan and deliver our care, reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer to home and the promotion of early intervention, prevention and greater choice and independence.

The Board has been working with health and social care professionals, voluntary, community group and patient and client groups to develop new ways of working, for example, the development of new patient pathways through Integrated Care Partnerships and Local Commissioning Groups.

The Board will also be contributing to the work of the Ministerial Programme Board which is looking at the design, development and implementation of the best model for efficient and effective planning, commissioning and performance management of HSC services in the future.

The Board will continue to support the DHSSPS and Health and Social Care organisations during 2016/17 to deliver further substantial and challenging efficiency and productivity savings, in order for the available resources to be utilised as effectively as possible.

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#### **PERFORMANCE ANALYSIS - DIRECTORS' REPORTS**

##### **REPORT OF THE DIRECTOR OF COMMISSIONING**

The role of the Directorate of Commissioning is to consider the needs of the entire population of Northern Ireland and to plan and arrange for health and social care services to meet those needs. It includes the Local Commissioning Groups which, as committees of the Board, ensure that services which are commissioned at a local level are sensitive to the needs of social and community issues, and are influenced by the involvement of both professional practitioners and local representatives.

##### **KEY PERFORMANCE HIGHLIGHTS**

In 2015/16, the Commissioning function of the Board has worked to reform and modernise services to ensure individuals are able to access services in a timely and appropriate manner within a climate of reduced budgets; rising patient demand; development of new and expensive drugs, and technologies that are changing the way services are delivered.

##### **Regional Commissioning**

*Services for people with Multiple Sclerosis (MS)* - the development of a service specification aimed at securing a consistent approach to the delivery of services for patients with MS irrespective of where they live in Northern Ireland will be taken forward by a newly established regional stakeholders group. This will aim to link the provision of services across primary, community and secondary care with community and voluntary organisations.

Progress to date has included securing local access to the provision of some specialist drug therapies, provision of phlebotomy services for MS patients in Primary Care and securing funding to increase the number of patients able to benefit from specialist drugs therapies recently approved by NICE and securing funding to take forward a project to develop a regional MS nursing network.

*All-island Congenital Heart Disease Network Board* - an all-island Congenital Heart Disease Network Board has been established and has met monthly since April 2015. Interim arrangements remain in place, through Service Level Agreements, for children from Northern Ireland to access surgery and cardiac catheterisation in the most appropriate location to meet their clinical needs. For most children requiring cardiac catheterisation diagnosis or treatment, this is now provided in Dublin through a collaborative approach involving Northern Ireland clinicians.

The Network Board is in the process of agreeing a Business Case which will enable progress to be made on taking forward the investment in capacity in Dublin to allow children from NI requiring cardiac surgery or cardiac catheterisation to access this on the island.

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#### Specialist Services Commissioning

**Rare Diseases** - the team welcomed the publication of the NI Rare Disease Implementation Plan in October 2015 to address the needs of people living with rare disease.

The team has continued to work with other nations through membership of the UK Rare Disease Advisory Group (RDAG) to commission highly specialised services as well as develop care pathways and service specifications to support referrals to highly specialised centres.

**Genetics** - the team worked with the BHSCT to:

- ensure access for patients and their families to UKGTN approved diagnostic tests for a range of genetic disorders; and
- the development of a service specification for medical genetics.

The team worked with a range of stakeholders to develop service specifications for paediatric and adult cystic fibrosis services. The specifications set out the core elements of the service and the standards by which cystic fibrosis services should be provided.

**Kidney Transplants** - the rate of living donor kidney transplants in Northern Ireland continues to be the highest in the United Kingdom. The transplant programme has continued to be more successful than we had originally anticipated, the take on rate of new end stage kidney disease patients has stayed fairly stable and home treatments have risen. This has resulted in reduction in hospital haemodialysis patient numbers.

**Neuromuscular** - the team has identified additional resources in 2015/16 and asked the BHSCT to bring forward proposals to ensure that care pathways are in place to support the seamless transition of young people living with neuromuscular conditions from paediatric to adult neuromuscular services. Over the last number of years, the diagnosis and management of neuromuscular conditions have improved, increasing life-spans so that patients who had previously survived only into childhood are now becoming adults.

**22q11.2 Deletion Syndrome** - the team has identified additional resources in 2015/16 to support the coordination of care for people living with this condition. This will support timely diagnosis and on-going care. People living with 22q will see a range of hospital specialists including foetal medicine, neonatology, paediatrics, cardiology, cardiothoracic surgery, immunology, plastic surgery, endocrinology, clinical genetics and psychiatry. Patients will also be seen by their GP and may be referred to a speech and language therapist.

**In-reach Services** - the team has established 'in-reach services' with Alder Hey Children's Hospital including:

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- the assessment of children with muscle tone problems involving local orthopaedic surgeons and therapists working as part of a multidisciplinary team with a neurosurgeon and therapists from Alder Hey; and
- Craniofacial assessment involving a local neurosurgeon as part of a multidisciplinary team with a specialist plastic surgeon and clinical nurse specialist from Alder Hey.

*Regional Intestinal Failure Service* - the team has worked with specialists in the BHSCT to develop a dedicated 10 bedded high dependency level unit for the management and treatment of patients with Intestinal Failure. This will support improvements in the outcome of patients with complex intestinal failure as evidenced in national frameworks. Intestinal failure is a condition where there is loss of nutrient absorption through the gut as a result of disease, infection, trauma or congenital defect. Treatment involves sophisticated abdominal surgery and complex management of nutritional needs over months, and in some cases, years.

### **CLINICAL GUIDANCE**

During 2015/16, the Board has continued to ensure timely access to NICE approved therapies for a range of conditions including biologic therapies for rheumatoid arthritis, psoriasis and inflammatory bowel disease, specialist ophthalmology conditions, cancer, hepatitis C and multiple sclerosis.

In particular, progress has been made for patients with chronic hepatitis C to get newly approved therapies treatment. The Board has worked with clinical colleagues in the BHSCT to start this treatment and this initiative will continue into 2016/17. The primary goal of chronic hepatitis C treatment is to cure the infection by eradicating the hepatitis C virus. The eradication of the virus is of significant benefit to each individual treated by halting their progression to serious liver disease and also to the population by reducing the prevalent pool of infection.

The Board is also responsible for the oversight and management of the implementation process for Clinical Guidelines. Work continues to support Trusts to implement Clinical Guidance, significant progress has been made in relation to guidance on colorectal cancer, organ donation, peritoneal dialysis and the management of chronic hepatitis B in children and young people.

During 2015/16, work has been on-going to fully establish the process for the introduction of Public Health Guidance. The Board has worked with colleagues within the PHA, Trusts and DHSSPS to revise the current process to ensure that guidance is applied in a more appropriate fashion, as Public Health Guidance can be wide ranging and contain recommendations which are not Trust specific.

### **CONTRACTS**

In line with the broader policy of using collaborative procurement as a means of obtaining greater efficiency in public sector contracts, Regional Commissioning engaged with the NI Civil Service and other government agencies to award a travel agency services contract. The Travel Agent services are used to facilitate patient and staff travel outside Northern Ireland. This collaborative

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approach reduces costs of procurement, obtains best pricing through competition and reduces transaction costs for all parties.

National Contact Points were set up for each UK territory to ensure the right access to healthcare advice is available depending on which part of the UK you are visiting or travelling from. Regional Commissioning is the National Contact Point for Northern Ireland and has published detailed advice on the Board website for patients travelling outside Northern Ireland for treatment. Regional Commissioning assisted the procurement of additional cardiac surgery services to meet the demand in Northern Ireland for this key service.

## **NETWORKS**

### **Critical Care Network (CANNI)**

CANNI continues to provide support to the Board by monitoring data relating to critical care bed activity and availability, providing early warning of capacity issues and advice on critical care services. The network also works in partnership with the Public Health Agency to monitor seasonal flu cases within critical care.

In 2015/16, CANNI continued to facilitate the processing of extra contractual funding requests for critical care patients, reviewing and developing the plan for the Adult Critical Care Transfer Service.

### **Pathology**

The NI Pathology Network (the Network) has developed a set of proposals for Pathology Service modernisation, including Pathology ICT modernisation, which will be published for consultation in 2016. Pathology modernisation proposals will create a single management structure for HSC Pathology services, enabling responsive, rapid decision making. It is expected to facilitate wider clinical transformation through the provision of robust, sustainable pathology diagnostics into the future.

In 2015/16, the Network:

- coordinated with the PHA Research & Development on two successful bids to establishment the NI Genomic Medicine Centre, securing total investment of £3.3m;
- assisted the successful regional bid to host a centre of excellence for the UK Precision Medicine Catapult;
- secured significant bridging funding for 24/7 laboratory services in all Trusts until implementation of modernisation; and
- secured agreement for the introduction of a regional primary care Laboratory Ordercomms system. The Board e-Health directorate will establish a project to bring this forward in 2016/17.



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#### **Neonatal Network NI (NNNI)**

In 2015/16, the Neonatal Network NI (NNNI) were able to secure recurrent investment to support the development of Allied Health Professional services in the Trusts' neonatal services to provide specialist support for children with significant disability and complex health care needs. Investment was also secured to augment nursing and medical staffing to the regional neonatal unit and capacity management across the region.

Key priorities for NNNI in 2015/16 were to achieve consistency and improvements to services supporting the neonatal care pathway and parental experience across the region. Highlights include:

1. Adapting and implementing NICE Guidance on early onset of Sepsis in Neonatal settings. Regional implementation of guidance is currently being audited by the network for compliance and consistency.
2. Developing a regional NNNI Policy for Testing and Isolation to Prevent Infection (TIPI) in Neonatal Units – this includes guides to staff and parents on testing for MRSA and Pseudomonas.
3. Developing a regional NNNI Guidance for the Prescription of Antimicrobials for neonates through engagement with professionals from neonatology, paediatrics, pharmacy, microbiology and infectious disease.
4. Developing a regional guideline on the management of women at risk of delivering extreme premature babies and transfer procedures. This guidance includes a parental information leaflet to support communication and decision making for parents.

## **PARTNERSHIPS**

### **Cooperation and Working Together (CAWT)**

An independent evaluation of the €30 million 'Putting Patients, Clients and Families First' cross border programme which benefited over 53,000 people, highlighted the CAWT Partnership's success in mainstreaming EU funded projects. Over 80% of services were mainstreamed or converted to core services as of April 2015, more than double the beneficiary target set by the Special EU Programmes Body. Approximately 166 health service staff from across the border region of Ireland and Northern Ireland came together to plan and manage formal cross border activity under the programme. A further 50 community and voluntary organisations were key partners in the planning and implementation of these projects.

Achievements of the CAWT cross border health partnership during 2015/16 include co-ordinating the first all-island guide to empower frontline workers to support children and young people affected by parental problems with alcohol and other drug use.

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CAWT's continued to support cross border emergency planning training by holding an Advanced Trauma Life Support course for medical and nursing personnel.

The CAWT Development Centre and the National Transplant Society organised an all-island transplant conference in Belfast, bringing together some of the most renowned global professionals from the USA, Northern Ireland, UK and Ireland in the field of transplantation.

### **LOCAL COMMISSIONING GROUPS (LCGs)**

#### **Belfast Local Commissioning Group**

The Belfast LCG area has an older population profile compared to other areas of Northern Ireland. The projected breakdown of the Belfast population from 2012 to 2027 indicates that the largest increases will be in the numbers of children and older people, groups with greater health needs than other age groups. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for health and social care. The extent of deprivation in Belfast council area is also greater than in any other local government district in Northern Ireland, with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The areas of deprivation within the Belfast area tends to be concentrated in north and west Belfast but there are also significant areas of deprivation in south and east Belfast. People living in more deprived areas tend to have greater health needs than those in less deprived areas.

Key highlights in 2015/16 include:

- over £10m targeted investments to support the opening of the new Emergency Department at the Royal Victoria Hospital and related unscheduled care services;
- investment in an Acute Care at Home scheme providing rapid response to support GPs in managing acutely-ill, frail older people at home, helping to avoid hospital admissions;
- a £1m investment to commission a dedicated paediatric MRI scanner at Royal Belfast Hospital for Sick Children allowing up to 2,500 children a year receiving their scan in a child-friendly environment;
- commissioning of a comprehensive stroke pathway to ensure access to specialist assessment within 24 hours for those at risk of a stroke; and
- commissioning of a proactive diabetes service model promoting early detection, prevention and self-care to reduce complications and avoid the need to use hospital services where appropriate.

#### **Northern Local Commissioning Group**

The Northern LCG is responsible for 466,724 people, or about 26% of the total population of Northern Ireland. It also has the highest numbers of people aged over 65 and 85 years, with further increases in these age groups projected over the next 5 to 10 years. This will have significant implications for health care as the shape and structure of health services will need to change to meet

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the needs of this growing group. The Northern LCG population also experiences a greater prevalence of cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

Key highlights in 2015/16 include:

- investment in extra capacity to provide an Out Of Hours Stroke rota within the Northern Trust;
- commissioned the diagnostic and treatment aspects for a sleep apnoea pathway. Investment has been provided to enable all patients to receive treatment in the Northern Trust, with no patients referred to BHSC with a suspected sleep disorder from July 2015; and
- Causeway Hospital pilot for Dermatology Photo Triage Pathway, allowing GP practices to refer patients with suspected malignant melanoma or squamous cell carcinoma (MM/SCC) to a dedicated photographic clinic, where patients are offered an appointment within two weeks of the initial referral. Approximately half of all dermatology referrals are for the diagnosis and management of skin cancer.

#### Southern Local Commissioning Group

The Southern LCG currently has a population of 365,712, representing 20% of the overall Northern Ireland population. 14% of the population are aged 65 years or older and like other parts of Northern Ireland, this demographic is projected to grow over the next five to ten years, requiring further investment in services such as the *Acute Care at Home* model and District Nursing. The Southern LCG has also seen large increases in immigration since July 2004 and accounts for some of the highest numbers of migrants in Northern Ireland.

Key highlights in 2015/16 include:

- extension of the *Acute Care at Home* service into Banbridge, Armagh and Dungannon. The team have been operational in the Craigavon district since September 2014 and have managed to assess and treat more than 770 older people with complex healthcare needs in their own home, either avoiding an admission to hospital or facilitating an early discharge;
- piloted the *Rapid Access Respiratory Service* over the winter months in 2015/16. Referred by local GP practices, the team provides early treatment for people with respiratory conditions, where possible avoiding the need for hospital admission;
- investment to support a fourth weekly breast clinic and two additional breast family history clinics each month. This will provide slots for an additional 974 new appointments and an additional 311 review appointments; and
- investment to support a second MRI Scanner at Craigavon Area Hospital to support demand for services, provide additional capacity and back up in the event of breakdown. This will enable an additional 15,550 patients to be scanned in 2016/17.

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#### **Western Local Commissioning Group**

The Western LCG is responsible for planning and commissioning health services for almost 300,000 people. Although the older people population is lower proportionately than the Northern Ireland average, the Western area is projected to see the greatest increase in people aged 65 years or older in the next ten years, a 40.1% increase compared to 29.7% for Northern Ireland. In 2013, about a quarter (25.3%) of the population of the Western area was considered to be living in deprivation. However, despite this, the western population showed better health outcomes than the Northern Ireland average, apart from for respiratory conditions such as asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerably worse, particularly due to anxiety and depression. There is also higher rate of children in need.

Although elective care waiting times remain challenging in the West and vacancies among medical staff persist, Western Trust largely has continued to deliver agreed volumes. The Urology service has supported urgent patients from the Causeway area in advance of plans to consolidate the service for these patients through Western Trust. Diagnostics delivery remains high performing and the Trust has sustained effective implementation of Primary Percutaneous Coronary Intervention.

Key highlights in 2015/16 include:

- social prescribing to overcome isolation among older people;
- compassionate Communities, which involves volunteers which support palliative care patients and initiation of the Altnagelvin Cardiac Assessment Unit, with direct access for patients with chest pain to cardiac care;
- introduction of Primary Care Talking Therapies enabling GPs to refer patients with anxiety and stress to local counselling services provided by voluntary organisations;
- completion of the Altnagelvin Radiotherapy Unit, Macmillan information and support hub and opening of the new Omagh Local Enhanced Hospital; and
- commissioned a step change in unscheduled care at Altnagelvin Hospital to improve patient flow in Emergency Department, supported by additional investment in domiciliary care to support timely discharge.

#### **South Eastern Local Commissioning Group**

The population of the South Eastern LCG is almost 350,000. Since 2001, the population in the South East has increased by 8.5% in total however, the percentage increase in the 85+ age band is significantly lower in the south east (38.4%) compared to Northern Ireland (41.9%). In 2013, 10% of the population living within the South Eastern LCG area were living within the most deprived of the Northern Ireland deprivation quintiles and there is a higher prevalence of heart disease, stroke, hypertension, asthma and diabetes in the south east compared to the regional average.

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Key highlights in 2015/16 include:

- investment in an *Early Supported Discharge* model for stroke victims and improved auditing for stroke across the south east;
- invested in the development of a *Mental Health and Wellbeing Hub* to offer therapies at earlier stages of people experiencing anxiety, depression and other mental health issues; and
- additional investment to enable the roll out of the *Primary Care Asymptomatic Sexual Transmitted Infection [STI] Initiative* to the Ards and Down localities. This service is the first of its kind in Northern Ireland and won the 2015 National GP award for Sexual Health.

Health and Social Care (HSC) faces multiple challenges that require clinical transformation and commissioning in a climate of reduced budgets has had knock on effects in obtaining services, new technologies or treatments in the face of rising patient demand.

The implementation of NICE guidance remains a priority for the Board going forward, however there is increasing pressure on the available funding for new technologies as growth in existing therapies continues to increase each year. The Board will continue to review the available funding on an on-going basis against the context of other competing financial pressures.

All LCGs have had to deal with challenging elective waiting times and look for creative solutions in managing patient conditions. The Northern LCG for example, has addressed this through service redesign.

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#### **REPORT OF THE DIRECTOR OF PERFORMANCE MANAGEMENT AND SERVICE IMPROVEMENT**

The Board's Directorate of Performance Management and Service Improvement is responsible for the collation, analysis, interpretation and presentation of Health and Social Care (HSC) data to inform effective decision making across performance management, service improvement, commissioning and financial management. It is also responsible for the development and on-going maintenance of a formal regular and rigorous process to measure, evaluate, compare and support the improvement of the performance of HSC, and the identification of best practice in scheduled and unscheduled care to improve the quality, efficiency and productivity of HSC services, working with Trusts to ensure service changes in line with best practice. This includes the use of service improvement methodologies, benchmarking, auditing current practice and agreeing improvement goals for on-going monitoring and performance management.

#### **KEY PERFORMANCE HIGHLIGHTS**

Progress has been made across a range of standards and targets during 2015/16 including:

- an improved position against the standard to ensure that 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures;
- performance remains strong against the 31-day cancer standard (98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat); and
- strong performance against the target to deliver a minimum of 80 kidney transplants (including live, DBD (Donor after Brain Death) and DCD (Donor after Cardiac Death)).

#### **Service Improvements in Scheduled Care**

Scheduled Care describes pre-arranged services for patients such as hospital treatment, diagnostic tests or surgery. Service improvement work seeks to improve the patient pathway so that patients are seen in a timely manner and the services they receive provide the most effective diagnosis and treatment. Examples of this work during 2015/16 include:

- two additional radiology trainee posts, with further plans in place for additional training places over the next five years as part of a regional implementation plan following recommendations of the on-going DHSSPS Imaging Review. This work is led by the Modernising Radiology Clinical Network;
- establishment of a fully representative NI Chronic Pain Forum with partners to identify priority needs for the development of pain services in Northern Ireland. Key areas of focus include: reducing inequities, development of flexible and responsive models of care,

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strengthening service user and care engagement through increased opportunities for self-management;

- development of new Trauma service for the residents of Newry & Mourne which is improving access to fracture care for patients;
- development and roll-out of a new fracture pathway which has reduced the number of unnecessary fracture follow-ups, improving the effectiveness and efficiency of the fracture service;
- development of regionally agreed Clinical Commissioning Group referral guidance for a range of urological and orthopaedic conditions. This information is being used to support GPs and improve the outpatient capacity;
- implementation of the vascular service review with the planned transfer of complex arterial vascular surgery activity to the Royal Victoria Hospital and the development of new regionally agreed pathways for common vascular surgery conditions;
- a second user survey of Audiology services care was completed by the Board, Trusts and Action on Hearing Loss and these recommendations are being used to improve services; and
- a review of specialist seating services was completed that focused on improving waiting times for complex needs.

#### **Service Improvements in Unscheduled Care**

Unscheduled Care describes those services that patients use unexpectedly or in times of emergency.

Within Unscheduled Care, focus continues on the range of issues and measures which support the effective and timely flow of patients and improved 4 and 12 hour waiting time performance.

The Performance Management Unscheduled Care Team is now part of the newly established Unscheduled Care Programme Team, supporting the initiatives of this group.

Key areas of work during 2015/16 include:

- daily SITREP assessment
- revision of Regional Escalation guidance
- regional Delayed Discharge Audits
- support initiatives to expand 7 day working
- regional mapping of transition services
- emergency Department Patient Flow
- delayed Discharge Transition Workstream
- Emergency Department Minimum Dataset development.

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The Unscheduled Care Team continue to be involved in, and leading on, a range of other areas such as Emergency Planning, Guidance on 'Missing Persons' for Emergency Department staff and on-going clinical audit to assist Trusts with service improvement and development.

Continuing performance challenges include:

- the need for further significant improvement in both the 4 and 12 hour performance for Emergency Department waiting times. The Board and PHA are working jointly with Trusts and other stakeholders to progress the implementation of the key products from the CMO/CNO Unscheduled Care Task Group and the unscheduled care agenda more generally;
- waiting times for access to elective care services. Given the scale of the recurrent capacity gaps in a number of specialties, and the on-going financial pressures in 2015/16 (which meant that it was not possible to undertake additional outpatient or inpatient/daycase activity until non-recurrent funding became available in November 2015 for elective care in-year), the number of patients waiting longer than the Ministerial standards continued to increase during the first nine months of 2015/16;
- the additional non-recurrent funding confirmed by the Minister in November 2015 has been utilised to secure additional capacity in-year primarily from a range of Independent Sector providers and is being targeted at those patients who have been waiting the longest for assessment and/or treatment. While over the course of the year, waiting times for elective care will have increased compared to March 2015, it is expected that the impact of the additionality associated with the non-recurrent funding will slow the rate of increase seen in the first nine months of the year;
- waiting times in relation to the 62-day cancer standard. The Board will continue the dedicated performance and service improvement work with Trusts to deliver improvements;
- waiting times in relation to patients accessing psychological therapies. The Board is working with relevant Trusts to ensure that the best possible waiting time outcomes are achieved on the basis of additional investment; and
- waiting times from referral to commencement of Allied Health Professional (AHP) treatment. The Board and PHA have worked with Trusts to complete a demand and capacity exercise to ensure there is sufficient capacity in each of the AHP services to meet patient demand. This exercise has now been concluded and the findings shared with Trusts. The Board and PHA will work with Trusts to agree the steps to be taken to implement the outcomes from the demand and capacity exercise and to address the waiting time position going forward.



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#### **Information Management**

The Information Management Team provides an information and analysis service that supports the performance, management, service improvement and delivery, commissioning and financial management agendas of the Board.

Over the past year, the team's work has focussed on:

- development of SharePoint sites to allow Health and Social Care users to access timely information and analysis from one central repository on Performance and Service Delivery issues, Clinical Coding and Information Standards, Data Quality issues and the Regional Data Dictionary;
- continual development and improvement of a real-time Emergency Department Pressures web-based dashboard which displays information around key emergency service pressure indicators;
- the development and on-going production of a twice daily situation report (SITREP) to assist with assessments of unscheduled care service delivery and the service improvement work of the Unscheduled Care Programme Team as well as developing hospital bed modelling reports to help plan for winter pressures;
- regular monitoring of performance against agreed contracted volumes for a range of elective activity and input to the production of a 5-year plan aimed at predicting demand and corresponding capacity required to bring elective waiting times into balance;
- developing greater management information reporting capability from the Clinical Communications Gateway Electronic Referrals System aimed at providing more robust GP referral information to help assess referral patterns and outpatient clinic use;
- establishment of a robust regular flow of high level community service metrics data from Trusts across each of the following workstreams - Domiciliary Care, Day Care, Social Work, Residential & Nursing Home Care, Community Nursing and Health Visiting and Allied Health Professionals;
- development of Data Definitions and associated minimum data sets for Dementia, Autism and Child and Adolescent Mental Health Services;
- leading the expansion of the Regional Data Warehouse to access datasets across a broader range of Acute and Community-based services;
- continuing to provide clinical coding support and advice to the HSC through a helpdesk function; development of guidance; delivering training to approximately 145 coding staff in

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the Trusts through a variety of courses and workshops; conducting audits to evaluate the level of accuracy and quality of coding for a range of services;

- continuing to provide advice and guidance on new/revised data definitions and standards; providing a data definitions helpdesk for the HSC; maintaining the NI Data Dictionary and producing System Technical Guidance; and
- further collaboration across health and social care including with UK colleagues through membership of groups such as the National Clinical Coding Qualification Board, UK Terminology Centre Governance Board and Coding Review Panel (CRP). There is participation in national Clinical Coding training, quality assurance working groups and as observers to meetings such as SCCI (Standardisation Committee for Care Information).

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#### **REPORT OF THE DIRECTOR OF INTEGRATED CARE**

The Directorate of Integrated Care is responsible for commissioning and managing General Medical, Dental, Optometric and Pharmacy services. It is also responsible for the development of Integrated Care Partnerships and the Health and Care Centre Development Programme.

#### **KEY PERFORMANCE HIGHLIGHTS**

##### **General Medical (GP) Services**

One of the biggest challenges facing Health and Social Care is an increasing number of patients living with long term conditions. This represents over 50% of the current GP workload. Many patients, especially the elderly, live with more than one long term condition adding to the complexity of management. Patients with these long term conditions can benefit from proactive management of their conditions including early diagnosis, problem recognition and appropriate referral. Social care support is also vital. Early identification of palliative care needs and appropriate management may be clinically indicated for some of these patients.

The resulting increase in GP work load requires a corresponding increase in the GP workforce to meet the needs of the population. The Board welcomes the Minister's announcement on 28 January 2016 that funding has now been allocated for 20 additional GP training posts, which will provide 85 training places each year.

In the last year, putting the patient at the heart of health care has meant shifting more services back into the community, making it more convenient for patients to access services. To support this, two key initiatives were introduced under the umbrella of the Northern Ireland Local Enhanced Service (NILES):

- getting blood samples taken at GP clinics - doctors in hospitals can now ask for patients' blood samples to be taken at GP clinics, making it more convenient for patients; and
- Pharmacists based at GP practices – patients can discuss their medicines while at the clinic and pharmacists can support GPs to strengthen medicines management practices.

GPs also recognise that more people prefer to conduct everyday tasks - such as booking appointments and ordering prescriptions, online instead of picking up the phone. Many have invested in new technology to accommodate this change of behaviour, increasing convenience for patients and allowing GP clinics to better manage the rise in patient numbers.

The Belfast Acute Care At Home Team for frail older people is a consultant-led multi-disciplinary project, designed to provide care to patients aged over 75 residing within the BHSC community services boundary. An important element of this team is GP involvement to enhance the care available in the community.

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Most practices, as members of a local GP Federation have chosen to combine their resources and work together to better provide this service. The Board recognises that GP Federations are an appropriate vehicle to deliver all the above models of working. Further engagement with GP Federations is envisaged to ensure practices can work together to provide improved or additional services for their patients.

#### **GP Out of Hours Services**

The GP Out of Hours (OOH) service is provided by five providers and covers the period when GP practices are normally closed. Performance is monitored on a quarterly basis. GP OOH services are required to triage 90% of urgent calls within 20 minutes and 90% of all other calls within 1 hour.

The GP Out of Hours service remains under considerable strain due to a combination of increasing demand and challenges around recruitment and retention of GPs. The Board has directed GP Out of Hours service providers to prioritise acute and urgent calls. Providers have also had to temporarily close some peripheral centres and concentrate the workforce on key centres in order to maintain a safe service. This has led to complaints from patients and MLAs, especially in the West and South of the province.

In terms of funding, the Board invested an additional £4.3m to meet service pressures, particularly over public holidays, on top of the core budget of £21.05m for 2015/16.

A range of local initiatives have been put in place including a service aimed at engaging local GPs to work in the OOH service. Each provider was also allocated a £30,000 per annum training budget. Plans for winter pressures were also funded by additional allocations totalling £850,000.

The OOH services worked closely with the Northern Ireland Ambulance Service (NIAS) to better identify and manage emergencies and improve alignment. A pharmacist prescriber pilot, designed to assist skill mix, was implemented in the Southern area. All OOHs providers were allocated funding to introduce an Additional Costs Scheme, whereby GPs who booked shifts in advance were given a contribution towards the rising costs of medical indemnity.

In spite of the pressure on the service, the overall number of complaints and adverse incidents remains low. The service is supported by a number of loyal and dedicated clinical and non-clinical individuals.

#### **Pharmacy and Medicines Management**

A key aim of the Board is ensuring safe, effective and efficient use of medicines. To this end, over £150m of efficiencies have been identified since 2010/11 and this has resulted in funding being made available for other aspects of patient care. In 2015/16, patients received over 38 million prescriptions issued by GPs and dispensed by community pharmacies.

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The Board continues to engage the public in how they use medicines and how medicines are wasted. The Medicines Waste campaign has dovetailed with other publicity messages such as Choose Well and on-going awareness around the harm from drug misuse. There are plans to develop further initiatives to improve medicines safety; and identify and deliver further efficiencies to support effective patient care.

Other specific objectives delivered in 2015/16 include:

- the further development and application of the NI Formulary to influence the choice of effective, quality prescribing of first and second line medicines in primary care and secondary care (<http://niformulary.hscni.net/>);
- maintenance of the Managed Entry process which provides an assurance that clinically and cost effective medicines are available to the population of Northern Ireland, based on up-to-date, independent and evaluated evidence;
- development of the Medicines Use Review service provided by community pharmacies;
- further implementation of the Home Oxygen service which has led to an improvement in the range of oxygen modalities available to patients with oxygen need;
- working with the Public Health Agency to deliver innovative harm reduction services for individuals who have addiction problems *e.g.* take-home naloxone scheme which has led to a reduction in deaths associated with heroin;
- development of the Health + Pharmacy accreditation scheme with the first pharmacies accredited;
- medicines safety continues to be a focus of activity. The Board's adverse incident reporting informs regional learning, and initiatives that were taken forward include improving the calculation of doses of opiates; improvements in the management of insulin by patients with diabetes and their carers, and improved prescription security. Dissemination of learning has improved through the use of a dedicated website: <http://www.medicinesgovernance.hscni.net/>; and
- the Board Accountable Officer for Controlled Drugs became responsible for convening the Local Intelligence Network to ensure the effective collaboration across a range of organisations in respect of good governance for controlled drugs. A key project that emerged in 2015/16 related to this work was the Controlled Drug Reconciliation project which involved a number of agencies and saw the development of a mechanism to protect against the potential for controlled drug diversion.

Within Pharmacy and Medicines Management, the most pressing challenges for 16/17 will be to finalise new pharmacy contract arrangements and to fully utilise clinical pharmacists in GP practices to support more effective medicines use by the public.

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#### **General Ophthalmic Services (GOS)**

The Board commissions and arranges for the provision of GOS and ophthalmic Local Enhanced Services (LES) for the population of Northern Ireland. Contracting with 266 ophthalmic practices regionally, the Board has arranged for the provision of a projected 437,242 HSC-funded sight tests (including 12,031 home visits) in 2015/16, and the issuing of 216,092 optical vouchers/repairs in the same period. The quality and patient safety agenda is at the forefront of service provision, with robust adverse-incident and complaints procedures reported on and managed.

In addition, the Board has commissioned a glaucoma/ocular hypertension enhanced service aimed at better managing demand for ophthalmology services for these long term eye conditions. In 2015/16, 1,923 patients accessed this service which resulted in less than one third (32%) being referred to secondary care outpatients; the remainder being managed, closer to home, in primary care.

The non-sight-threatening acute eye pilot in the Armagh/Dungannon area of Southern Local Commissioning Group (LCG) is complete and is currently being evaluated. In the period April 2015 – March 2016, 870 assessments have been carried out with approximately 80% of the patients being managed locally in primary care optometric practice, removing the need for attendance at eye casualty and outpatients, freeing GP capacity. This has resulted in an 11% reduction in GP referrals to ophthalmology in 2015/16 compared to 2014/15. The pilot is being evaluated for access, clinical outcomes, patient experience and cost-efficiency, building the evidence for potential roll-out.

2015/16 saw the launch of the world's first ophthalmic Project ECHO. Aimed at democratising medical knowledge and building a community of practice to share experience through tele-mentoring, ECHO offers the potential to build capacity within the health economy, allowing patients to be treated closer to home.

In the important area of ophthalmic public health, the Board worked closely with the Public Health Agency (PHA) to accredit the first cohort of community optometrists offering brief intervention around smoking cessation in 2015/16. The impact of smoking on eye health is well established, and stopping smoking at any stage has a positive impact on many eye diseases.

As with many health and social care specialties, eye care continues to experience increasing demand. Demographic changes and an aging population, coupled with new and emerging technologies and increasing expectations, require the Board to work closely with all partners and stakeholders to manage demand in primary care, bridge the gap between primary and secondary care, and streamline pathways and flows within the hospital system. Working with the PHA, the Board leads on the regional strategy for eyecare services, "Developing Eyecare Services." This strategic approach provides a cohesive blueprint to bring about effective reform in elective care and outpatient demand, commissioning for best clinical outcomes and optimal eyecare across high street and hospital sectors.

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#### **General Dental Services (GDS)**

While the dental health of Northern Ireland children has improved in recent years, there is still a significant burden of illness associated with tooth decay. Each year more than 5,000 children here receive a hospital general anaesthetic in order to have decayed teeth extracted. The Board has, for many years, been working with researchers and dental care providers to develop more effective and efficient ways of preventing dental disease.

The full results of the Northern Ireland Caries Prevention in Practice (NIC-PIP) trial are due to be published during 2016. The trial is the largest primary care based decay prevention study ever undertaken in the UK. The study looked at children aged 2-4 years who had fluoride varnish applied to their teeth by their family dentist. The children were followed up for a period of three years and preliminary results indicate that these children had fewer decayed teeth than children who did not receive the varnish.

In the last 12 months, the Board has also worked closely with Trusts to enhance disease prevention schemes across a range of patient groups. This year's focus has been on decay prevention in older adults. The Board provided the Western Trust's Community Dental Service (CDS) team with a £23K funding package to develop a pilot for an oral health improvement scheme for dentate elderly patients who live in nursing or residential homes. The scheme provides an extended preventive programme to residents and includes the application of fluoride to patients' teeth by dental care professionals. Clinical academics from Queens University Belfast have provided advice on research methodology to ensure that the pilot can be appropriately evaluated.

The Board continues to manage the delivery of GDS through 1,066 dental practitioners working in 379 high street practices across Northern Ireland and works with the Business Services Organisation to ensure that treatment claims are valid and paid appropriately. Dental care quality is assured through the Referral Dental Service (RDS). The RDS carries out dental examinations on patients who have recently received treatment. In addition to routine monitoring of care quality, during 2015/16, annual reviews were completed for the Oasis pilot Personal Dental Services scheme and the Dental Foundation Trainee scheme. Orthodontic monitoring work was also undertaken this year.

The Board is also moving towards electronic means of communication with general dental practitioners, reducing the amount of printed materials produced. As an interim solution, we have developed an electronic monthly information sheet available on the Business Services Organisation dental webpage. This allows for more efficient and effective delivery of information from the Board to the individual dentist, while simplifying storage and retrieval for practitioners.

An urgent priority for the Board is to establish a fully functional portal as many general dental practice ICT requirements, such as health and care number look up, access to alerts and access to the clinical care gateway (CCG) require an accessible and functional portal. All GDS practitioners have crypto cards and are able to remotely access the dental portal securely, however, problems

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with the functionality of the portal are being experienced and it is hoped to resolve these during 2016.

A pilot is planned for spring 2016 to test use of the CCG for e-referrals from the BHSC Community Dental Service (CDS) to hospital specialist services. Following evaluation, we hope to roll this out across Northern Ireland. Likewise, once connectivity issues have been resolved, we plan to give all Northern Ireland GDPs access to the CCG.

#### **Integrated Care Partnerships**

Integrated Care Partnerships (ICPs) are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists and other healthcare professionals from the voluntary and community sectors, local council officers; service users and carers. Throughout Northern Ireland, seventeen ICPs have been operating since June 2013 to improve service delivery and coordination to keep people well in local communities. Each partnership covers a population of around 100,000 people.

Throughout 2015/16, ICPs have been implementing the service changes commissioned and funded by Local Commissioning Groups.

A range of projects are now in place including:

- Acute Care at Home in Belfast;
- Rapid Response Respiratory Clinic in Craigavon;
- Enhanced Care at Home in North Down and Ards;
- Nursing Home In Reach in the Northern area;
- Integrated Respiratory Services in Belfast and in the Western area; and
- Integrated Diabetes Footcare Pathway in the Northern area.

Early indications show that progress is in line with the anticipated activity and outcomes. ICPs have established a Local Accountability Agreement with each of the Local Commissioning Groups, and this sets out the process for reporting, performance management and evaluation of these projects.

Work has continued to support the development of mature and effective partnerships through the work of a third sector co-ordinator who has been appointed to support the Voluntary and Community sector representatives on ICPs to work together more effectively, and to ensure the sector is a full and equal partner in all of the ICP's work.

Capability and development work continues to be delivered to the ICP service users and carers through a regional forum for shared learning and support. The addition of local council representation on ICPs has also been progressed throughout the year and early discussions indicate significant potential for the delivery of more integrated health and wellbeing and care services.

An interim review of ICPs is underway focussing on lessons learned in relation to partnership working and processes followed to date. The recommendations from this review along with the



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outcome of the DHSSPS evaluation of ICPs will help shape the focus for 2016/17. ICPs will work to share learning from best practice delivered to date and scale up local integrated care pathways. New clinical priorities will be included over the next twelve months.

#### **Project ECHO NI**

Project ECHO® (Extension for Community Healthcare Outcomes) <http://echo.unm.edu> is a pioneering telementoring programme which was developed in the School of Medicine at the University of New Mexico.

The mission of Project ECHO® is to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and underserved areas, and to monitor outcomes of this treatment. With the use of video-conferencing technology, the ECHO programme trains primary care providers to treat complex diseases. Participants benefit by receiving evidence-based, best practice guidance from specialists, and case-based learning from presentations, with participants having opportunities for live questions and answers. There is also opportunity to translate new knowledge into practice to improve outcomes for chronic conditions common to primary providers.

The Board received funding of £403k from the Executive Change Fund in 2015-16 and is currently working in partnership with Northern Ireland Hospice to pilot the use of the Project ECHO® model across health and social care. The project pilot period is from October 2015 until 31st March 2016. There are approximately 50 ECHO sessions set up (November 2015 – March 2016) across the following Knowledge Networks using a hub and spoke model:

- GP Trainees – Dermatology;
- Palliative Care – Nursing Homes;
- Optometry/Ophthalmology;
- Diabetes; and
- Palliative Care;

The pilot will be evaluated and will help inform decisions around the future of ECHO® in Northern Ireland.

#### **Primary Care Infrastructure Development Programme**

The Primary Care Infrastructure Development (PCID) Programme invests in and redevelops new health and care centres across Northern Ireland through a ‘hub and spoke’ model so that health services can be provided in a more integrated manner, closer to home for those using the service, in line with the recommendations of Transforming Your Care.

A Regional Strategic Implementation Plan (SIP) outlining proposals for the future development of primary care infrastructure, funding options and timescales for implementation has been developed by the five Local Commissioning Groups and work on the first phase of the hub schemes is progressing well.

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In 2015/16, two new hub facilities in Banbridge and Ballymena were successfully completed and opened; a third hub in Omagh is under construction and third party development schemes in Lisburn and Newry are at an advanced stage of the procurement phase. Construction of these hubs is expected to commence in early 2017 and it is anticipated that they will open to the public in 2018/19, providing co-located GP and Trust services to the local communities.

The Board has also established and successfully launched the GP Infrastructure Loan Scheme using alternatives to traditional public funding methods. This innovative scheme utilises Financial Transactions Capital (FTC) in the form of loans to GPs to enable them to undertake premises developments and improvements for health and social care purposes. Two tranches of the scheme were launched in 2015/16 and have resulted in approximately £9m being made available to GPs for premises improvements. As a result of the success of this scheme, further FTC funding has been allocated in 2016/17 to enable a further tranche of loan applications to be sought from GPs.

Work has been ongoing in 2015/16 to support GPs in spoke facilities to undertake premises improvements and deliver the service model described in Transforming Your Care. One such example is the new integrated Student Health Service at Queen's University Belfast which brings a holistic approach to student health by locating general practice alongside BHSCT adult psychology services.

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#### **REPORT OF THE DIRECTOR OF SOCIAL CARE AND CHILDREN**

The role of the Board's Directorate of Social Care and Children is to commission social work and social care services for people with different individual needs who require support to live life fully and as independently as possible, and to protect the interests of children and adults at risk of abuse. During the year, a number of initiatives and developments were progressed across the following service areas.

#### **KEY PERFORMANCE HIGHLIGHTS**

##### **Social Work Strategy**

The Social Care Directorate has continued to lead the implementation of the DHSSPS Social Work Strategy and has been developing an approach to service improvement supported by the following:

1. Establishment of Dedicated Board Social Care Services Improvement Team.
2. Development of Board Social Care and Children's Regional Service Improvement Plan.
3. Specialist Improvement Science Training for 6 Social Care Staff.
4. A Regional Quality Improvement Training Programme for Social Work

##### **Services for People with Mental Health Needs**

In 2015 / 16, the Board developed a new regional guide for the delivery of mental health psychological care and provided funding for an additional 50 staff in specialist psychological interventions, (CBT, Interpersonal Therapy, Counselling Addictions). This includes extending Psychological Therapy Hubs in primary care across all of the BHSCT area and introducing two pilot sites in the other 4 Trusts. The Board further invested a further £530k in strengthened Primary Care Hubs Services for People with Learning Disability.

Following a needs assessment, funding was secured for futures planning services so adults with a Learning Disability can move to appropriate homes with care in the community and further training for parents/carers and staff. A care pathway is also being developed for people with learning disability and dementia.

A fundamental review of the Mental Health and Wellbeing Service Framework was completed this year and the new draft Service Framework will be issued by the DHSSPS for public consultation before 31 March 2016. The Board has also developed a new Regional Trauma Model which has received ministerial endorsement.

In line with the Addictions Commissioning Framework (2012), a review of Tier 3 Addiction Services has been undertaken and the review of historical homicides involving people receiving

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mental health services has been completed. As a result, two fresh independent inquiries were required. One is completed and another is underway.

The review of the Releasing Time to Care and Crisis Resolution Home Treatment showed both initiatives to be well embedded in practice, having improved outcomes and experiences for people using these services.

#### **Children's Services**

##### **Historical Institutional Abuse Inquiry**

The Board has continued to provide the co-ordination role for all legacy Health and Social Care information required by the HIA Inquiry. This has involved not only identifying and providing relevant corporate and client files to the Inquiry but also assisting with the search for and subsequent support of other staff, many of whom are retired, to provide statements to the Inquiry. In some cases following statutory requests from the Inquiry, this also requires the actual preparation or overview of HSC statements. Given the intensity of the Inquiry, this has been a very demanding task.

##### **Kinship Foster Care**

Three additional fostering social work staff per Trust have been appointed to enhance kinship foster care service and improve support to children and their foster carers.

We commissioned a new resource for kinship carers, developed by the Regional Adoption and Fostering Service in partnership with Voice of Young People in Care (VOYPIC). The resource is available to foster carers and members of the public via the Regional Adoption and Fostering Services website.

##### **Looked After Children (LAC)**

Implementation of the Board Commissioning Specification for Looked After and Adopted Children. This specification will ensure all LAC have access to therapeutic services regardless of age, placement type or duration. The specification established the role of LAC therapeutic services within the wider range of Children's Services and seeks to ensure Trusts have in place protocols with other Trust services to enhance and promote the welfare of Looked after and adopted children.

A cross Departmental initiative involving the Department of Health, Social Services and Public Safety, the Department of Culture, Arts and Leisure, the Health and Social Care Board and voluntary sector providers has successfully secured in year funding targeted at promoting inclusion and integration for looked after children in sports, arts and leisure activities.

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#### **Leaving Care and Aftercare**

This year shows continued growth and investment in the Going the Extra Mile (GEM) Scheme with 265 young people continuing to live in safety and with stability with their former foster carers. Additionally this year saw the opening of a new jointly commissioned supported accommodation project for vulnerable young people in Enniskillen. A joint initiative between social care and the Northern Ireland Housing Executive, the project is providing 13 bed spaces for care leavers and young homeless.

Cross agency working between the Board, Health and Social Care Trusts and the Social Security Agency is being progressed this year with the shared aims of creating greater awareness of Social Security Agency policy and procedures regarding benefit entitlements of young people leaving care, supporting practice that promotes financial uptake in line with entitlement, strengthening cross agency working and ensuring timely preparation for Welfare Reform changes.

#### **Children and Adult Mental Health Service (CAMHS)**

The development of an Integrated Care Pathway for CAMHS is underway involving CAMHS staff from all Trusts, and representation of both parents and children and young people on the project group. The pathway will be issued for consultation in early February and the final pathway will be issued before the summer of 2016.

A fundamental review of Autism Services with a view to remodelling referral assessment, diagnostic, and intervention services is underway and as part of this review, a survey was conducted in 2016 to capture the experiences of children, young people, their families and staff who have used the service. The survey which will inform service improvements and developments in both CAMHS and Autism services was conducted in 2016, with a full report on the findings and outcomes to be completed by June 2016.

The Ministerial announcement in February 2016 of an additional £2m for Autism services is very welcomed. It will help fund new capacity teams and clinical staff specifically trained in assessing Autism, in each Trust to improve assessment times. In addition, these resources will be used to expand Autism specific support services, and improve access to wider services such as: Speech and Language Therapy, Community Paediatrics and Occupational Therapy.

Work is progressing on the implementation of the recommendations from the Acute CAMHS review. Of particular note is progressing with the establishment of a Managed Care Network for Acute CAMHS. This is at an early stage but full establishment of the network should be completed during the course of 2016/17.

A new Gender Identity Service for Children and Young People and a New Forensic Mental Health Care Team for Children and Young People was established.

A new Psychological Care Learning Together Working Framework for CAMHS was created which highlighted a need for additional training in CBT, Psychotherapy and Interpersonal Therapies.

## **HEALTH AND SOCIAL CARE BOARD**

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#### **Older People and Adults Services**

##### **Dementia Services**

During 2015/16, work on the implementation of the Dementia Strategy continued with funding made available to appoint two Dementia Navigators in each Trust.

We put in place a new stepped care model designed to enable people with dementia to live well, supported by follow on care following a review of Dementia Services. The regional Dementia Collaborative provided a template for the re-design of memory services and development of service standards and care pathways.

A Dementia Learning and Development Framework was developed with input from a wide range of stakeholders and a new ‘delirium bundle’ with screening, assessment, prevention and management of delirium tools was piloted across 10 hospital sites and a comprehensive package of training delivered.

##### **Adult Safeguarding**

In 2015/16, the Northern Ireland Adult Safeguarding Partnership (NIASP) along with colleagues in the Police service, the Regulation and Quality Improvement Authority and the Public Prosecution Service revised the Protocol for Joint Investigation of Adult Safeguarding Cases. This clarifies and simplifies the investigation process and places the adult in need of protection at the centre of any decision-making.

The Board worked with local Trusts and service users to develop a “Keeping Safe” programme to support adults at risk by developing skills and techniques to protect themselves from neglect, abuse or exploitation.

The Board established an Adult Safeguarding Collaborative resulting in the development of a new demand and capacity model.

##### **Carers**

The Carers Strategy Implementation Group (CSIG) formally appointed five new carer members in November 2015. The new members will be instrumental in helping the group achieve improved services and outcomes for carers regionally.

A regional evaluation of home based short breaks was completed in October 2015 and carers were asked if/how the service had met their needs. The majority responded positively regarding their experience with half indicating that their physical health had improved as a result of the services provided.

The Board also undertook a review of Carers’ experience of the carer assessment process.

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#### **Reablement**

Reablement is designed to enable people to gain or regain their confidence, ability and the necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, a deterioration in health or injury. For the year 2015/16:

- 5,031 people started reablement;
- 84.4% were discharged within 6 weeks; and
- 40.9% of those reabled were discharged without the need of a further care package.

The successes achieved within the Reablement service will be celebrated in the Spring of 2016 at a regional event, following which the Reablement Project Board structure will be redesigned to be subsumed into a Community Care Taskforce.

#### **Domiciliary Care Review**

In 2015/16, the Board established a regional Domiciliary Care Review Group involving a range of stakeholders (DHSSPS, Trusts, RQIA, NISC). The review group also established links with the Patient Client Council, Commissioner for Older People, Age NI and engaged with service users and carers. The review examined the challenges and functions of the service and a final report on its findings was approved by the Board in 2015/16. The report sets out a series of recommendations for change which provide a strategic framework for development.

In parallel, the Board led a regional project to develop, specify and implement a live electronic monitoring system for domiciliary care. The monitoring system will improve the scheduling and rostering of domiciliary care visits to benefit clients, service providers and support more efficient back-office administration of the service. It will also promote lone worker safety, provide information to support better service planning and commissioning and enhance communication with the domiciliary care workforce. Current planning is to procure the system by during 2016/17 with implementation rollout in late 2016/17.

#### **Hospital Services – Unscheduled Care**

Implementation of key products from the Unscheduled Care Task Group and the wider unscheduled care agenda has continued, helping improve patient flow and reducing the length of time patients wait in Emergency Departments for admission.

The following have been produced in partnership with the Trusts and relevant organisations:

- Regional Guiding Principles to enable effective Discharge Planning from Hospital and Transition Settings;
- Regional Discharge Documentation for effective and safe transition from hospital to community settings; and

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- Developed a New Stepped Care Model for older people and people with long term conditions with a view to improving early intervention and improving the experience of transition from hospital to home.

#### **Physical and Sensory Disability**

The Board has continued to implement the 'Physical and Sensory Disability Action Plan' in partnership with key stakeholders from the DHSSPS, Public Health Agency and Community and Voluntary Sector. Good progress continues to be made across a number of key areas including a review of communications services for people who are deaf.

#### **Self Directed Support (SDS)**

SDS is a new model for social care based on a new relationship with service users and carers. It provides individuals with the flexibility to design the support they need to best meet their goals/outcomes. This can include a wide and diverse range of support mechanisms, drawn from either the statutory, private or community and voluntary sectors, or a combination of all of the above.

Key achievements in 2015/16 include:

- completion of a full SDS Equality Impact Assessment;
- significant stakeholder engagement to raise awareness of SDS and secure key HSC staff 'buy-in' to this significant change;
- provider engagement to build capacity for provider readiness to deliver SDS;
- launch of SDS implementation in June 2015 across all Trusts, with initial figures demonstrating a positive response from service users;
- development of supporting resources – including staff and service user guides and an outcome measurement toolkit; and
- training of over 2,700 HSC staff in SDS awareness, process and support planning.

As SDS gathers greater momentum, it is changing the face of social care by embedding the principles of personalisation, coproduction and Personal and Public Involvement to give Service Users and Carers greater choice, control and independence over their lives.



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#### **Northern Ireland Single Assessment Tool (eNISAT)**

Extensive engagement with staff and stakeholders has resulted in a new electronic version of the eNISAT being introduced across the region. This enhancement aids the multi-disciplinary assessment process which focuses on a person centred holistic approach.

As part of the on-going drive to reduce duplication and facilitate the sharing of key service user information across the region, eNISAT has linked up with the Northern Ireland Electronic Care Record (NIECR) to ensure that key service user information contained in the eNISAT is available to all professionals with access to the NIECR - whether in the Acute, Primary Care or Community sectors.

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#### **REPORT OF THE DIRECTOR OF CORPORATE SERVICES**

The Board's Corporate Services department provides business and organisational support across a range of functions that play an important part in ensuring the effectiveness of the organisation. These provide for the monitoring and maintenance of internal governance, the management and protection of business information, the provision of an effective communications service, and support in responding to major incidents and emergencies. Work to discharge this range of functions has included the following:

#### **KEY PERFORMANCE HIGHLIGHTS**

##### **Governance Function**

###### **Governance Framework**

In order to ensure a sound system of internal control, the maintenance of effective governance arrangements continued to be a priority task for the Board this year. A review of the overarching HSCB Governance Framework was completed during 2015-16. This Framework assists the Board of the HSCB, through the Chief Executive, to sign the annual Governance and Mid-Year Assurance Statements. It also highlights the key components and structures that underpin a sound system of governance and internal control, encompassing a robust Assurance Framework, Corporate Plan, fully functioning Risk Register and continued compliance with relevant Controls Assurance Standards.

###### **Serious Adverse Incidents (SAIs)**

The Board has continued to monitor and learn from the reporting and follow up of SAIs across the HSC and Family Practitioner Services:

- Enhancement to current process
  - As a result of the a recommendation in the report "The Right Time, The Right Place" by Sir Liam Donaldson, the DHSSPS, working in partnership with HSCB/PHA and Trusts agreed to pilot a new process for reviewing and notifying child deaths as part of the new Regional Mortality and Morbidity Review (RM&MR) System. SAIs relating to child deaths are currently being managed through this process with the mandatory requirement to report the death of a child as an SAI having been removed from the SAI criteria with effect from 1 February 2016. The pilot period for the new process will run through until 31 January 2017, when an evaluation will be conducted.
  - Revisions were also made to the current SAI service user/family engagement checklist. The checklists inform the HSCB on the level of engagement the reporting organisation has made with service users and families during the SAI process. This amendment has enabled a consistent approach to capture and monitor this information on a regional basis.
  - During the reporting period, the panel of lay persons, (already involved in the complaints process), availed of relevant SAI training, including Root Cause Analysis. They and are

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now available to be called upon by HSC Trusts and HSCB, Directorate of Integrated Care to be a member of a SAI review team, particularly when a degree of independence is required.

- Sharing SAI Learning
  - A range of SAI Learning communications have continued to be issued throughout 2015/16:
    - Learning Letters
    - Best Practice Reminders
    - Learning Matters Newsletters
    - Bi-annual Reports
    - Thematic Reviews
  - A regional SAI Learning Workshop was held in April 2015. The aim of the event was to provide an opportunity to share learning from SAIs regionally. HSC Trusts and Primary Care presented a number of case studies for discussion and a relative of a patient involved in a SAI, shared their experience of the process and the impact it had on their family.
  - Training was provided to HSCB/PHA staff on conducting a thematic review in January 2016.

#### **Safety and Quality Alerts**

The Board and PHA continue to monitor and co-ordinate the implementation of regional safety and quality alerts, letters and guidance via the Safety and Quality Alerts Team. This provides the mechanism for gaining regional assurance that alerts and guidance have been implemented. During the reporting period the regional Safety and Quality Alerts Protocol was reviewed and issued across the HSC.

#### **Information Governance**

Information Governance is the collective title for the structures, policies, procedures and controls needed by the Board to help meet its regulatory, legal and operational requirements for the management of the information it holds and processes on a daily basis. Key areas of responsibility under the Information Governance umbrella include compliance with Freedom of Information and Data Protection legislation, the application of appropriate records management systems and the maintenance of appropriate information risk processes to ensure the safe and secure processing of information at all times.

#### **Records Management**

During 2015/16, work continued on the Board's Records Management processes with further development of Meridio, a dedicated system to manage and control the ever increasing volume of electronic documents and records generated by the organisation. The Information Governance Team participated in the review of the DHSSPS guidance document 'Good Management, Good Records' and the development of a new Health and Social Care tender for the provision of secure off-site storage of records.

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#### **Information Risk**

Information risk processes were enhanced during 2015/16 with the introduction of the Board Information Risk Policy. The policy provides direction for all staff in the organisation with regard to information risk. The policy highlights roles and responsibilities, the identification and registering of information assets, the assessment and appropriate treatment of information risks.

#### **Freedom of Information and Subject Access Requests**

During the year, the Board received and responded to a number of Freedom of Information (FOI) requests as follows:

- 79 Freedom of Information requests were received during 2015/16;
- 94% of these requests were answered within 20 working days;
- 6 Subject Access Requests were also submitted and responded to by the Board during this period. 83% of these requests were answered within 40 calendar days; and
- there were no major Data Protection incidents during 2015/16.

#### **Environment and Sustainability**

- energy audits and space utilisation surveys were completed in the main Board offices during 2015/16. A range of energy saving initiatives were progressed during the year to support the Board's policies on Environmental Management and Waste Management which included cardboard and paper recycling programme, a bin recycling pilot, installation of low energy lighting schemes and a rezoning of heating within buildings. Display Energy Certification (as defined in NI SR208/170 as amended) is undertaken annually and is made clearly visible to staff and visitors to increase awareness of energy usage;
- the roll out of a Unified Communications Network (Voice Over IP) to all four Board offices concluded in 2015. The network underpins the strategic objective to improve services through modern technology. Benefits include instant messaging and free internal calls producing savings of 65%;
- the Multi-Functional device fleet continued to produce significant savings on printing costs through a reduction in paper requirements and more efficient use of fewer machines. The reduced energy consumption resulted in a smaller carbon footprint; and
- environmental issues and sustainable clauses are considered as part of the process for tendering and award of contracts by BSO Procurement and Logistics service, as a Centre of Procurement Expertise.

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#### **Social and Community Issues**

##### **Equality, Human Rights and Diversity**

During 2015/16 the Board continued its work to equality screen new and revised policies and develop staff capacity through training. These include:

- mandatory Diversity Training, including disability awareness training made available for all staff through the HSC Discovering Diversity e-learning platform;
- Equality Impact Assessment (EQIA) training developed by colleagues in BSO Equality Unit and Board staff participated and completed this course;
- a rise in the number of Equality Impact Assessments being carried out across business areas, namely into the Review of Communication Support Services, Stroke Modernisation and Pathology Modernisation;
- developing a new classroom-based training course to implement human rights based approaches into work for staff. A human rights based approach was also piloted to develop the Independent Guardian Service (which emanated from new legislation on Human Trafficking and Exploitation); and
- consulting with key stakeholders on revised Equality and Disability Action Plans and to further embed and mainstream equality, diversity and human rights.

##### **Human Resources (HR)**

The Human Resources service is provided to the Board by staff in the Business Services Organisation.

Work areas include pay and conditions, employee relations (both improvement of and resolution of individual cases), retained recruitment i.e. quality assurance role, job evaluations. This involves working with managers, staff and Trade Union organisations. A suite of reviewed, new and amended policies and procedures have been concluded and will be rolled out to HSCB following SMT approval during 2016/17, with appropriate training for managers and staff.

In light of the announcement in November 2015 regarding the future re-shaping of the Health and Social Care Board, HR have been working closely with Senior Management to maintain strong communication links with staff and Trade Unions on the future challenges and impact such change will present. To date, these have included information sessions by the Chair and Chief Executive of HSCB, the Permanent Secretary, pensions representatives and individual sessions with staff as required. This afforded opportunities for staff to ask questions and share views on the process underway. This will continue with HR involvement in the development of relevant documentation to support the future process. Human Resources staff have supported the HSCB's 2015/16 Voluntary Exit Scheme which a number of staff have availed of.

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The Recruitment Scrutiny Group involving senior management and HR continues to meet weekly to manage the recruitment process taking into account, the need for organisational re-shaping, VES and the provision of business continuity whilst awaiting the development and implementation of future models of care.

As an Equal Opportunities employer, training is available and offered to all staff throughout the year. The HSCB continues to participate in the Disability Placement scheme which commenced in December 2015 and provides 6 month employment opportunities for individuals with disabilities. There is also the opportunity, after four months on the scheme, for participants to apply for internal posts within the organisations participating in the scheme.

HR staff support and work with HSCB colleagues in the pursuit of improved health and wellbeing initiatives. This is delivered via the Organisational Workforce Development Group, Attendance Management Policy, Occupational Health Service and the provision of short information sessions to address targeted health issues identified through attendance monitoring.

#### **Corporate Business**

During 2015/16, Corporate Business staff continued to provide administrative support to the Board and its 14 Committees, including five Local Commissioning Groups, and serviced public meetings of the Board and Local Commissioning Groups held in venues throughout Northern Ireland.

The term of office for a significant number of members across the five Local Commissioning Groups ended during 2015/16 and Corporate Business staff supported a proactive recruitment process which enabled each LCG to remain quorate to conduct its business and discharge its duties.

An annual review of the Board's Standing Orders was undertaken which, together with Standing Financial Instructions, provides a comprehensive business framework to enable the organisation to discharge its functions.

In addition, the Board's Register of Interests for Directors, Local Commissioning Groups and Committee Members who are not members of the Board, was also reviewed and completed during the year.

The Board's Corporate Induction Programme continued throughout 2015/16 and was facilitated by teleconferencing arrangements to each of the four main offices of the Board.

The 2015/16 – 2020/21 Board Property Asset Management Plan, which demonstrates effective asset management of public assets, achieved compliance with Departmental requirements (2015). The Plan provides a clear understanding of how property assets support service delivery and ensures that each asset is fully utilised with the necessary controls in place for attaining efficiencies.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Complaints**

The Board has responsibility for the monitoring of Health and Social Care complaints. Through agreed mechanisms, the Board has oversight of all Health and Social Care complaints raised at Trust and Family Practitioner level. The analysed information is considered by the Regional Complaints Subgroup meeting which meets on a bi-monthly basis. The Board has produced its sixth annual report on complaints. In addition, the Board undertakes the role of 'honest broker' in family practitioner complaints. This involves a degree of mediation and communication in an effort to reach an agreed position between the complainant and the Practice. The Board is also required to investigate and respond to complaints regarding commissioning decisions that affect individual service users.

In June 2015, the Board held its second Annual Learning from Complaints event. Building on the success of last year, this event, attended by Health and Social Care staff including Consultants, nurses, service managers, general practitioners, Practice managers and complaints staff, concentrated on the issue of 'Communication' which features in a significant number of complaints regarding Health and Social Care services. A number of key note speakers presented their experiences of communication difficulties, including using the right language and the value of making an apology. A newsletter summarising the learnings from the event was circulated widely across the service.

Two further service user focus groups were held in November 2015 and March 2016, hearing experiences of the complaints procedure from older persons and those service users with a disability, and/or their carers.

#### **Emergency Planning and Business Continuity**

The Board adheres to the DHSSPS 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'.

The Board, PHA and BSO work collaboratively to continually review and enhance emergency preparedness arrangements. The Joint Emergency Planning Board, chaired 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 co-ordination of major event planning and preparation for adverse weather. This year, working collaboratively with the HSC Trusts and following the tragic events in Paris on 13 November 2015, the Board led on a 'walkthrough' exercise using a scenario involving mass casualties, to test the HSC response to an incident of this magnitude and pace and to make improvements in terms of information flow, co-ordination and communications.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

The Board's Corporate Business Continuity Plan meets the requirements of the International Standard, ISO 22301. Work continues to protect the resilience of the Board's critical functions in the event of a sudden interruption to normal business.

#### **Communications**

During 2015/16, the Board's Communications Team continued to implement and monitor the Board's Corporate Communication Strategy to ensure successful communication and engagement with all its stakeholders.

In implementing the strategy and providing communications support to HSC colleagues, a number of activities were managed by the Communications Team. The following provides a snapshot of those activities:

- media management –the coordination of responses to all media enquiries (radio, TV, online, newspaper and specialist publications); a 24 hour media contact service; proactive and reactive preparation and distribution of material for the media including press releases and statements; identifying media opportunities; arranging press conferences, press briefings, radio and TV interviews; providing media training and a media monitoring service. During the period, media relations were managed for a number of high profile issues. These included emergency department waiting times, elective care arrangements, the budget and financial plans, winter pressures, the Child Sexual Exploitation Thematic Review, proposals to change statutory residential care and the proposals for major reform to HSC structures;
- social media - this continued to be an area of growth and to keep ahead of developments, the Communications team introduced new platforms and tools to communicate effectively with the general public and specific audiences, for example, HSCB Twitter and Facebook accounts featuring short videos and animation. Regular evaluations using analytical tools measured the effectiveness of social media in raising awareness of HSCB issues, the types of audiences reached, and engagement rates with these audiences;
- web and intranet development – online communications continued to be a valuable method of providing information to the public. New and innovative ways of presenting material and gaining feedback was progressed. A review of existing online systems was carried out and arrangements put in place for the development of new sites;
- special events - the communications team provided advice and support for events, visits, launches and conferences. Examples include the Marie Curie Rapid Response Service; NI Adult Safeguarding Partnership conference; eHealth and Care Awards and the Belfast Integrated Care Partnership initiative, Acute Care at Home;
- publications – newsletters and e-briefs were prepared for a number of Board initiatives including Transforming Your Care, You in Mind leaflets for mental health service users and contributions to the regional publication, NI Health Matters;



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

- public affairs - the communications team provided support for engagement with public and elected representatives and provided monitoring of activities throughout the year; and
- internal communications – staff continued to be kept informed about health and social care issues and, in particular, the proposed changes to HSC structures. New methods of progressing two-way communications were established including timely staff information sessions and tailored electronic communications.

During the period, communications support was also provided to the Board's five Local Commissioning Groups, Integrated Care Partnerships and Social Care Partnerships. Other key work included preparing communication plans for a number of Board strategies including the social work, dementia, domiciliary care, day opportunities and reablement strategies. The team also supported communications for Board consultations and every effort was made to ensure that information shared was accurate, relevant and timely.

A number of public campaigns were also successfully implemented including;

#### 1) the Choose Well Public Awareness Campaign

Following two successful 'Choose Well' campaigns to raise awareness of the range of healthcare services and to encourage people to choose the service most appropriate to their needs, a third campaign was launched during 2015/16. Developed and implemented by the Board, this high profile campaign is supported by the Health Minister, British Medical Association, Community Pharmacy NI, Patient Client Council and health and social care organisations across Northern Ireland. This year's campaign continued with a targeted campaign using TV, radio, posters, press, social media, online and outdoor advertising.

#### 2) The Medicines Waste campaign

This effective regional campaign encouraged the public to think before re-ordering repeat prescriptions and to use generic medicines where possible.

#### 3) Social work campaign

A number of activities were organised during the period to raise awareness about social work including an on-going programme of social media, social work awards and a student forum.

Effective partnership working was also demonstrated during 2015/16 as the communications staff worked closely with other organisations to ensure safe and successful communications for events and major incident planning events.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **REPORT OF THE DIRECTORATE OF TRANSFORMING YOUR CARE**

Following the departure of the Director, Mrs Valerie Watts (Chief Executive) has led the Directorate.

Transforming Your Care is an overarching road map for change in the provision of health and social care services in Northern Ireland, which was published following a review by the Minister for Health, Social Services and Public Safety in 2011.

The Health and Social Care Board is responsible for leading the implementation of a number of the recommendations made in the Review.

#### **KEY PERFORMANCE HIGHLIGHTS**

##### **Developing and implementing new models of care**

In 2015/16, the Board prioritised £15m of its own funds to allow continued investment in projects to proceed and to enable a small number of new projects to be taken forward. The Northern Ireland Executive also made available £1.5m of Change Funds to allow three new initiatives to proceed.

One of the central tenets of reform has been the shifting of resources from hospital settings into care in primary or community settings. By the end of 2015/16, £52m of the projected £83m described in the Transforming Your Care report is estimated to have been shifted left and this is anticipated this to rise further in 2016/17.

The Health and Social Care Board has led a number of key TYC initiatives this year:

##### **Regional Care Pathways**

In May 2015, a new regional project commenced to standardise the design and treatment of patients with specific conditions. The project is led by a Steering Group with HSC-wide organisational and multi-disciplinary representation and has adopted a Quality Improvement approach to pathway design and testing, with co-production from service users. The first two pathways designed are for treatment of children who suffer asthma attacks, and the diagnosis and assessment of adults who are suspected of having heart failure. The pathways are designed, drawing upon NICE guidance and regional frameworks and specify care for patients in an easy to follow flow chart. The children's asthma project is now in the testing phase.

##### **Directory of Services (DoS)**

In 2015, a regional DoS project was initiated, facilitated by the TYC Directorate. The aim of the DoS is to simplify access to health and social care information for healthcare professionals and members of the public.

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### HSC Online

The focus of the HSC Online project is to facilitate public access to more health and social care information electronically. A specific objective is to develop an online service which will provide access to health and social care information while promoting education and self-care. The development of this service is now being taken forward through the *nidirect* official government website.

Further information about HSC Online and DoS are available within the Director of eHealth's report.

#### Regional Outpatient Reform

The Board, Public Health Agency (PHA), Health and Social Care Trusts (Trusts) and Primary Care have been engaged in a process of outpatient reform for a number of years and this has generated success in a range of medical and surgical speciality areas.

The regional Outpatient Reform Project was established to coordinate HSC-wide efforts to bring about reform of outpatient services across Northern Ireland. Outpatient reform is about introducing new, more effective arrangements for delivering outpatient care, designed around patient needs and with reduced waiting times, ensuring that outpatient services are appropriate, provided in the right place at the right time and maximising the use of technology to provide an excellent service.

A regional Steering Group is in place to direct the project and four initial specialty areas are being taken forward for reform: General Surgery including Gastroenterology, Gynaecology, Rheumatology, and ENT.

Multi-Disciplinary Workstreams are developing plans in each specialty area and working towards reform:



The Regional Outpatient Reform Steering Group met on 10 March 2016, during which an update was provided in relation to the cross-cutting themes for reform emerging from the four specialty based Multi-Disciplinary Workstreams.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

The Steering Group supported the proposals to progress partnership working between Primary and Secondary Care by developing solutions to managing demand differently, and alternatives to referral as appropriate; to improve the interface between Primary and Secondary Care through regionally standardised referral communication, regional implementation of eTriage, developing regional Care Pathways, and utilising the skill mix of Multi-Disciplinary Team; and to transform outpatient review.

Going forward the regional outpatient reform work will be progressed as part of a single process for scheduled care reform; next steps are to be communicated HSC-wide shortly.

#### **Integrated Care Partnerships (ICPs)**

The 17 ICPs have made significant progress across the clinical priorities (services for the frail elderly and those with some long term conditions: respiratory conditions, diabetes and stroke).

Since 2012, £15.8m has been invested in ICPs from Transforming Your Care transitional funding as well as investment from core funding and demography funding. Further information about their progress is set out in the Director of Integrated Care's Report within this Annual Report.

#### **Self Directed Support (SDS)**

The Social Care and TYC Directorates of the Board are working collaboratively to take forward Self Directed Support, a new model for social care which recognises how different individual needs sit within a wider network of personal and social care in the community, and provides individuals with the flexibility to design the support they need to best meet their goals/outcomes. This can include a wide and diverse range of support mechanisms, drawn from either the statutory, private or community and voluntary sectors, or a combination of all of the above.

#### **Statutory Residential Homes**

In June 2014, following public consultation, the Board approved the criteria against which statutory residential homes for older people would be evaluated to support decision making about their future. Due to wider environmental changes in independent sector residential care, the Board was requested by the Minister for Health, Social Services and Public Safety to pause the current statutory residential homes change process.

#### **Reablement**

Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability and the necessary skills to live independently, especially after having experienced a health or social care crisis.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Domiciliary Care Review**

The Board established a regional Domiciliary Care Review Group to examine the challenges and functions of the service. A final report on its findings was approved by the Board in November 2015. The report sets out a series of recommendations for change which provide a strategic framework for development.

Further information about Self Directed Support, Statutory Residential Homes, Reablement and Domiciliary Care Review can be found in the Director of Social Care's Report within this Annual Report.

#### **Communication and Engagement**

Working closely with the Board's Communications Team, the TYC Directorate has continued to engage with stakeholders across Northern Ireland about the progress of projects and their outcomes.

In addition to this, the Transforming Your Care e-Zine continued to be issued this year, highlighting projects from across the Board, the PHA, the 6 Trusts, primary care, and our third sector partners.

The e-Zines have included a wide range of stories of reform including Integrated Care Partnerships, Reablement, eHealth, the NI Electronic Care Record, Self Directed Support, NIAS Alternative Care Pathways, developments in Primary Care infrastructure, Palliative Care, Rapid Response Nursing, Acute Care at Home, Family Nurse Partnerships and Carers.

The Transforming Your Care website has also been updated to reflect information on new projects, and to share service user and carer stories. This year, together with the DHSSPS and PHA, we also published the 2<sup>nd</sup> annual update on progress with Transforming Your Care. It demonstrated that of the 99 proposals set out in the original report, the implementation of 50 proposals have been completed, 46 are in progress, and three have been deferred subject to the evaluation of the ICP model.

We have continued to support and progress the HSC Knowledge Exchange which provides access to resources, good practice, leading thinking and up to date news and events across local, national and international systems to everyone in the HSC system – both statutory and independent sectors. Membership of the Knowledge Exchange continues to grow, and the site now has specialist areas for Integrated Care Partnerships, Reablement, Social Work Strategy and Care Pathways.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **KEY CHALLENGES**

##### **Funding**

The provision of funding for reform has been slower than expected but by the end of 2015/16, we will have invested £41.4m since 2012 in the model of care set out in Transforming Your Care from a variety of sources. The reform and transformation agenda remains a high priority for the Board and the Minister, and we continue to work closely with DHSSPS to seek additional funding to support its implementation.

##### **Engagement**

As recognised by the Donaldson Report, gaining public and political support for major reform is challenging, although there is strong agreement on the need for change and the model set out in TYC. Continued engagement with the public, interested groups and politicians will be prioritised in the coming year in conjunction with the work being carried out by Professor Bengoa and the Expert panel to enable views to be discussed and concerns to be alleviated.

##### **Clinical and Staff Leadership**

It is important that staff, both professional and management, have the confidence, capability and capacity to lead change. We are engaging closely with the DHSSPS in relation to workforce and with the HSC Leadership Centre in relation to supporting leadership development, as well as ensuring that the priority reform projects are clinically led with representation from across our HSC system including DHSSPS, Commissioners, Trust and Primary Care.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **REPORT OF THE DIRECTOR OF eHEALTH AND EXTERNAL COLLABORATION**

The World Health Organisation defines eHealth as “the use of information and communication technologies (ICT) for health”.

#### **KEY PERFORMANCE HIGHLIGHTS**

During 2015/16, an eHealth and Care strategy was publicly launched by the Minister for Health. The strategy communicates how technology can support better health and wellbeing, and provides the basis for monitoring and supporting progress on the implementation plan.

In 2015, the eHealth and Care Board conducted research into the potential costs and benefits of investment in a single health record for Northern Ireland. This research report concluded that Northern Ireland should build on the internationally renowned success of the NI Electronic Care Record (NIECR), now used by over 23,000 clinicians, to provide safer, faster care. The quality and scope of information on the NIECR has been growing since its launch in June 2013, with increasing numbers of staff using it. It is also reducing the need for tests and repeat appointments, and improving the quality and safety of care, for patients.

The goal of a single health and care record is an ambitious agenda that has the potential to radically improve health and wellbeing for the citizens of Northern Ireland. For this to be delivered between 2016 and 2020, it will require a significant investment and reform programme.

During the past year, the Board continued to invest in eHealth and Care systems and services to support transformational change. Achievements in 2015/16 include:

- funding of €3m (Euros) for the development of innovative solutions to support those recovering from stroke, and a programme developing additional eHealth support for frail older people. We continue to develop partnerships and collaborate with partners across Europe and further afield to secure support for the development of innovative solutions to meet current service challenges. In addition to these benefits, health and social care seeks to attract additional funding from European competitive funding streams;
- clinical eLearning tools - working with a local company to launch an innovative new tool to support clinicians to safely improve their clinical image interpretation skills. This development was recognised in March 2016 at the NI Healthcare awards as the best example of using technology innovation to drive healthcare improvement;
- investment has continued in the development of electronic referral, assessment and discharge processes. Taken together, these three projects have the potential to significantly accelerate assessment of referrals, care decision making, and care communication processes. They will significantly reduce the burden of paper referrals and manual booking processes that usually delay decision making and add cost in health and care systems;

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

- HSC Online – a program to establish high quality, trusted health and care information, accredited by the HSC, to support NI citizens delivered the first phase of new information on ‘nidirect’ in March 2016. The first phase focussed on the conditions that most frequently generate questions to health web resources, and will further develop during 2016/17. Investment during 2015/16 in creating access to GP appointment booking and repeat prescribing systems will see the proportion of GP practices able to offer these services rise from 45% to over 90% by June 2016;
- Directory of Services (DoS) – The DoS aims to simplify access to health and social care information for healthcare professionals and provide a consistent level of detail about health and social care services which will be maintained and accessible regionally through one single point of entry. Once established, a patient facing format may also be made available via HSC Online, which will provide a public facing portal into health and social care. Further phases of the project will support the ability for HSC professionals to make direct referrals to a range appropriate services, ensuring patients receive timely, appropriate and directed support to meet their immediate health and social care needs; and
- appointment of Chief Clinical Information Officers (CCIO) for the six Trusts is now complete. The CCIOs will support the improved use of eHealth among healthcare professionals.



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **REPORT OF THE DIRECTOR OF FINANCE**

##### **Overview**

The Health and Social Care Board (HSCB) received a Revenue Resource Limit (funding) from the Department of Health, Social Services and Public Safety (DHSSPS) in 2015/16 of £4,406m (excluding non-cash of £17.8m). In addition to this the HSCB also received income from other sources of £51.1m and capital allocations totalling £3.1m.

The funds received are utilised by the HSCB to commission a wide range of health and social care services for the population of Northern Ireland from Trusts, Family Health Service Practitioners, Business Services Organisation and other third sector organisations as well as funding the running costs of the HSCB.

The HSCB has an operational responsibility to ensure the overall financial stability of the Health and Social Care (HSC) system within Northern Ireland including the Trusts, HSCB and the Public Health Agency (PHA). In 2015/16 the significant financial constraints required rigorous planning, monitoring, management and decision making with respect to the budget by the HSCB. Throughout the year the HSCB worked closely and pro-actively with all HSC Trusts and the DHSSPS in order to address the on-going severe financial challenges faced by the system. This ultimately necessitated the development of a revised financial plan during the year in order to maintain the quality of services required, to manage the increased demand and corresponding financial pressures being experienced by Trusts.

The financial statements presented in this Annual Report and Accounts highlight a surplus of £0.6m for the HSCB. The HSCB also has a responsibility to ensure that the HSC system as a whole breaks even and with the implementation of the revised financial plan; this was delivered in 2015/16.

The Statement of Financial Position shows a negative position of £172,182k at the 2015/16 financial year end. I can confirm that we expect the liabilities will be met as they fall due through the cash draw down mechanism. Funding for 2016/17 has been approved by way of an allocation letter, received from the Department on 24 March 2016.

##### **Outlook**

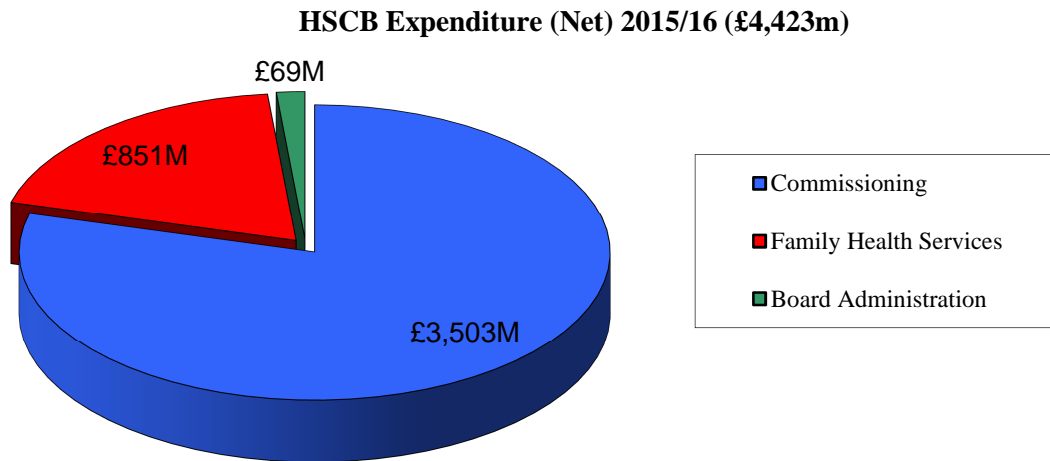
The outlook for 2016/17 continues to be extremely challenging with financial pressures experienced in previous years continuing to grow in 2016/17 and outstrip additional available funding. This will impact on the HSCB's desire to commission new beneficial Health and Social Care (HSC) services and will require HSC organisations to deliver further substantial and challenging efficiency and productivity savings, in order for the available resources to be utilised as effectively as possible.

# HEALTH AND SOCIAL CARE BOARD

## ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

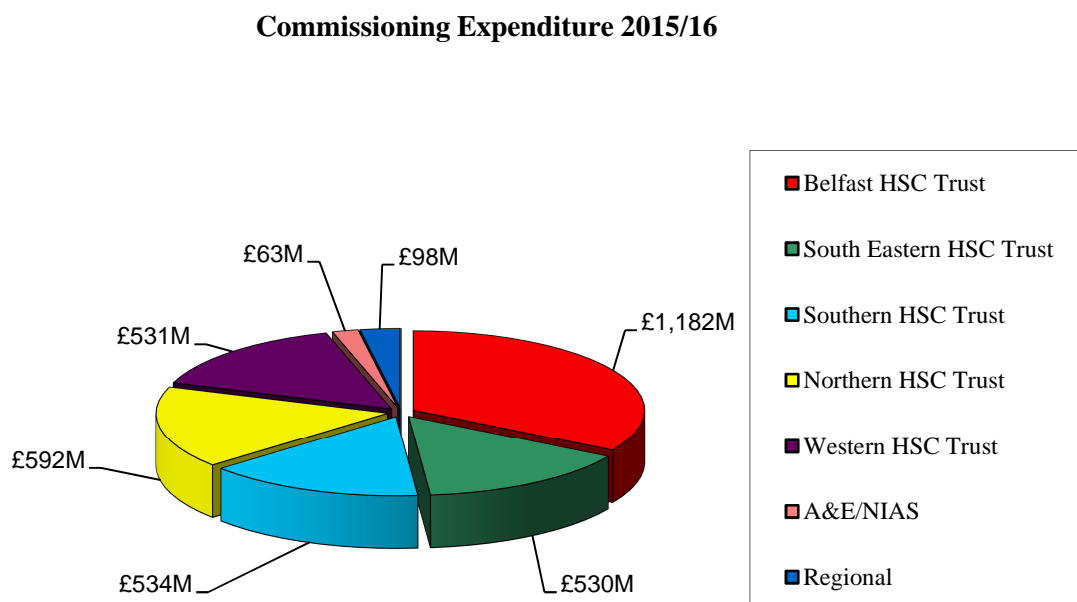
### Health and Social Care Board Expenditure 2015/16

The Board's net expenditure falls into three main areas as seen below:



### **Commissioning**

The Board commissions most of its services from local Trusts with a small amount being delivered by other providers, as seen below:



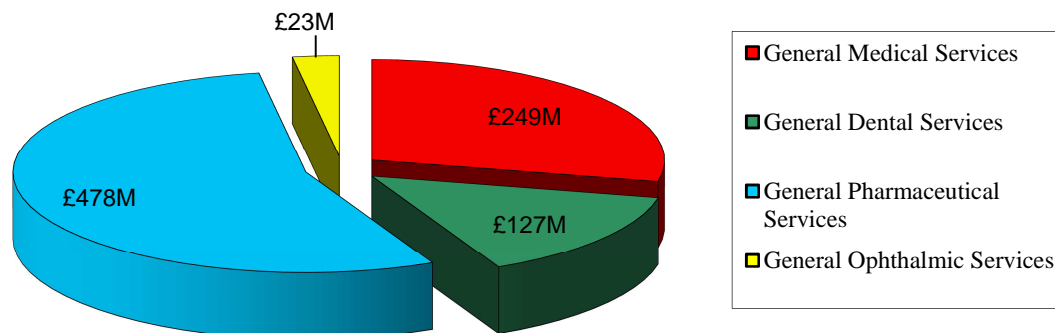
# HEALTH AND SOCIAL CARE BOARD

## ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

### Family Health Services

The Health and Social Care Board spent £877m on Family Health Services in 2015/16 to meet the health and social care needs of local populations. The breakdown by service area is shown below.

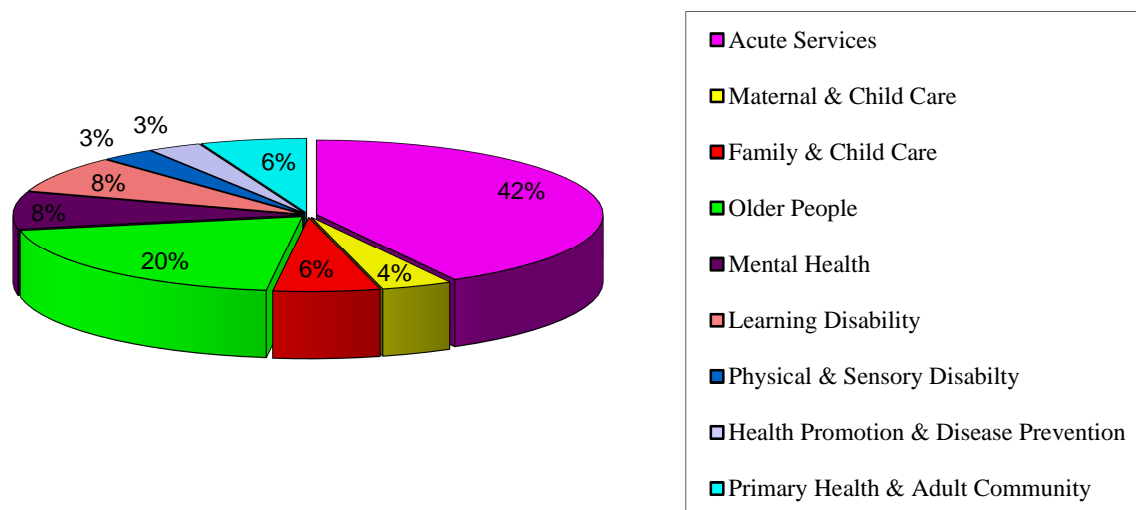
**FHS Expenditure 2015/16**



### Programmes of care

Commissioning resources expended via the various providers set out above are deployed within nine Programmes of Care as follows:

**Programmes of Care 2015/16**



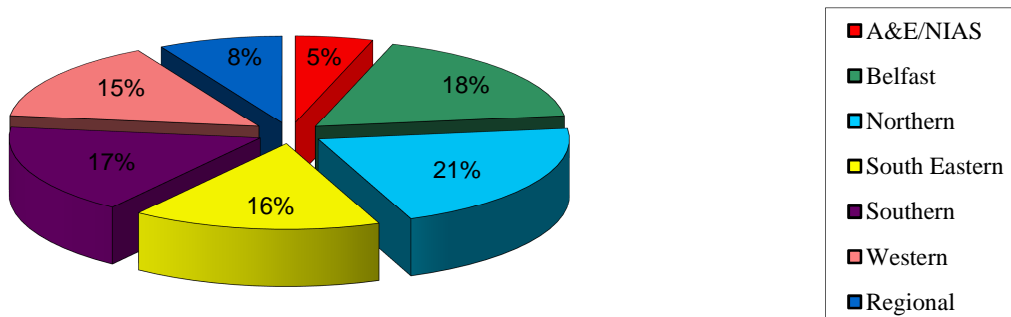
Source of data Strategic Resource Framework 2015/16

# HEALTH AND SOCIAL CARE BOARD

## ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

### Local Commissioning Group Expenditure

Local Commissioning Net Expenditure 2015/16



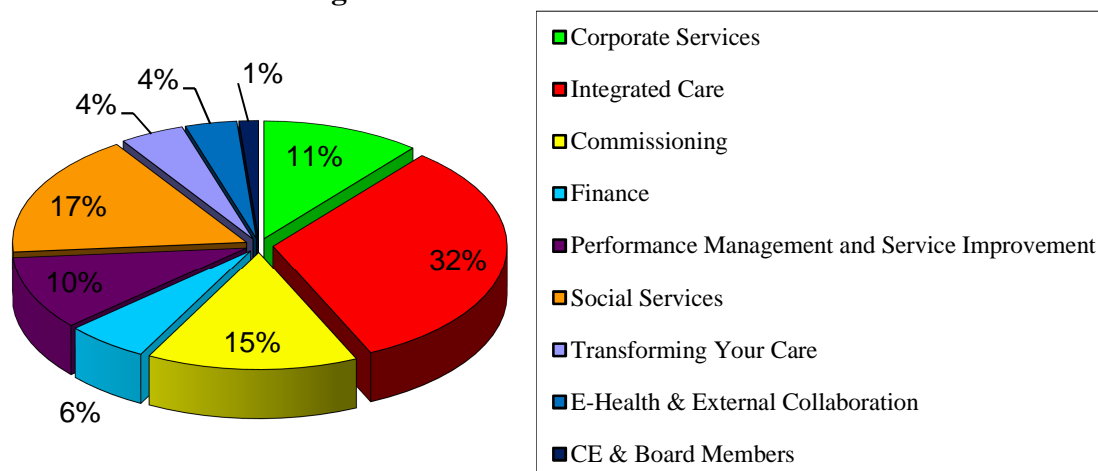
Source of data Strategic Resource Framework 2015/16

### Health and Social Care Board Management Costs

At the centre of the Health and Social Care Board are the staff who manage the delivery of these high quality services. During the 2015/16 financial year the HSCB faced the difficult challenge of having to release £5.4m of its management and administrative budget whilst continuing to successfully deliver its many and complex functions. Looking forward into 2016/17, the challenges will escalate further due to an additional budget reduction of £2.7m, along with the Minister for Health’s announcement in November 2015 regarding his intention to close the HSCB. It will be a significant challenge for the HSCB to deliver the savings required and ensure that core functions continue to be delivered to the standard that its stakeholders expect.

The percentage breakdown by Directorate of the Health and Social Care Board’s staff costs and goods and services for 2015/16 is shown below.

HSCB Management costs 2015/16



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Public Sector Payment Policy – Measure of Compliance**

The Department requires that the Health and Social Care Board pay their Non Health and Social Care trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The HSCB's payment policy is consistent with the Better Payments Practice Code and Government Accounting Rules, its measure of compliance can be found within note 14 of the Annual Accounts within this combined document.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **REPORTS FROM THE BOARD'S COMMITTEES**

The Board has a number of Committees to scrutinise important aspects of its work. These cover the following:

- Reference;
- Governance;
- Audit;
- Pharmacy Practices; and
- Remuneration and Terms of Service.

A report now follows from each of these Committees on their work during the past year.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Report of the Board's Reference Committee**

The role of the Board's Reference Committee is to ensure that the highest quality of health and social care is maintained in Northern Ireland. Primarily this is achieved by monitoring the professional standards of family care practitioners: GPs; dentists; pharmacists; and opticians, and considering complaints and feedback about any relevant matters, referring any such cases for further investigation. Depending on the nature of each case subsequent investigation can involve the Board, other agencies or relevant professional bodies such as the General Dental Council, the General Medical Council, the General Ophthalmic Council or the Pharmaceutical Society of Northern Ireland. The work of the Committee is dependent on support from Board officers and their staff.

Within the 2015/16 year, the Reference Committee met on two occasions. Since its establishment in 2009, the Committee has considered 29 cases and concluded 17.

The Committee has established processes to ensure that any cases coming before it are considered in a fair and confidential manner and, with Board professional leads, regularly reviews the operation of these processes to ensure they are fit for purpose. The Committee also continually monitors and reviews individual cases to ensure the information presented is current. Occasionally concerns over relevant strategic issues are raised with the Health and Social Care Board.

Cases that can require consideration by the Reference Committee can relate to:

- failings in professional standards;
- Serious Adverse Incidents involving a practitioner, particularly when an incident puts the public at risk; and
- matters referred by the police, the Coroner, or other legal entities

In overall terms, the Committee remains of the view that the quality of care and clinical standards provided by family practitioners across Northern Ireland remains of a very high standard. Any such failings remain as rare events, and the Committee acknowledges that much work continues to maintain and develop standards. This process is being actively pursued with the input and assistance of practitioners and their representative organisations.

#### **Membership of the Reference Committee:**

Mr Brendan McKeever, Chair

Dr Melissa McCullough, Non-Executive Director

Mrs Fionnuala McAndrew OBE, Executive Director/Director of Social Care and Children's Services

#### **In attendance:**

Dr Sloan Harper, Director of Integrated Care – professional advice

**Mr Brendan McKeever**

**Chair of the Board Reference Committee**

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Report of the Board's Governance Committee**

The Governance Committee is made up of four Non-Executive Directors: Dr Robert Thompson (Chair); Stephen Leach; Dr Melissa McCullough; and John Mone. To ensure an integrated understanding of risks across the organisation, there is considerable overlap between the Non-Executive membership of the Governance and Audit Committees. However, the Governance Committee includes a Non-Executive member with a professional nursing background.

In addition, the Board's Senior Management Team is in attendance at all meetings of the Governance Committee. During the 2015/16 financial year, the Governance Committee met on four occasions: 2 April 2015; 4 June 2015; 24 September 2015 and 28 January 2016. In addition to these scheduled Committee meetings, a joint meeting of the Audit and Governance Committees was held on 8 October 2015 to consider the Mid-Year Assurance Statement.

The Governance Committee provides assurance to the Board across a broad range of areas, including:

- management of corporate risk;
- quality, safety and standards in health and social care;
- Social Care Delegated Statutory Functions;
- controls assurance and internal control;
- serious adverse incident management;
- complaints management;
- litigation management;
- maintenance of the reputation, image and integrity of the Health and Social Care Board;
- professional regulation; and
- information governance.

During 2015/16, the Committee considered a range of important issues, including the Board's Corporate Risk Register, the year-end Governance Statement, the mid-year Assurance Statement, Learning Reports, including thematic reports, from Serious Adverse Incidents (SAIs), Board/PHA Emergency Preparedness and Response, relevant RQIA reports, General Medical Services Governance Reports and reviewed Safety and Quality Alerts.

Once approved by the Committee, minutes of Governance Committee meetings are brought to the attention of the full Board at the subsequent public Board meeting.



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Current membership of the Governance Committee:**

Dr Robert Thompson (Chair)

Mr Stephen Leach

Dr Melissa McCullough

Mr John Mone

**Dr Robert Thompson (Chair)**  
**Governance Committee**

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Report of the Board's Audit Committee**

In its work, the Audit Committee has sought to balance independent oversight of the business of the HSCB with support and guidance to management. The Committee has carried out its duties in 2015/16, effectively and to a high standard, and helped to provide value for the HSC.

The members of the committee are individuals who between them have significant experience within the HSC or other public and private sector business areas and have the knowledge and experience to properly discharge their duties. In addition, the Chair attends the regional Audit Committee Chair's Workshop to ensure regional developments are taken account of in the Committee's business. They are supported by members of senior management of the HSCB and the Internal and External Auditors, who attend each meeting of the Committee. The Committee considers its own performance by undertaking an annual self-assessment exercise based on good practice guidance issued by the National Audit Office and HM Treasury. In the 2015/16 assessment the Committee evidences and considers that it substantially complies with these good practice standards.

The annual schedule of business considered by the committee covers the key areas within the Committee's remit as set out within its Terms of Reference, and is supported by information provided by HSCB management and the Internal and External Auditors. The Committee considers that this information is of a high standard and ensures that committee members have the information they need to give proper consideration to all matters brought before them. The Committee has open access to senior management and the Chair has monthly meetings with the Director of Finance.

The Committee provides regular updates to the full HSCB Board and shares minutes with all Board members, which are subsequently published on the HSCB website. The Chair and members of the Committee have annual appraisals by the Chair of the HSCB as Non-Executive Directors and have opportunities to avail of training to support them in their role.

The Audit Committee consider that they have good working relationships with both the External and Internal Auditors and met privately with both without management being present on 4 June 2015. In addition, the Chair held bi-lateral meetings with both the auditors in during 2015.

During the year, the Audit Committee met 4 times and was quorate at each meeting, an additional meeting was held with the Governance Committee to consider management's Mid-Year Assurance Statement. The Director of Finance, the Assistant Director of Finance, the Head Accountant, Internal Auditor and External Auditor, or their representatives attend all meetings of the Committee.

#### **2015/16 Work Programme**

The formal role of the Audit Committee is set out in its terms of reference, which are available by accessing the following link:

[www.hscboard.hscni.net/board/Standing\\_Orders\\_February\\_2016.pdf](http://www.hscboard.hscni.net/board/Standing_Orders_February_2016.pdf)

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

The Audit Committee annually advise the Board and Accounting Officer on:

- the strategic processes for risk, control and governance and the Governance Statement;
- the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified and management's letter of representation to the External Auditors;
- the planned activity and results of both Internal and External Audit;
- the scope and effectiveness of Internal control, including management's assessment of compliance with Controls Assurance Standards and amendments to key documents;
- adequacy of management response to issues identified by audit activity, including the External Auditor's management letter;
- assurances relating to the corporate governance requirements for the organisation; and
- anti-fraud policies, whistle-blowing processes and oversight arrangements for suspected fraud investigations.

These planned activities were considered by the Committee and were informed by reports prepared by management and Internal and External Auditors which the Committee considered were comprehensive. Management also proactively brought issues to the Committee which they felt were relevant.

In addition, during 2015/16 the Audit Committee had a special focus on management's implementation of Internal Audit Recommendations and as a result an additional review was conducted by management in quarter 3. This process has resulted in an improvement in the number of recommendations which have been fully implemented at the end of year review (86% 2015/16, 74% 2014/15).

A key consideration for the Committee is considering any new business areas which may impact on the Annual Accounts, or any changes to Accounting Policy since the prior year. During 2015/16 the Committee considered management's implementation of new business for the Board in the form of the issuing of loans to GPs for infrastructure schemes, this included the Recognition, Measurement, Disclosure and associated credit risks of this scheme.

Subsequent to the Minister for Health's announcement in October regarding the future of the Board, the Committee also considered:

- the interpretation of Going Concern for the presentation of the Board's 2015/16 Annual Accounts and Report;
- the good practice guide received by the NI Audit Office regarding 'Managing Fraud Risk in a Changing Environment'; and

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

- views from Management that the increased risks on the system of Internal Control as a result of reducing staff numbers were captured within the Board's risk register.

The Committee reviewed the 2014/15 Annual Accounts prepared by the Director of Finance and, focused on key areas of judgement and complexity, critical accounting policies, provisioning and any changes required in these areas or policies. In making a recommendation to the HSCB Board to approve the Annual accounts and report for 2014/15, the Audit Committee sought views from both the Internal and External Auditors.

With the support of management, the Audit Committee reviewed the HSCB's 2014/15 Annual Report and recommended to the Board that it considered the Annual Report was fair, balanced and understandable.

#### **External Audit**

During the year, the Audit Committee reviewed the External Audit strategy and the findings and recommendations of the External Auditor from its review of the Annual Report and Accounts.

The HSCB's External Auditor is the NIAO Comptroller and Auditor General – appointed by the NI Assembly. NIAO have subcontracted the work of the External Audit to ASM Chartered Accountants.

#### **Internal Audit**

The annual Internal Audit Plan and Strategy was considered by the committee in light of the key risk areas of HSCB's business. The committee also considered the experience of the Internal Auditors through their adherence to Public Sector Internal Audit Standards (PSIAS) and by reviewing their Charter and noting the satisfactory outcome of their self-assessment against the PSIAS.

The Audit Committee assessed the on-going effectiveness and quality audit processes on the basis of meetings and by constructive challenge of recommendations made.

In considering all of the work streams and assurances set out above, the Audit Committee considered whether the HSCB's established governance and control environment was effective, and reviewed and considered the evidence on which the assurances provided by Internal and External Auditors were based. The Committee also paid special attention to the Assurances and performance of the HSCB's Shared Service Provider (BSO) due to previous performance and audit findings. The work programme set out above informed the Committee's view on:

- the HSCB's systems of Internal control;
- the HSCB's compliance with statutory requirements, guidance and Codes of Conduct; and
- assurances received from third parties.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

In summary, the Audit Committee considers that there is an effective system of governance and control within the HSCB and that Assurances received are of a standard which meets the Board and Accounting Officers needs during 2015/16.

#### **Current membership of the Audit Committee:**

Mrs Stephanie Lowry (Chair)

Dr Robert Thompson

Mr Robert Gilmore

Mr John Mone

**Mrs Stephanie Lowry**  
**Chair of Audit Committee**

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Report of the Pharmacy Practices Committee**

The Board is required under The Pharmaceutical Services (Northern Ireland) Regulations 1997 to maintain the list of pharmaceutical and appliance contractors.

It exercises this duty through the Pharmacy Practices Committee (PPC) which deals with applications to:

- Join the pharmaceutical list (to open a community pharmacy);
- Provide domiciliary oxygen services;
- Non-minor relocations (where the proposed relocation of the pharmacy is in a different neighbourhood); and
- Applications for changes to opening hours.

The audio-visual trial was extended into 2015/16 following limited uptake in 2014/15 and there has been only one applicant availing of this facility in the current year. It is intended to carry out an evaluation around year end to determine if this facility will be provided on an on-going basis to persons attending PPC.

The Board decides upon minor and temporary relocations.

As the Committee needs to assess the needs of the population on a local level and define the neighbourhood which a proposed pharmacy would serve, the Board has constituted the Committee under the Chair and Vice-Chair into four panels. Mrs Stephanie Lowry, Non-Executive Director, has joined the Committee as Vice Chair. The service provided by the members of the Committee is greatly appreciated.

Separate to the work of the PPC, the DHSSPS and Board has initiated a needs assessment process which will support PPC decision making and inform future arrangements for managing the deployment of pharmaceutical service provision.

For the period 2015/16, the Pharmacy Practices Committee dealt with the following applications:

Full applications: 3 (3 refused)

Oxygen applications: 1(1 approved)

Change of hours: 3 (2 approved)

Non-minor relocations: 2 (2 refused)

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Current Membership of the Pharmacy Practices Committee:**

Mr John Mone (Chair)

Mrs Stephanie Lowry (Vice Chair)

Other members of the committee are dependent on where the committee is being convened. The quorum comprises contractor pharmacists, non-contractor pharmacists and non-pharmacists (lay members).

**Mr John Mone**  
**Chair of the Pharmacy Practices Committee**

**HEALTH AND SOCIAL CARE BOARD**

**ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

**Accounting Officer Signature – approval of individual sections within Performance Report**



**Mrs Valerie Watts  
Chief Executive**

Date 9 June 2016



## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### ACCOUNTABILITY REPORT - GOVERNANCE REPORT

##### Directors' Report

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

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 its full time staff who have been appointed to lead each of the Board's 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 for Health, Social Services and Public Safety.

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. All appointments are made following open competition, governed by the overriding principle of selection based solely on merit. The Non-Executive Directors are independent and reflect wider outside and community interests in the decision making of the Board.

The Board comprised the following directors during the year 1 April 2015 – 31 March 2016:

##### 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



Mrs Stephanie Lowry

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### Executive Directors



Valerie Watts  
Chief Executive



Mr Paul Cummings  
Director of Finance



Mrs Fionnuala McAndrew  
Director of Social Care and  
Children



Mr Dean Sullivan  
Director of Commissioning



Mr Michael Bloomfield  
Director of Performance and Corporate  
Services

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

Dr Sloan Harper, Director of Integrated Care, Health and Social Care Board.

Mrs Pamela McCreedy, Director of Transforming Your Care, Health and Social Care Board until May 2015.

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.

Mrs Mary Hinds, Director of Nursing and Allied Health Professionals, Public Health Agency.

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

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Board of Directors**

The Board of Directors is made up of a Non-Executive Chairman, seven Non-Executive Directors, the Chief Executive and four Executive Directors. Executive directors are employees of the Health and Social Care Board. Non-Executive directors are those appointed to their roles by the Minister.

#### **Chairman, Dr Ian Clements**

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.

#### **Chief Executive, Mrs Valerie Watts**

Valerie Watts took up post as Chief Executive of the Health and Social Care Board in July 2014. Mrs Watts has over 30 years' public sector experience, beginning her career at the Royal Victoria Hospital where she oversaw competitive tendering for ancillary support services. 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.

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

Mr Gilmore lives in Co Down and is a self-employed Management Consultant and 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 Board Member of the Department for Regional Development and a member of its Department Audit and Risk Assurance Committee. He was formerly a Director in a Local Strategy Partnership, 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 is currently a Commissioner with the Criminal Cases Review Commission.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Mrs Stephanie Lowry, Non-Executive Director**

Mrs Lowry has 30 years' experience working in both the private and public sector throughout her career. She has held several public appointments in a variety of areas, including Independent Board Member with the Department of Culture, Arts and Leisure; Deputy Chair of the Health and Safety Executive and was a member of the Office of the First Minister and Deputy First Minister (OFMDFM) Audit Committee and an Independent Assessor for Public Appointments. She has been a Non-Executive Director of the Health and Social Care Board since 2013.

#### **Dr Melissa McCullough PhD, MsC Clinical/Bioethics, LLB, Non-Executive Director**

Dr McCullough lives in Belfast and is a Senior Lecturer in Clinical Ethics & Law at Brighton & Sussex Medical School, University of Sussex. She has been a Non-Executive Director of the Health and Social Care Board since 2009. Melissa has been a visiting lecturer at the Royal College of Surgeons of Ireland since 2006 and her interests are primarily in human rights & healthcare, equality and justice in priority setting in health care and policy, commissioning and public health ethics. She also has an interest in public engagement including performing arts & ethics and works with local voluntary bodies in Belfast and Brighton.

#### **Mr Brendan McKeever MSc, PGCE, Non-Executive Director**

Mr McKeever is a User Consultant at Queen's University and the University of Ulster 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. He has been a Non-Executive Director of the Health and Social Care Board since 2009.

#### **Mr John Mone MSc, BA, Non-Executive Director**

Mr Mone lives in Co Armagh. Until his retirement in 2007, Mr Mone had been Executive Director of Nursing at the former Craigavon Area Hospital Health and Social Services Trust and former Director of Healthcare and Nursing and Executive Director on the Trust Board of the former Armagh and Dungannon HSS Trust. He has also served on the Board of Governors of St John's Primary School; member of the NI Research Ethics Committee and Middletown and District Community Development Association. He has been a Non-Executive Director of the Health and Social Care Board since 2009.

#### **Dr Robert Thompson MB, BCh, FRCGP, Non-Executive Director**

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

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

Social Services Board in a senior capacity where he assisted with the development of many services provided to patients by GPs.

#### **Director of Finance, Mr Paul Cummings**

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.

#### **Director of Social Care and Children, Mrs Fionnuala McAndrew OBE**

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 afterwards 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).

#### **Director of Commissioning, Mr Dean Sullivan**

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

#### **Director of Performance and Corporate Services, Mr Michael Bloomfield**

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. Michael was appointed Head of Corporate Services in the Board in March 2011 and in November 2012, also took on the role of Acting Director of Performance Management and Service Improvement.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Related party transactions**

The HSCB is an arm's length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the HSCB has had various material transactions during the year.

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.hscb.hscni.net](http://www.hscb.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 2016 was £52,000.

#### **Statement on Disclosure of Audit Information**

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.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES**

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health, Social Services and Public Safety has directed the Health and Social Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Health and Social Care Board, 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 Accounts Direction issued by the Department of Health, Social Services and Public Safety 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 Health and Social Care Board will continue in operation.\*
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Health and Social Care Board.
- Pursue and demonstrate value for money in the services the Health and Social Care Board provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Principle Accounting Officer for Health and Personal Social Services Resources in Northern Ireland has designated Valerie Watts of the Health and Social Care Board as the Accounting Officer for the Health and Social Care Board. 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 Health and Social Care Board's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

\*It should be noted that the Minister for Health announced in November 2015 his intention to close the HSCB and realign its activities across the wider HSC system. However, no formal timeframe for closure has been advised and as DHSSPS have confirmed the HSCB's budget for the period 2016/17, HSCB is expected to continue as constituted for the 2016/17 financial year. The financial statements, therefore, have been prepared on a going concern basis.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **GOVERNANCE STATEMENT**

##### **1. Introduction / Scope of Responsibility**

As Accounting Officer and Chief Executive of the Board, 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, Social Services and Public Safety (DHSSPS).

##### ***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 DHSSPS, 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 (HSC) Trusts

HSC 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 HSC 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 HSC Trusts of agreed objectives and targets and also provides a process whereby the HSCB and PHA can work closely in supporting HSC Trusts to improve performance and achieve desired outcomes.

##### ***Inter-relationship with DHSSPS and HSCB***

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



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

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

The HSCB provide the DHSSPS with quarterly (or as required) assessments of the progress being made in the delivery of DHSSPS 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 departmental officials, to discuss the HSCB's operational and financial performance; policy developments and corporate control issues.

#### **2. Compliance with Corporate Governance Best Practice**

The HSCB applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. 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 enables 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 two conflicts of interests declared at Board meetings: one on 13 August 2015 and one on 12 September 2015, appropriate action was taken in accordance with the Code of Conduct. There were abstentions or dissensions from voting on a number of occasions and these are recorded in the public Board minutes.

##### ***Register of Interests***

The HSCB has in place a Register of Interests for the following groups:

- **Directors:** These are reviewed annually and where relevant throughout the year. They are noted at public Board meetings and published on the HSCB website.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

- Committee Members: There is a Register of Interests for each of the five LCGs which are also subject to annual review and if relevant throughout the year. These are noted at public LCG meetings and also published on HSCB website.
- There is a Register of Interests for those involved in Board Committees who are not HSCB Officers and relates solely to those who participate in the Pharmacy Practices Committee. This Register is also reviewed annually.
- Staff: A Register of Interests for all HSCB staff was established in March 2015. This is reviewed annually.

#### ***Gifts and Hospitality Policy***

The HSCB Gifts and Hospitality Policy was published in April 2012 and is compliant with 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. During the reporting period, the Committee received two reports at its meetings on 2 April and 24 September 2015.

#### ***Performance Appraisal System***

During 2015/16, Performance Appraisals were completed and Performance Development Plans agreed for 72% of staff. In addition, the DHSSPS carried out its annual appraisal with the HSCB Chair who, in turn, carried out an annual assessment of each Non-Executive Director.

LCG Vice-Chairs assumed the position of Interim LCG Chairs during the period under review and have met with the Chair on a regular basis.

#### ***Training***

“Essential Skills” refresher training, which was last undertaken in 2013 and valid for 3 years, would be due in 2016. While no further training was provided during the period under review, and given the Ministerial announcement (November 2015), 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 2015/16 was approved by the Board at its meeting on 14 April 2016. From 2015/16, ALBs are required through their mid-year assurance statement, that the tool is being completed, actions are being addressed and that 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. The completed 2015/16 self-assessment evaluation included one mandatory case study focussing on performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **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); and
- 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 consequent 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 on 4 June 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, 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 Chief Executive and the Executive Directors, Director of Finance, Director of Commissioning, Director of Social Care and Children and Director of Performance Management and Service Improvement are employees of the HSCB. A number of Directors from the Board's Senior Management Team also attend Board meetings including the Director of Integrated Care, the

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

Regional Director of eHealth and External Collaboration, the Director of Corporate Services, 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 Board's five Local Commissioning Groups and by representative/s of the Patient Client Council.

The HSCB has three main functions:

- to commission a comprehensive range of modern and effective health and social care for the 1.8 million people who live in Northern Ireland;
- to performance manage the delivery by HSC Trusts of care services to ensure that these achieve optimal quality and value for money, in line with relevant government targets and relevant legislative requirements; and
- to effectively deploy and manage its annual funding from the Northern Ireland Executive to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

In the 2015/16 year, the Board met on 11 occasions and, in accordance with the Board's Standing Orders, were quorate for each meeting. During this period there was 100% attendance at three meetings; 92% attendance at six meetings; 77% at two meetings during the period under review. There were no special Board meetings held during this period.

During the reporting period the following should be noted with regard to Executive Board membership:

- the continued secondment of the Director of Performance Management and Service Improvement, an Executive Director, as Programme Director for the development of a Clinical Leadership programme within HSCNI; and
- the Director of Corporate Services continued as Acting Executive Director of Performance Management and Service Improvement during this period.

#### ***Role of the Audit Committee***

The DHSSPS has the right to be represented at any meeting of the Audit Committee. The Department's policy is to be represented at one meeting per year, and a DHSSPS observer attended the Committee meeting on 28 January 2016. The Audit Committee comprises 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 any meeting 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 (March 2014) 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

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2012) 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 2015/16 financial year five meetings of the Audit Committee were held, along with a joint meeting with the Governance Committee to consider the mid-year Assurance Statement.

During the year the Audit Committee advised the Board and Accounting Officer on the following:

- the strategic processes for risk, control and governance and the Governance Statement;
- the accounting policies, the accounts, and the annual report of the Board, including the process for the preparation and review of the accounts prior to submission for audit, levels of error identified and management's letter of representation to the external auditors;
- the planned activity and results of both internal and external audit;
- the scope and effectiveness of the system of internal control;
- adequacy of management response to issues identified by audit activity, including external audit's management letter and implementation of actions to address the audit findings;
- assurances relating to the corporate governance requirements for the organisation; and
- anti-fraud policies, whistle-blowing processes and arrangements for special investigations.

The Audit Committee assessed itself against the 5 good practice principles published in the Audit and Risk Assurance Committee Handbook (NI), published by DFP in March 2014, 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.

The Audit Committee produce a full annual report which may be found within the Annual Report Section of this document.

#### ***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;

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

In the 2015/16 year, the Governance Committee met on four occasions: 100% attendance at three meetings; and 75% attendance at one meeting.

During the year the Governance Committee considered the following:

- management of corporate risk;
- quality, safety and standards in health and social care;
- progress on implementation of Safety and Quality Alerts and RQIA recommendations;
- Social Care Delegated Statutory Functions;
- controls assurance and internal control;
- Serious Adverse Incident management;
- complaints management;
- identification of Regional Learning from (Serious Adverse Incidents) SAIs and Complaints;
- litigation management;
- maintenance of the reputation, image and integrity of the HSCB;
- professional regulation;
- information governance; and
- other matters, excluding finance that pertains to good corporate governance.

In addition to the overarching Governance and Audit Committees, the HSCB has a range of other organisational structures in place to support corporate governance arrangements. Key components of this structure include:

- The operation of an *Assessment Panel*, to consider and determine, where the Board has rejected a closure notice, whether a General Medical Services contractor should be permitted to close his list of patients, and if so, the terms on which he should be permitted to do so and to consider where the Board wishes to assign new patients to contractors which have closed their lists of patients. The Assessment Panel has not been required to meet during the 2015/16 year.
- The establishment of a *Disciplinary Committee* structure following a targeted consultation exercise. The Board at its meeting of 10 December 2015 gave approval to the members of the HSCB Disciplinary Committee secured by a public appointment process. Members include two legally qualified Chairpersons, three lay persons, and two pharmacy, one dental and one optometry representatives. Members were subsequently approved by the Permanent Secretary in accordance with Schedule 1, section 7 of the Health and Social Care (Reform) Act (NI).

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- The operation of a *Governance Officers Group*. This is a multi-disciplinary team who are accountable to the HSCB Senior Management Team for the operational implementation of governance activities across the HSCB. One of the functions of this group is to consider and agree any issues that require to be brought to the attention of the Governance Committee.
- The operation of five *Local Commissioning Groups* to exercise the Board's function under Section 9 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. In accordance with HSCB Standing Orders, LCGs have met at least nine times during 2015/16 with two LCGs reporting an inquorate meeting in the period under review. However, appropriate action was taken in accordance with the Code of Conduct.
- The operation of a *Pharmacy Practices Committee* to exercise the functions of the Board under Regulation 6 (9) the Pharmaceutical Regulations (NI) 1997, on behalf of the Board and in accordance with Schedule 4 of the same Regulations. The Pharmacy Practices Committee held four meetings during 2015/16 and has been quorate on each occasion.
- The operation of a *Reference Committee* to exercise the HSCB's function under the Disciplinary Procedures Regulations (NI) 1996 with respect to the referral of disciplinary matters relating to Family Practitioner Services. During the period under review, the Reference Committee met twice and was quorate on each occasion.
- The operation of a *Remuneration and Terms of Service Committee* (also comprised of Non-Executive Directors) to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives and Consultants within Departmental policy. In accordance with HSCB Standing Orders, the Remuneration and Terms of Service Committee met on one occasion and was quorate.
- The operation of a *Review Panel* to conduct oral hearings in relation to removal from the Primary Medical Performers List other than in circumstances where the HSCB is obliged to remove a performer's name or in relation to suspension of a performance or in review proceedings. The Review Panel has not been required to meet during the period under review.
- A meeting of the *Joint Audit and Governance Committee* is convened to consider and approve the Board's Mid-Year Assurance Statement enabling the Chief Executive, as Accountable Officer for the HSCB, to attest to the continuing robustness of the organisation's system of internal control. The Audit and Governance Committees have met on one occasion during the reporting year.

The Terms of Reference of each Committee is kept under review throughout the year.

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#### **4. Framework for Business Planning and Risk Management**

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

##### ***Business Planning***

The Board has a range of statutory duties and shall, as a corporate body, exercise the functions assigned to it by the DHSSPS, 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 Department to be the functions of the Board, including the Government Resources and Accounts Act (NI) 2001.

##### Commissioning Plan

In line with the above statute, the Board 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 Executive and the DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Plan Direction. It encompasses the system of reform and modernisation, to ensure that the Board, as the Commissioner of health and social care services is able to meet the increased demand, make the best use of the resources available, and adapts to changing expectations and ways of delivering care.

##### Corporate Plan

Many of the Board's objectives and responsibilities for the year 2015/16 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 2015/16 have been subject to bi-annual review. The first of these reviews was carried out as at 30 September 2015 and was approved by the Governance Committee at its meeting on 28 January 2016. The second of these reviews was carried out as at 31 March 2016 and will be approved by SMT prior to being approved by the Governance Committee.



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Following approval of the 2015/16 Corporate Plan, DHSSPS identified some additional objectives to be included in the Board's corporate monitoring and reporting processes and these were included as an Annex to the 2015/16 Corporate Plan. Progress on these has been monitored in line with the above bi-annual reviews.

#### ***Planning for 2016/17 Corporate Plan***

In planning for 2016/17, the HSCB's Senior Management Team held a series of workshops to identify key priorities and corporate objectives for the coming year, in light of recent and forthcoming staffing changes within the HSCB and the announcement by the Minister for Health on his proposals to remodel HSC commissioning structures and close the HSCB. The Senior Management Team engaged with staff in their respective teams as part of this process.

In taking forward key priorities and objectives during 2016/17, the HSCB will:

- continue to work closely with our colleagues in the PHA; so learning from incidents, complaints and patient experience, as well as regional and national reports, is disseminated and acted upon to continually strive to improve the quality and safety of the services so valued by the local population;
- continue to ensure effective user engagement by implementing its Personal and Public Involvement (PPI) strategy;
- continue to promote equality and diversity in all its functions, and will reflect the duties placed on it to implement Human Rights legislation and the relevant conventions, and to make more explicit how commissioning decisions support these duties; and
- in conjunction with PHA colleagues, fully contribute to the implementation of regional policies and initiatives including Quality 2020 and the new 'Making Life Better' strategy.

#### **Business Continuity Plan**

The Board Corporate Business Continuity Management System (Policy and Plan) has been reviewed and revised to align 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 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 incident reporting and information systems that play a vital role in identifying and managing risk.

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

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independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004, standard (adopted by DHSSPS) and 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. Training in this programme is also incorporated in the overarching corporate induction programme.

#### Risk Appetite

- 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.

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The HSC Regional Risk Matrix, adopted by the HSCB with effect from April 2013 is included as an appendix to the Governance Framework and is consistent with DHSSPS mandatory guidance *An Assurance Framework: A Practical Guide for Boards of DHSSPS 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.

- Acceptable Risk

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.
- have a high potential for incidents to occur; would 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.

- Risk Activity

The Governance Committee agreed changes to its schedule for reporting on HSCB Governance arrangements at its meeting in June 2015. 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 30 September 2015, 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; and
- action being taken forward.

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The Governance Committee approved the substantive review as at 30 September 2015 and the review by exception as at 31 December 2015 at its meeting on 28 January 2016.

#### Stakeholder Risk

- Serious Adverse Incidents (SAIs)

On 1 May 2010 the responsibility for the management and follow up of SAIs transferred from DHSSPS to HSCB working jointly with PHA and collaboratively with RQIA. In response, the HSCB issued the “Procedure for the Reporting and Follow up of SAIs.”

During 2012/13 the HSCB, working with the PHA, undertook a review of the procedure issued in 2010 with a final version being issued in September 2013 for implementation on 1 October 2013, and with full operational implementation on 1 April 2014.

The arrangements for managing SAIs reported to the HSCB/PHA include:

- regional reporting system to the HSCB for all SAIs;
- the nomination of a Designated Review Officer to review and scrutinise reports;
- SAI Review Sub Group meetings to consider reports, identify themes and learning;
- overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAI Review Sub Group and agree actions and assurance arrangements; and
- escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports; and
  - assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAIs on a weekly basis. This review may result in the risks emanating from an SAI being placed on either a Corporate or Directorate Risk Register and this may also identify the issue as an internal control divergence.

During the reporting period, there were a number of issues that were identified within the current process that required immediate implementation and were therefore issued to all ALBs in June 2015:

- a revised SAI service user/family/carer engagement checklist to enable easier data input and more meaningful information output, allowing for a systematic approach to monitor this information;

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- minor revisions to both the Level 1 and Level 2/3 review templates and to also incorporate the above checklist;
- in addition, the HSCB and PHA issued flowcharts to all HSC organisations in order to assist both reporting organisations and HSCB/PHA staff when managing the following:
  - SAIs that are also being reviewed as adult or children’s safeguarding incidents;
  - Interface incidents that have been reported via the SAI process; and
  - Early Alerts that have reported in line with DHSSPS process.
- Child Death Notifications

In October 2013, the criteria for reporting a SAI were revised to include the death of every child in receipt of HSC services. The rationale behind this change was to provide clarity in terms of reporting all child deaths and to enhance the culture of learning and review.

The report “The Right Time, The Right Place” by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having “*a detrimental effect on the system*”. He also stated that “*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*”. Hence, he recommended that, “*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*” This was an issue the HSCB/PHA had already identified and work had commenced on an alternative arrangement for child death notification.

During this reporting period, DHSSPS, working in partnership with HSCB/PHA and Trusts, have agreed a new process for recording, reviewing and reporting of all child deaths as part of a new Regional Mortality and Morbidity Review (MMR) System.

DHSSPS issued the new Child Death Notification process to the HSC in January 2016, for implementation on 1 February 2016. In conjunction with this new process, the HSCB issued a set of revised SAI criteria to all Departmental ALBs. The introduction of this process will be regarded as a pilot with a review being performed after one year.

- Learning from SAIs

It is important that when a serious incident occurs, there is a systematic process for investigating and learning from the event. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

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- **Quality Safety and Experience (QSE) Group**

Core to the quality and safety processes and structures within the HSCB, has been the establishment of a jointly chaired QSE Group which provides an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup and a Regional Complaints Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alert Team (SQAT)**

The work of the QSE group is closely aligned to the HSCB/PHA SQAT, which is responsible for overseeing the implementation and assurance of Regional Learning Letters and Guidance issued by HSCB/PHA and other organisations. The team meet fortnightly and is chaired by the Director of Public Health/Medical Director, PHA. The team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

#### *SAI Learning Mechanisms*

Learning opportunities from SAIs can be identified by the reporting organisation, DROs the Regional SAI Review Sub Group or QSE Group and learning can take the form of:

- local organisation actions, these are implemented and monitored by individual organisations;
- formal learning letter – **There were no learning letters issued during the 2015/16 year;**
- formal learning reminders – **19 learning reminders have been issued during the 2015/16 year;**
- Thematic Reviews – commissioned by the Regional SAI Sub Review Group and the QSE Group, to review trends, patterns and provide an in-depth analysis. Three thematic reviews have been carried out during 2015/16 with key learning points being disseminated across the HSC;
- Learning Matters newsletter – HSCB and PHA has developed a regular newsletter to ensure that local incidents are shared regionally to drive improvements for patients and services across the HSC. The 5th edition of the newsletter was issued on 7 April 2016; and
- the SAI bi-annual Learning Report provides an overview on all learning letters/thematic reviews carried out and/or reported on during the year of reporting. The latest edition covered the period 1 April to 30 September 2015 and was issued to the wider HSC in February 2016.

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#### *SAI Related Training*

- SAI Learning Events

The HSC Safety Forum has hosted two Regional SAI Learning Workshops during the period. The first on the 14 April 2015 and the second was held on 11 March 2016 both at Mossley Mill, Newtownabbey. The events provided an opportunity to share learning from SAIs regionally. HSC Trusts and Integrated Care presented a number of case studies for discussion. A relative of a patient involved in a SAI and a senior Clinician both shared their experience of the process and the impact it had on them individually and their wider family. Feedback on both events has been very positive and a third event is scheduled for next year.

- Designated Review Officer (DRO) Workshops

Workshops for DROs were carried out during September and October 2015, across each of the four locations. The rationale for holding the workshops provided DROs with a clear outline of the key stages of the:

- SAI process taking account of any recent/imminent;
- Service User/Family Engagement process;
- learning process;
- Early Alert Process; and
- provided an overview of key documentation involved in the process.

#### Working with Trust SAI Groups

- BHSCT RCA Forum for Chairs

Following the success of DROs attending the first BHSCT RCA Forum for Chairs in November 2014, DROs across a number of programmes of care were invited to attend the third Forum in October 2015.

This provided Trust RCA Chairs with a perspective on the role of a DRO within the SAI process. The meeting also provided an opportunity for DROs to share anonymised examples of well written review reports.

- NHSCT SAI Review Group

The NHSCT SAI Review Group invited DROs across a number of programmes of care, to meet with this group which comprises of their Lead Directors to do a Question & Answer session on Monday 20<sup>th</sup> July 2015. The Trust welcomed this opportunity and the session was positively evaluated by all members present.

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#### Involving Laypersons in the SAI Process

The panel of lay persons (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis and are now available to be called upon to be a member of a SAI review team, particularly when a degree of independence to the team is required.

- **Complaints**

‘Complaints in Health and Social Care’ advises that the HSCB should have oversight of all HSC complaints; is responsible for the monitoring of complaints and processes and for the identification and dissemination of learning from complaints. Complaints officers review the information returns received from HSC Trusts and Family Practitioner Services Practices and share complaints relating to Emergency Departments, Maternity and Gynaecology, Patient Experience, Falls and Nutrition, Palliative Care, Allied Health Professional issues, Mis-identification, Venous Thrombo Embolisms and Social Care issues with relevant professionals. Issues of concern/themes and trends are discussed at the monthly meeting of the Regional Complaints Sub-Group, which is attended by professionals from the HSCB and the PHA. If necessary, issues are escalated to the QSE Group for any necessary action. Quarterly reports on complaints are shared with the QSE Group, the Senior Management Team and the Governance Committee of the Board. In addition an annual report on complaints is produced each year. The Board’s sixth annual report on complaints is available on the Board website.

In June 2015, the Board hosted its second Annual Complaints Learning Event, which had stakeholder representation from the Board, the PHA, the HSC Trusts, FPS, RQIA, COPNI and PCC. Two service users also contributed to the event, via a pre-recorded video link and expressed their views in relation to the Complaints Process. The event focused upon learning arising out of complaints specifically relating to the theme of ‘communication’. Following the event, and to highlight key messages and themes a Newsletter was developed which was circulated to all attendees and colleagues within Primary Care.

As part of the continual evaluation of the HSC Complaints Procedure, and in accordance with the ‘HSCB Audit of Inequalities Action Plan’ (2013 - 2018), the Board conducted a workshop with a group of ‘older persons,’ in November 2015 to ascertain their views of the Complaints Process, and to establish why service users may decide not to make a complaint following a negative experience.

It is apparent that treatment and care to include privacy and dignity, remain major issues of concern. It was noted that these issues are consistently the highest category of complaint across HSC Trusts and Family Practitioner Services and therefore to acknowledge and address this issue, these topics will be reviewed in greater detail at a Complaints Learning Event in 2016/17.



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- **Medical Negligence Cases**

The Board is responsible for the management of outstanding medical negligence cases which pre-date Trust status (pre-1996). A Preliminary Advisory Group meets regularly to review activity on cases and in particular those listed for hearing during the financial year, which require specific authorities. This Group is attended by the Assistant Director of Legal Services (BSO), Public Health Consultants from the Public Health Agency (PHA), the Complaints/Litigation Manager and a representative from the Finance Directorate.

- **Emergency Preparedness**

The Board adheres to the DHSSPS 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 DHSSPS 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.

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#### **5. Information Risk**

The identification and management of information risks is a key element of the Board'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.

2015/16 saw the 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.

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 and updates were provided as necessary at each meeting. Quarterly reports to SMT and six monthly reports to the HSCB Governance Committee were provided from the Senior Information Risk Owner who attends both groups. Further assurances were sought via self-assessment and subsequent internal audit verification of the Information Management Controls Assurance Standard and a separate Information Governance audit as part of the HSCB's rolling Internal Audit Programme.

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#### **6. Public Stakeholder Involvement**

The HSCB working collaboratively with the PHA recognise 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. As Commissioners we are committed to embedding PPI into our culture and practice. 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. Some examples of good practice include:

- 40 service users or carers have been recruited onto the 17 Integrated Care Partnerships;
- 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;
- development of HSC online;
- continued engagement of service users, patients and staff in relation to TYC reforms;
- 2nd Service User Recognition Day, attended by service users and carers, which celebrated the valuable contribution made by service users and carers;
- personalisation – service user and carer input into how services are delivered. Self-directed Support and Direct Payments are the main vehicles to enable this to happen; and
- Health and Social Care Board continues to commission Personal and Public Involvement training for both staff and service users and carers.

The Health and Social Care Board has developed, in conjunction with service users and carers, a new action plan to be implemented 2015 – 2018. A Personal and Public Involvement Core Group, chaired by the Director of Social Care and Children and which has representative leads from each Directorate, meets on a monthly basis to ensure these key actions are driven within each directorate.

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#### 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 provides a clear, concise structure for reporting key information to the Board, Committees of the Board, SMT and other groups/forums. It will also identify 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.

During the reporting period, the Governance Committee agreed changes to its schedule for reporting on HSCB Governance arrangements, with the framework now being reviewed on an annual basis.

As part of the annual review, as at 31 March 2016, there were a total of 90 assurance functions contained within the HSCB Assurance Framework relating to the following domains:

- DOMAIN 1** Corporate Control (CC) the arrangements by which the HSCB directs and controls functions and relates to stakeholders.
- DOMAIN 2** Safety and Quality (SQ) the arrangements for ensuring that health and social care services are safe and effective and meet patients' needs.
- DOMAIN 3** Finance (FIN) the arrangements for ensuring the financial stability of the HSC, for ensuring value for money and for ensuring that resources allocated by the Minister/Department are deployed fully in achievement of agreed outcomes.
- DOMAIN 4** Operational Performance and Service Improvement (OPSI) the arrangements for ensuring the delivery of Government and Ministerial targets and required service improvements.

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The review indicated the following, in relation to the 90 assurances:

- 85 assurance functions have been achieved;
- 4 assurances were partially achieved, or are work in progress towards achievement and will be reported on in the next review;
- 1 assurance was not applicable at the time of the review;
- 0 assurances were no longer relevant as they have/will be included within another assurance function.

The review was approved by the Senior Management Team on 3 May 2016 for onward referral to the Governance Committee for approval at its meeting on 5 May 2016.

#### ***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; and
- data quality updates (performance reports).

#### ***Delegated Statutory Functions***

HSC Trusts submit an annual monitoring report on the delivery of statutory functions with a midyear return on Corporate Parenting. This is analysed by HSCB and an overview report on findings was considered by the Board at its meeting on 10 September 2015 and submitted to DHSSPS. HSC 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, ensure that this area is kept under constant review.

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#### *Controls Assurance Standards*

The HSCB assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress was expected in 2015/16.

The HSCB achieved the following levels of compliance for 2015/16.

<b>Standard</b>	<b>DHSS&amp;PS Expected Level of Compliance</b>	<b>HSCB Level of Compliance</b>	<b>Audited by Internal Audit</b>
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)	95%	-
Environmental Cleanliness	75% - 99% (Substantive)	Not Applicable	-
Environment Management	75% - 99% (Substantive)	81.5%	-
<b>Financial Management</b> <i>(Core Standard)</i>	75% - 99% (Substantive)	87%	BSO IA
Fire safety	75% - 99% (Substantive)	93%	-
Fleet and Transport Management	75% - 99% (Substantive)	Not Applicable	-
Food Hygiene	75% - 99% (Substantive)	Not Applicable	-
<b>Governance</b> <i>(Core Standard)</i>	75% - 99% (Substantive)	91%	BSO IA
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	90%	-
Infection Control	75% - 99% (Substantive)	Not Applicable	-
Information Communication Technology	75% - 99% (Substantive)	88%	-
Management of Purchasing	75% - 99% (Substantive)	83.2%	-

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<b>Standard</b>	<b>DHSS&amp;PS Expected Level of Compliance</b>	<b>HSCB Level of Compliance</b>	<b>Audited by Internal Audit</b>
Medical Devices and Equipment Management	75% - 99% (Substantive)	Not Applicable	-
Medicines Management	75% - 99% (Substantive)	Not Applicable	-
Information Management	75% - 99% (Substantive)	81%	BSO IA
Research Governance	75% - 99% (Substantive )	Not Applicable	-
<b>Risk Management</b> <i>(Core Standard)</i>	75% - 99% (Substantive)	92%	BSO IA
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	86.5%	-

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#### **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 2015/16 Internal Audit reviewed the following systems:

- Financial Review
- Asset Management
- Management of Voluntary Organisation Contracts, including Visits to Organisations
- ICT – e-health
- Performance Management – Outpatient Review Appointments
- Performance Management - Internal
- Family Practitioner Services – General Medical Services
- Family Practitioner Services – General Dental Services
- Commissioning – Investment Proposals
- Risk Management
- Complaints Management and Claims Management
- Brightstart programme
- Family Practitioner Payment System – review of Business Services Process\*

(\* denotes report not subject to categorisation)

All received a satisfactory level of assurance\*, with the exception of one element of the Financial Review in relation to travel processing and Internal Performance Management. The recommendations relating to these reports are highlighted in detail below.

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, 8 weaknesses in control (priority 1) were identified in the following reviews:

- Financial Review – travel processing
- Asset Management
- Management of Voluntary Organisation Contracts, including Visits to Organisations
- Family Practitioner Services – General Dental Services
- Performance Management – Internal
- Risk Management



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- Management of Investment Proposal Templates

Recommendations to address these control weaknesses have been or are being implemented and are specifically highlighted in the following section.

#### Financial Review – Travel processing

A priority 1 recommendation was made relating to the manual processing of travel reimbursement payments for LCG members outside of the payroll system and the incorrect claiming of home to base mileage for some claims. Action has been taken to ensure all travel payments are paid within the HRPTS system and any amendments for Tax and NIC have been processed for the individuals concerned. Home to base mileage guidance has been sent to all staff and the specific claims highlighted in the report have been reviewed and amendments processed.

#### Asset Management

One priority 1 recommendation was made relating to the maintenance of the Asset Register by the Business Services Organisation (BSO). Actions to cleanse and update the register have been taken in 2015/16 and HSCB has received assurances from BSO in this regard.

#### Management of Voluntary Organisation Contracts, including Visits to Organisations

There were 2 priority 1 recommendations made relating to the prompt signing of Service Level Agreements and the stage of implementation of the procurement plan. Management have made significant progress on these recommendations during 2015/16.

#### Family Practitioner Services (FPS) – Dental Services

A recommendation was made relating to the legislative position in respect of incident management, which management have undertaken to discuss with the DHSSPS. A second recommendation was made to update the annual return from Dental Practitioners to ensure it was easier to differentiate between informal and formal complaints received, which management have amended in the return for 2016/17.

#### Performance Management - Internal

The Internal Auditor made a priority 1 recommendation regarding the development of a formal internal performance management framework which management accepted.

#### Deferral of Implementation of Recommendations

Subsequent to the Minister's announcement regarding the future of the HSCB, a review of outstanding audit recommendations was undertaken in January 2016. This review considered whether individual recommendations should continue to be implemented while the future of HSCB functions are being developed. Following this review Management assessed that there are a total of 11 recommendations which will be deferred, but kept under review while the outcome of future structures is being developed.

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#### Management of Investment Proposal Templates

A priority 1 recommendation focussed on the development of the processing of Post Project Evaluations across all areas of the HSCB and dissemination of learning, which Management have accepted and will develop during 2016/17.

#### ***Regulation Quality Improvement Authority***

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 most recent six monthly report on progress for the period ending 30 September 2015 was approved by the Governance Committee on 28 January 2016. The report for the period ending 31 March 2016 is due to go to SMT for approval in May 2016 and for noting at Governance Committee in June 2016.

#### ***National Confidential Enquiry into Patient Outcome and Death Reports***

A similar system has been introduced 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 (June and December each year). The report on progress for the period ending 30 June 2015 was approved by SMT on 8 September 2015 and noted by the Governance Committee at its meeting on 24 September 2015. The report for the period ending 31 December 2016 was approved by SMT on 5 April 2016 and noted at Governance Committee on 7 May 2016.

#### ***External Audit***

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2015, the NI Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the HSCB's accounts, with no priority 1 or 2 issues being raised.

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#### 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*

###### Dental Prior Approval

The BSO processes payment claims from dentists made under the Northern Ireland General Dental Services (GDS) contract but higher value courses of treatment (those above £280) must first be checked for clinical appropriateness by dental advisers in BSO before treatment may begin. This process is referred to as prior approval. Following the introduction of a new computerised payment system in December 2014, a series of problems in the processing of prior approval claims came to light and approval turnaround times increased month on month. However, by June 2015 a number of payment system “fixes” were in place which, alongside increased dental adviser input, lead to a reduction in the number of cases breaching the target eight-week turnaround time. A process mapping exercise led by staff from the HSC Leadership Centre has now commenced and it is expected that further reductions in numbers of excess waiters will be achieved.

###### Framework for Monitoring and Obtaining Assurance in Respect of Primary Care Pharmaceutical Services

The terms of service for pharmaceutical contractors are loosely defined and currently do not address all aspects of service provision. The HSCB has a rolling programme of post-payment verification for pharmacy contractors in place under its SLA with the Business Services Organisation, however, to date there has been no process in place for receiving and monitoring assurance in respect of compliance with terms of service and with professional standards. This leads to clinical and financial risk, including an inability to provide an assurance that the 535 Pharmacy Contractors are meeting their requirements regarding the promotion of reporting, management of and implementation of learning from serious adverse incidents/adverse incidents and near misses.

The HSCB has been negotiating with Community Pharmacy NI (CPNI) to establish a community pharmacy assurance process to ensure appropriate governance arrangements are in place for service provision. This would incorporate provision of signed governance returns to the HSCB and visits to contractors by HSCB staff. A clinical governance framework has been developed which includes

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new areas where HSCB wishes to seek assurances e.g. adverse incident reporting and follow up. The process will include visits to community pharmacies by HSCB staff. Pilot assurance visits will commence in April 2016 and it is anticipated that the final assurance visit programme would commence in September 2016.

The absence of a requirement to provide an assurance to the HSCB and the need to develop a revised Terms of Service has been highlighted to the DHSSPS. The HSCB will work with DHSSPS to update this.

#### Resettlement

During 2015/16 the targets for resettling Mental Health and Learning Disability patients were 23 and 36 respectively. At the end of March 2016, 5 Mental Health patients and 10 Learning Disability patients have moved to appropriate homes in the community.

At 31st March 2016 18 long stay patients remain in Mental Health Hospitals. Plans are in place to resettle 10 of these during 2016/17. The remaining 8 patients currently require inpatient treatment.

At 31st March 2016 25 long stay patients remain in Learning Disability Hospitals. Plans are currently in place to resettle 11 of these during 2016/17 and the Trusts are working on plans for another 8, with a further 5 being resettled in late 2017. These delays are due to planning and building issues. One patient currently requires inpatient treatment and the other has sadly deceased.

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

#### Quality, Quantity and Financial Controls 2015/16

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 began in 2014/15 to face very significant financial challenges, taking into account pressures faced by Trusts, as well as planning to meet further service development pressures to fully address demographic growth, and planned service enhancements to meet the commissioning and performance agendas within the HSC sector. These financial constraints continued to be rigorously monitored and managed by the HSCB throughout the financial year. However, these significant financial challenges continue to pose an on-going risk to maintaining the quality and safety of Health and Social Care Services which continues to be monitored and mitigated, where possible, by the DHSSPS, HSCB and HSC Trusts.

During 2015/16 the HSCB worked closely and pro-actively with all HSC Trusts and the DHSSPS in order to address the significant difficulties faced. However, in order to maintain the quality of services required and to absorb the increased demand presenting, it was necessary to develop a revised 2015/16 financial plan and financially balanced Commissioning Plan in order to achieve an HSC breakeven position.

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Additional measures to manage the pressures facing the HSC sector, included:

- implementation by Trusts of contingency and curtailment measures which were considered to have the least impact on patient care;
- allocation of additional funding to Trusts from November monitoring largely to help tackle waiting lists for out-patient, in-patient, day case and diagnostic appointments; and
- establishment of a revised financial plan and financially balanced Commissioning Plan.

Implementation of the above measures enabled all HSC Trusts and the HSCB to achieve financial breakeven in 2015/16.

Looking forward to 2016/17, it is anticipated that, despite the additional funding for Health and Social Care set out in the 2016/17 budget, the difficulties faced within the HSC sector will accelerate further, this is set against a backdrop of uncertainty regarding impending changes to the HSC structures following the Minister's announcement in November 2015. During 2016/17 the HSCB will continue to proactively work with the DHSSPS and HSC Trusts in order to review and develop financially effective solutions which will seek to maintain the integrity of services to the public and secure financial balance. These solutions will be required to meet unavoidable pay and price, demand and demographic pressures. These pressures will have an impact on the DHSSPS' and HSCB's ability to take forward key HSC strategic developments and associated key performance indicators.

In addition, the HSCB's budget for 2016/17 has been reduced by a further £2.7m recurrently, representing 10% of the administration budget. This is in addition to the reduction of £5.4m or 15% made in 2015/16, making £8.1m or 25% over the two years. While plans have been drafted to address this issue, which includes access to a Voluntary Exit Scheme, this reduction will significantly impact on the capacity which the HSCB has to deliver its functions.

Actions taken during 2015/16 with respect to financial planning and associated efficiency plans for 2016/17, will contribute towards mitigating the qualitative risks associated with managing services within a constrained budget.

#### Elective Care

Waiting times for access to elective care have increased compared to the position at the end of March 2015 however; there was significant reduction in the number of patients waiting longer than the Ministerial maximum waiting times during the final quarter of 2015/16. At the end of March 2016:

- 135,192 patients were waiting longer than nine weeks for a first outpatient appointment compared with 107,957 at the end of March 2015 and 99,381 were waiting longer than 18 weeks compared to 69,730 at end of March 2015;

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- the number of patients waiting longer than nine weeks for a diagnostic test has increased from 17,435 at the end of March 2015 to 19,638 at the end of March 2016; and
- 32,676 patients were waiting longer than 13 weeks for inpatient or daycase treatment compared to 27,780 at the end of March 2015; and the number waiting longer than 26 weeks has increased from 13,622 to 17,601.

The increase in waiting times is due to a number of factors including a year-on-year increase in referrals and the resultant gap between patient demand and funded capacity in a range of specialties; agreed volumes of funded activity not being fully delivered across a number of specialties by some providers; and in particular the impact of the wider financial position.

Reasonable progress had been made over the last number of years in delivering sustainable improvements in elective care waiting times however, the position deteriorated in 2014/15 due to the wider HSC financial position and the lack of additional (non-recurrent) funding to enable Trusts to secure additional capacity (either in-house or in the independent sector (IS)) in the second half of 2014/15 and this continued into 2015/16.

In November 2015, the Minister confirmed the allocation of substantial additional non-recurrent funding for elective care in-year. This funding was utilised to secure additional capacity primarily from a range of IS providers and was targeted at those patients who had been waiting the longest for assessment and/or treatment. Trusts were also funded to carry out as much additional in-house activity as possible. Utilising this level of funding at such a late stage in the year presented a challenge to Trusts and the IS, however the HSCB worked closely with Trusts to maximise the use of this additional funding, targeting it at the longest waiting patients. While over the course of the year, waiting times for elective care have increased compared to March 2015, there was a significant improvement in waiting times during the final quarter of the year as a result of the impact of additional activity associated with the non-recurrent funding allocated in November 2015.

There has been a continued improvement in the delivery of commissioned volumes of core activity for new outpatient assessments – regionally during 2015/16 there was a 6.5% (26,362) under-delivery of core activity compared to 7.0% in 2014/15. In relation to delivery of commissioned volumes of inpatient/daycase volumes, there was a 7.9% (12,233) under-delivery of core activity in 2015/16. While this is a slight deterioration on 2014/15 (6.8%), it represents an improvement on the position earlier in the year (August 2015) when there was a 9.6% under-delivery of core activity. This regional position, however, masks much larger under-delivery in individual specialties in some Trusts.

Given the scale of the under-delivery of core capacity across a range of specialties in Trusts in 2015/16, the HSCB has required Trusts to produce elective improvement plans for a number of specialties detailing the forecast improvement in delivery of core and waiting times by September 2016. The HSCB will monitor Trusts' performance against these plans at regular elective performance meetings to ensure that progress is being made to deliver the agreed outcomes or, where this is not the case, to agree what remedial actions the Trusts plan to take.

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In relation to recurrent capacity gaps, the HSCB has provided significant recurrent investments for elective care in recent years and further investments were finalised in 2015/16. However, notwithstanding these investments, demand has continued to increase and significant capacity gaps remain in a number of specialties. Subject to the availability of funding, the HSCB will continue to seek to make targeted recurrent investments.

In response to a request from the Department, the HSCB has developed a draft Elective Care Plan setting out how it will work with local health economies, including HSC Trusts and primary care, with appropriate regional support and additional capacity from the IS, to manage demand and deliver sustainably shorter waiting times for elective care, subject to the availability of funding. The draft Plan is being finalised taking account of comments received from the Department.

The HSCB is taking forward a comprehensive programme of outpatient reform working in partnership with Trusts, ICPs and GP Federations. Key opportunities being progressed include the use of electronic referrals and banner guidance, e-triage, project ECHO, enhancement of services in primary care to manage demand more effectively, and new arrangements for delivering outpatient services in secondary care.

#### Emergency Department (ED)

Performance against the 4-hour and 12-hour ED standards remains below the level required (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).

Regionally during 2015/16, there has been an increase in the number of patients who waited longer than 12 hours in ED (3,875) compared to 2014/15 (3,170). During 2015/16 there has been an increase in the number of patients waiting longer than 12 hours in four of the five Trusts, with only BHSCT achieving a reduction in the number of patients who waited longer than 12 hours – 917 in 2015/16 compared to 1,756 in 2014/15.

In relation to performance against the 4-hour standard, regionally during 2015/16 76% of patients were treated and discharged, or admitted within four hours compared with 78% during 2014/15.

Improving performance against the 4 and 12 hour standards remains a priority and revised arrangements, jointly led by the Board and Public Health Agency (PHA), have been put in place to take forward the unscheduled care agenda. The revised structures comprise a Strategic Accountability Group, a Regional Network Group and five Locality Network Groups.

#### Cancer Services

Trusts are required to ensure from April 2015, that at least 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days and that all urgent breast cancer referrals are seen within 14 days. Regionally during 2015/16, 71% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days and 76% of urgent breast cancer referrals were seen within 14 days.

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Achievement of the 62-day cancer access standard is becoming increasingly challenging with the growing incidence of cancer due to an aging population, increasing suspect cancer referrals and the challenging financial climate. The HSCB is actively engaged with the HSC Trusts on this issue in trying to address, strategically, some of the pressures that are facing cancer services across the region through a process of targeted investment, service redesign and benchmarking quality with NHS England colleagues.

In relation to the 14-day breast cancer standard, the regional position is largely due to performance challenges in Belfast, Northern, South Eastern and, to a lesser extent the Southern Trust during 2015/16 with 43%, 78%, 66% and 93% of urgent referrals respectively seen within 14 days in 2015/16. The continued strong performance in the Western Trust should be acknowledged, during 2015/16, 99% of urgent referrals were seen within 14 days.

The deterioration in performance in these Trusts has largely been due to increased demand, in particular following breast cancer awareness month (October) and a range of staffing issues. Given the seriousness of this position and the need to improve access to the Breast Service for women with suspect cancer, the HSCB worked closely with the relevant Trusts to agree a number of actions to improve waiting times. These included, for BHSCT, securing additional capacity from other Trusts and the temporary re-direction of urgent referrals and the allocation of recurrent funding to appoint additional staff to enable the Trust to better respond to the higher level of demand. For the remaining Trusts, additional clinics were put in place to reduce the backlog of patients waiting. As a result of these actions, performance has improved in recent months – during March 2016, 88% of urgent referrals were seen within 14 days compared to 49% in December 2015.

#### Allied Health Professionals (AHP)

Trusts are required to ensure that, from April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment. At the end of March 2016 15,310 patients were waiting longer than 13 weeks for AHP treatment.

Over the last year, the HSCB and PHA have worked with Trusts to complete a demand and capacity exercise to ensure there is sufficient capacity in each of the AHP services to meet patient demand. This exercise has now been concluded and the HSCB and PHA will work with Trusts to agree the steps to be taken to implement the outcomes from the demand and capacity exercise and to address the waiting time position going forward, subject to availability of funding.

The HSCB allocated additional (non-recurrent) funding to Trusts during the latter part of 2015/16 from the November monitoring round to reduce the backlog of patients waiting for AHP services in-year. As a result of this funding, a large number of additional new and review patients received AHP treatment during the final quarter of 2015/16.

#### Healthcare Acquired Infection (HCAI) – MRSA

The 2015/16 target to have no more than 49 cases of MRSA across Northern Ireland was not achieved – during 2015/16 there were 75 cases of MRSA. With regard to individual Trusts, the



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number of cases of MRSA in the Southern and Western Trusts was within their respective target levels for 2015/16. The remaining Trusts, however, exceeded their target levels.

#### Healthcare Acquired Infection (HCAI) – C. Difficile

Regionally the 2015/16 target to have no more than 309 cases of C. Difficile across Northern Ireland was not achieved – during 2015/16 there were 392 episodes of C. Difficile. While all Trusts exceeded their maximum target levels for the year, it should be noted that the Northern Trust exceeded its annual target by only one case.

#### Children’s Services (Unallocated Cases)

Trusts report that pressures further into the system are impacting upon their capacity to reduce the numbers of unallocated cases. This specifically refers to an increased number of children entering the looked after system which is also resource intensive.

The majority of unallocated cases are within the Family Intervention Teams which means that they will have been subject to an initial assessment. In addition, there are on-going screening mechanisms within Trusts which allow for escalation and a response to cases where the risk may have increased for any reason. The vacancy control measures within Trusts will also continue to impact in this area as there are delays in getting replacement staff where temporary or permanent vacancies arise for a range of reasons.

The Children’s Services Improvement Board receives a monitoring return on a monthly basis and will continue to monitor the numbers of unallocated cases and determine what additional actions are feasible.

The HSCB initiated a three stage process from Sept 15 – Sept 16:

- Stage 1 - Scoping and reasons including recovery plans
- Stage 2 - Process Mapping
- Stage 3 - Systems Redesign

Additional guidance for family support and sign off initial assessment are both still to be agreed.

#### Mental Health Access - Child/adolescent and Adult

Trusts are required to ensure that from April 2015 no patient waits longer than 9 weeks to access child and adolescent (CAMHS) or adult mental health services and that no patient waits longer than 13 weeks for psychological therapies.

- CAMHS

At the end of March 2015, 73 patients were waiting longer than nine weeks which was an improvement on the previous year. The majority of the breaches were in the Northern Trust (72) who continued to implement their recovery plan. The breaches steadily reduced in the Northern Trust and by the end of September 2015 had reached zero and this performance has been sustained.

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Since the end of April 2015, there have been ongoing breaches of the nine-week standard in Belfast, and Western Trusts and, at the end of March 2016, 34 patients were waiting longer than nine weeks to access CAMHS, 25 in Belfast and 9 in Western.

- Adult Mental Health and Dementia Services

Regionally at the end of March 2016, 338 patients were waiting longer than nine weeks to access adult mental health services. The majority of the breaches were in the Primary Care and Community Mental Health services in Belfast (246) and Southern (81) Trusts. BHSCT has plans in place to recover the nine week waiting times over the next three months. In Southern Trust it is anticipated that the development of primary care hubs will reduce demand for their specialist services.

In respect of dementia services, at the end of March 2016, 69 patients were waiting longer than nine weeks, all in the Southern Trust. A major redesign of dementia services in the Southern Trust is underway and it is expected, during the course of 2016/17, to implement a new stepped care model which aims to reduce the time a person is required to wait for a dementia assessment.

- Psychological Therapies

Regionally at the end of March 2016, 1,176 patients were waiting longer than 13 weeks to access psychological therapy services compared to 912 at the end of March 2015. This increase reflects increasing demand for psychological care particularly in mental health and adult health psychological services. While there have been ongoing breaches of the 13-week maximum waiting time standard, the vast majority patients waiting longer than 13 weeks at the end of March 2016 were in South Eastern (50%) and Belfast (29%) Trusts.

In relation to South Eastern Trust, the HSCB has, through a combination of additional funding, made available £389k to address psychological therapy pressures in the Trust. This will result in the appointment of four additional psychological therapists and the establishment of primary care hubs. It is anticipated during 2016/17 that a significant reduction in the number of people waiting beyond 13 weeks will be made. In relation to Adult Health Psychology services, specialist Pain Management remains under resourced in Belfast and SE Trust. Belfast and SE Trust LCGs are developing a number of pilots designed to expand the capacity of these services which aims to reduce the need for specialist one-to-one intervention - this will be evaluated in March 2017. It is also important to note that despite Northern Ireland having 25% higher rates of mental ill health when compared with Great Britain, investment in Psychological Therapies Services on a comparative basis is significantly lower than rest of the UK. The recurrent gap for psychological therapy services alone is estimated to be in the region of £12 million. Consequently, the position regarding accessibility to psychological therapies remains vulnerable to continued breaching of the access standard. The HSCB has acknowledged that there is a recurrent capacity gap in these services across all Trusts and as a result psychological therapies has been registered as an on-going cost pressure.

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#### Ambulance Response Times

Regionally in the year to the end of March 2016, 54% of Category A calls were responded to within eight minutes (target: 72.5% by March 2016). While 2015/16 performance is below the required level, it should be noted that performance improved month-on-month from December 2015.

Ambulance response times have been impacted by an increase in the number of calls responded to and staffing issues. The Trust is taking forward a number of actions to address these issues including a significant recruitment and training programme for operational staff and a continued focus on the management of staff absence. During 2015/16 the HSCB invested (£1m) to enhance capacity in the Northern and South Eastern areas.

#### Paediatric Congenital Cardiac Services (PCCS)

In early 2015 an all-island Congenital Heart Disease (CHD) Network Board was established which includes representation from HSCB and PHA. The Network Board is currently finalising an implementation plan for the establishment of an all-island CHD service to include interventional cardiology and cardiac surgery.

Interim arrangements are in place, through Service Level Agreements, for children from Northern Ireland to access surgery and cardiac catheterisation in the most appropriate location to meet their clinical needs. As part of these arrangements for most children requiring cardiac catheterisation diagnosis or treatment, this is now provided in Dublin through a collaborative approach involving Northern Ireland Clinicians. The majority of surgery is provided by specialist centres in GB, pending the establishment of capacity in Dublin. The Board is monitoring these arrangements on an on-going basis.

#### Implementation of Reform

In 2015/16 the main control issue that existed related to the lack of funds curtailing the pace at which reform could take place. This in turn contributed to public and political perceptions that reform was failing. This control issue is anticipated to continue into 2016/17.

To address the issue in 2015/16 reform continued to be embedded in the core HSCB Business and £15.6m of HSCB funds were prioritised to support the continuation of projects that were implemented in prior years and to initiate some further schemes.

In June 2015, a report was submitted to the DHSSPS, as part of a report to the Health Committee, setting out progress against the 72 TYC proposals for which the HSCB has lead or joint responsibility. Of the 72 proposals:

- 6 are complete;
- 29 are complete with on-going work embedded in normal business;
- 3 are nearing completion;
- 32 are in progress; and
- 2 have been deferred.

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To address this control issue in 2016/17, the HSCB has again prioritised funds to support continuation of reform projects, and monies have been made available through the Transformation Fund.

#### Statutory Residential Homes

The Stage One consultation report on criteria to assess the future role and function of statutory residential care homes was approved by the Health and Social Care Board on 12 June 2014.

In the summer of 2015 Health and Social Care Trusts assessed their residential care homes against the criteria in accordance with the process agreed with the Board. This has included a review of their positions on new admissions following proposals about the future for each individual home.

The five Local Commissioning Groups (LCGs) across Northern Ireland have undertaken local needs assessments of services for older people in order to provide a context for consideration of local Trust proposals. This has involved discussions between the Board, LCGs and Trusts to inform the production of a composite report on the proposed future of statutory residential provision for older people.

The Trust evaluation and the LCG Needs Assessments resulted in each Trust developing a set of proposals for public consultation about changes to their statutory residential care for older people, and Trusts have subsequently consulted upon same.

Any further progression of the process has been put on hold until the end of May 2016, on the basis of the Minister's instruction to review the Statutory Residential Home process in light of Four Seasons Nursing Home announcements with regard to closure of a number of homes across Northern Ireland.

Health and Social Care Trusts have subsequently met with Local Commissioning Groups to ascertain if changes to Four Season's nursing homes will impact on recommendations contained in their original proposals for provision of Statutory Residential Homes. It is anticipated that Trusts will bring forward the conclusion of their proposals to their respective management teams and Trust Boards in the summer of 2016. Proposals will then be subject to Board and Ministerial approval prior to implementation.

At March 2016 there are 163 permanent residents in the 18 statutory residential homes which may be affected by changes. (Skeagh residential home in the SHSCT area has been temporarily closed for some time due to a landslip.).

Current permanent residents will not be affected and there remains a firm commitment that they will be able to remain in their existing home for as long as they wish, and as long as their care needs can continue to be met there.

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#### Health Visiting

The DHSSPS 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.

The PHA continues to work closely with HSCB and HSC Trusts to increase health visiting capacity and compliance with the child health promotion programme. Investment has resulted in the regional health visiting workforce increasing from 362.2 WTE to 397.5 WTE. The funded vacancy rate at March 2016 is 32.65 WTE as a result of resignations and retirements. The temporary vacancy rate fluctuates as a result of maternity and sick leave. The PHA is leading work on Phase 4 Delivery Care (health visiting) and regular workforce updates from HSC Trusts will continue to be analysed.

All health visitors from the student Health Visitor group, graduating October 2014 (n=38), have been recruited onto permanent employment contracts. 54 students of the 58 students graduating in October 2015 have also been recruited and efforts are being made to recruit the remaining 4 health visitors. A further 40 students are expected to graduate in October 2016.

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).

#### GP Out of Hours (OOH) Services

The Urgent Primary Cares service continues to face considerable challenge due to increasing demand. Not all GP Out of Hours providers are meeting KPI standards set out in the Service Specification. Concerns relate to the 20 minute and 1 hour triage targets, particularly during busy times such as weekends and public holidays.

The situation is exacerbated by insufficient numbers of GPs, and 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 Out of Hours provision. HSCB officers continue to liaise with DHSSPS colleagues regarding pay rates. Business cases require to be submitted to DFP by DHSSPS.

An Additional Cost pilot scheme was implemented in July 2015 with the aim of filling more OOH shifts in advance. The scheme provides a contribution towards the costs of working in OOH, e.g.

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indemnity. Feedback from providers, together with a review of data received to date, suggests that the scheme has been effective. It is proposed to continue the pilot into 2016/17 and include a local scheme in addition to the regional one.

It is proposed to continue to refine existing OOH Local Enhanced Services (LES) and implement where none existed in 2016-17. The OOH LES is currently running in the Western, South Eastern, Southern and Northern 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 LES has been implemented in the South Eastern area to improve capacity at weekends and bank holidays and four GMS practices have contracted to provide GPs for approximately 70 OOH shifts. A similar LES has been implemented from November 2015 in SHSCT area involving 12 GMS practices. The LES in the Northern area commenced in January 2016 and involves 6 GP Practices. These enhanced services will be evaluated in terms of numbers of additional GP hours or sessions secured at the end of March 2016 and revised on the basis of outcomes.

The Southern HSC Trust GP OOH, in particular, experienced problems over the Christmas and New Year period in terms of filling shifts. The Southern HSC Trust has issued a number of early alerts highlighting a risk around the provision of GP OOH cover over the redeye period, i.e. midnight to 8am, due to a reduction in medical cover. The Southern HSC Trust, with support from HSCB and the DHSSPS, has implemented an action plan. In addition, Dalriada Urgent Care has carried out a peer review which focussed on GP recruitment, retention, nurse triage and support to existing management. The subsequent report contained a series of recommendations which the SHSCT are taking forward with support from the HSCB.

The HSCB participated in the review of GP OOH Provision Working Group which had been established by DHSSPS with a view to examining the current delivery of GP Out of Hours service across NI, 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 will be actively involved in the implementation of these recommendations.

#### Service and Budget Agreements

There continue to be issues with securing Trust sign-off for Service and Budget agreements (SBAs). The HSCB's position is that activity levels within the SBAs are reasonable in the context of available resources, but as at the end of March 2016, counter-signed SBAs have only been received from 3 Trusts (South, West and NIAS). The remaining Trusts (Belfast, South Eastern and Northern) were not content to sign SBAs. This matter will be followed up at Director and Chief Executive level with a view to securing resolution.

#### Child Sexual Exploitation (CSE)

The HSCB continues to respond to concerns surrounding CSE under Protocol for Joint Investigation procedures. "Operation Owl" has now been stood down although a number of investigations are on-going. The HSCB made additional investments to retain and increase the capacity of Trusts to address issues around CSE within each Trust. Local Trust and Police Service

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of Northern Ireland meetings also continue to address CSE issues and social work staff complete risk assessments on any young person who may be at risk of CSE. The risk assessment tool, which was updated in October 2014, is applied across all Trusts. The funding for CSE leads has been made recurrent and Trusts are at various stages of appointing staff on a permanent basis. The HSCB also issued additional non recurrent funding of approximately £100k which mainly supported raising awareness and additional training for staff.

The HSCB has re-specified the requirement for a regional service working directly with young people suspected of being subject to CSE and to provide training and consultation to a range of staff across a number of agencies. The newly procured service will commence on the 1<sup>st</sup> April 2017. A 3-year contract has been awarded to two different providers to provide a therapeutic support and consultation service, and a separate contract for specialised staff training. The HSCB has also reviewed the missing children guidance and is reviewing how statistical data is collated at the HSCB. The revision of the guidance has been completed jointly with PSNI and joint training will follow. Trusts and Voice of Young People in Care are engaging with young people directly to ensure their views are available and taken into account.

The HSCB and PHA also participate in a response team set up and chaired by the DHSSPS to respond to the recommendations identified in the CSE in Northern Ireland Report of the Inquiry which reported in November 2014. The report identified 17 key recommendations with 60 supporting recommendations. An implementation plan was developed by the DHSSPS for submission to the Minister.

The Safe Guarding Board Northern Ireland (SBNI) thematic review was delayed until final issue in December 2015. Young people potentially at risk of CSE come from both the community and from Looked After placements. Many of these young people present with complex and difficult issues which can be compounded by alcohol and drug misuse which continues to be addressed/supported by additional funding by the HSCB.

#### Domiciliary Care

Previous difficulties in the residential and nursing home sector have illustrated risks arising from market instability and the difficulties which result from it. The Board and Trusts have reviewed contingency and oversight arrangements in these services but are becoming increasingly aware of challenges in the delivery of domiciliary care. This is largely due to issues associated with the identification of agreed rates for care, the potential impact of tendering initiatives across the region, staffing issues (recruitment, retention, training etc.). These can, in turn, be compounded by domiciliary care being a regular source of cost savings in the current, challenging, financial climate.

The combination of these factors has resulted in a renewed focus of the service in the form of a Regional Review of Domiciliary Care, which is led by the HSCB in conjunction with DHSSPS and Trust colleagues in liaison with voluntary sector partners. The objective is to establish robust information about the volume of care delivery and associated funding, an informed analysis of market functioning and stability, obtaining the views of users, staff and providers, comparing and analysing existing models of delivery to identify recommended best practice options for the future.

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Concerns about market instability and the ability of Trusts to secure consistent access to sustainable domiciliary care services led to the Board establishing the regional Domiciliary Care Review Group in 2014. The group involved a range of stakeholders (DHSSPS, Trusts, RQIA, Patient Client Council, NISCC, Commissioner for Older People, Users/Carers) and examined the current functioning of the service in the context of ongoing financial and workforce planning pressures. The Group produced a review report in November 2015 containing recommendations that will provide a strategic framework for future service development and improved market monitoring arrangements.

Where domiciliary care service failures have arisen in terms of a provider's inability to deliver on contracted services volumes, Trust contingency plans have been shown to have operated well and service continuity for clients and carers has been maintained. Trust domiciliary care procurements are still to complete, but these, and the additional funding announced for the sector in February 2016 by the Minister for Health, are expected to provide the foundation for improved stability.

#### Historical Institutional Abuse Inquiry

The HSCB is a core participant to the Inquiry and represent all current and previous statutory bodies. The Inquiry is covering the year 1922-1995. The demands of the Inquiry remain challenging and additional staff have had to be allocated to this work. There has been an ongoing challenge to provide the Inquiry with adequate records both from legacy Boards and also from Trusts and their predecessor legacy organisations. At times this has led to some criticism of the HSCB in its role as core participant. Trusts and Board have provided available files, and in situations when files do not exist or cannot be found explanations regarding file destruction arrangements have been given to explain some of this. Other potential criticism focuses on whether action was adequate and robust. These actions need to be set in the context of legislation, policy and practice at that time, but differing views are emerging.

The period from now until the end of the Inquiry will focus not only on other voluntary units, but also three statutory units. HSCB will be expected to provide full information in respect of the latter and all measures will be taken to do so.

#### Western Trust Financial Support

During the course of 2014/15 the financial pressures faced by all Trusts continued to increase, most notably in the case of Western Health and Social Care Trust (WHST). While the application of a range of measures, including additional funding from HSCB, enabled all other Trusts to achieve a breakeven position for the year to 31 March 2015, this was not achieved in WHST which reported a deficit of £6.7m.

Following discussions with the DHSSPS the Board was asked to provide additional monitoring via a Project Board, chaired by the Director of Finance of the HSCB, and included a membership of HSCB Directors, various Trust Directors and was supported by an external advisor, Mr Phil Taylor, a former NHS Chief Executive and Finance Director.



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The Project Board conducted a review and monitoring project in 2 phases, including the review of:

- Financial Control systems;
- Budgetary Control system and reports;
- 2014/15 expenditure trends and financial performance;
- 2014/15 Financial reporting;
- 2014/15 Contingency Plans
- 2015/16 Efficiency Plans;
- 2015/16 Income and Expenditure Reports; and
- Review and Approval of Trust 2015/16 Budgets.

The 2<sup>nd</sup> phase commenced in June 2015 and involved an increased level of monitoring and support to the Trust which was aimed at supporting the achievement of all aspects of the plan. This required the Project Board to review progress on improving service efficiency and financial performance within the Trust. This Project Board included HSCB Directors, various Trust Directors and was supported by Mr Phil Taylor.

There was a structured approach to Project Board meetings with an agenda, reports tabled, actions listed and minutes taken. Progress at the time of writing suggests the Trust will deliver financial balance in 2015/16, and progress continues to be made towards an improved recurrent financial position, which will be kept under review in 2016/17.

#### GP Workforce

A shortage of GPs has had considerable impact on service delivery, notably on filling of shifts and achievement of KPIs by OOH providers and also on day-time general practice due to the low level of supply of sessional doctors available to provide locum sessions in practices. Northern Ireland has the lowest number of GPs per population measure in the UK and 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. This means that retirement rates in NI are likely to have a greater impact than in England. In the absence of a longer term plan to increase GP numbers there is a considerable risk to the on-going continuity of general medical services provision to patients, particularly in relation to sustaining out of hours services and the continued existence of smaller practices in more isolated locations.

To date 65 WTE GP training places have been funded by DHSSPS through the Northern Ireland Medical and Dental Training Agency (NIMDTA) each year. In 2014/15 there were 184 applicants for the 65 available places. Based on various reports, including the DHSSPS “Review of Workforce Planning for the Medical Profession”, September 2006, and the Deloitte 2010 report “Review of the Medical Workforce”, it is widely accepted that this number should be increased. The 65 WTE GP training places in NI falls significantly below the 95 GP training places that would be equivalent to existing GP training provision in England, and further below a planned increase to numbers in England. The recommended number of GP training posts in England would equate to 111 GP training places in NI. The HSCB therefore welcomes the Minister’s announcement on 28 January 2016 that funding for an additional 20 training places will be made available, however, would note that this falls short of the numbers believed to be required in light of the workforce issues.

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The HSCB has sought to mitigate the GP workforce issue at operational level by providing additional funding to general practices to increase staff capacity, such as establishment of practice based pharmacist posts. The returner and induction scheme for GPs absent from provision of primary care for 24 months has been reviewed and changes made to shorten the time frame required to return to practice after the period of absence while continuing to ensure that GPs can return safely to the workplace. Further changes to this scheme are planned for 2016/17, taking account of developments elsewhere across the UK. The NI retainer scheme has also been reviewed and was issued in 2015/16 with a view to establishing its effectiveness in increasing GP capacity.

The HSCB works closely with GP practices that are experiencing specific difficulties due to GP supply issues with a view to sustaining service delivery to patients.

The HSCB will participate in the Future of GP-led Services Working Group established by DHSSPS to consider the delivery of primary care medical services delivered in GP surgeries by GPs or other healthcare professionals. This review will include assessment of what the future demand for primary care services may look like and the impact on workload; the mix of skills necessary to meet and manage this demand and trends in the make-up of the existing primary care workforce; and the implications of these trends for the future provision of primary care. The group published its report on 23<sup>rd</sup> March 2016. The report includes a number of recommendations in relation to the GP workforce including recruitment of at least 10 additional GPs from the EU in 2016/17; development of a costed plan for the remaining additional trainee places required to achieve an annual intake of 111 GP places by 2019/20; ensuring effective formalised measures are in place to support newly qualified GPs and help retain the existing GP workforce, with a particular focus on supporting rural and single-handed practices; establishment of a database of GPs from NI who are working elsewhere, carrying out a survey to seek to understand their reasons for leaving, and developing a plan to encourage those considering a career in general practice to remain in Northern Ireland; and completion of research into overall GP workforce requirements for the next decade.

#### **Business Services Transformation Project/Shared Services**

The Business Services Transformation Program (BSTP) introduced new HSC wide computer systems in 2012/13 and began implementation of Shared Services for Accounts Payable, Receivable and Payroll in 2013/14.

While BSO has made significant progress in the control environment for Accounts Payable and Accounts Receivable there remains priority 1 audit recommendations for Payroll, which had a limited assurance by the Head of Internal Audit. These priority 1 audit recommendations have limited impact on HSCB and therefore this control issue is not considered as a significant issue for 2015/16.

In addition, the HSCB has been advised that the Recruitment and Selection Shared Service has been given an Unacceptable level of assurance from the Internal Auditor in March 2016, whilst having a lesser impact directly for HSCB there is concern regarding the wider HSC and the impact that this may be having on the timely recruitment of essential staff vacancies throughout the region. The

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delivery of these shared services will continue to be closely monitored by the HSCB via monthly assurances and performance reports, with any issues raised at the regular Customer Forum meetings.

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

#### HSCB Business Continuity

In light of the Ministerial announcement in November 2015 to close the Board, together with VES and recruitment restrictions, it is considered that going forward this could impact on the Board's ability to deliver its statutory, mandatory and business planning requirements.

The HSCB continues to work with the Department and all other relevant stakeholders and has put in place the following controls:

- regular updates to staff as and when information becomes available;
- SMT process to identify key business priorities;
- Board staff to fully participate in DHSSPS project arrangements to design new arrangements;
- regular review of key duties as staff leave the HSCB;
- corporate approach to VES applications; and
- scrutiny panel to consider request for new posts.

In line with International Accounting Standards (IAS1) and HM Treasury's Financial Reporting Manual, the Director of Finance has considered whether given this announcement, the HSCB should still be considered as a 'going concern'. HM Treasury guidance indicates that as the HSCB has a budget plan and will be in existence for the 2016/17 financial year that this is sufficient evidence of 'going concern'. The Annual Accounts within this document have therefore been prepared on that basis. This will be kept under review during 2016/17.

#### Independent Home Care

As a result of information about the increasing pressure on providers arising from difficulties in staff recruitment and retention, adequacy of the hourly rate being paid for care and the implementation of the Living Wage in 2016, the HSCB initiated a review of the service during 2015. This work included a comparative analysis of Trust service models and methods of delivery, examination of the interfaces with other kinds of domiciliary care provision, analysis of funding and activity data and examination of service models in other jurisdictions. The review included a significant degree of engagement with service users, carers, the sector itself and significant statutory, independent and voluntary sector providers.

The outcome of this work has been the identification of recommendations with the potential to stabilise and improve the service. These include proposals to establish a Community Care Task Force with a very specific remit to focus on community care service delivery and to develop a coordinated approach to service improvement. The priority issues to be addressed by the HSCB are the need to address the cost pressure arising from the implementation of the Living Wage from 1<sup>st</sup>

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April 2016, to examine the implications of the WHSCT tendering exercise for domiciliary care both locally and regionally and to progress the business case for the procurement of an electronic domiciliary care monitoring system. Work is also ongoing to improve information about activity and expenditure on domiciliary care.

#### **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.

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 2015/16.

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#### **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, Social Services and Public Safety (DHSSPS), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, where permitted by DHSSPS, agreeing the discretionary level of performance related pay.

A circular on the 2015/16 Senior Executive pay award had not been received from the DHSSPS by 31 March 2016, therefore related payments have not been made to Executive Directors.

The 2014/15 Senior Executive's pay award was set out in DHSSPS circular HSC(SE) 1/2015 and was paid in line with the Remuneration and Terms of Service 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 2015/16. 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 DHSSPS 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. Four of the HSCB's Non-Executive Directors have recently had their terms of office extended by the DHSSPS for 12 months.

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

##### **Early Retirement and Other Compensation Schemes**

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2015/16.

##### **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

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

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#### 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 2014/15.

	2016	2015
Highest Earner's Total Remuneration (band in £000s)	150-155	150-155
Median Salary (£)	37,921	34,530
<b>Median Total Remuneration Ratio</b>	<b>4.1</b>	<b>4.4</b>

#### Senior Management Remuneration – Non Executive Members (Table Audited)

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 2015/16 or 2014/15:

Name	2015/16				2014/15			
	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
I Clements	30-35	100	-	30-35	30-35	400	-	30-35
S J Leach	5-10	-	-	5-10	5-10	200	-	5-10
M McCullough	5-10	100	-	5-10	5-10	0	-	5-10
R Gilmore	5-10	100	-	5-10	5-10	200	-	5-10
B McKeever	5-10	-	-	5-10	5-10	500	-	5-10
J Mone	5-10	100	-	5-10	5-10	300	-	5-10
W R Thompson	5-10	-	-	5-10	5-10	0	-	5-10
Stephanie Lowry	5-10	100	-	5-10	5-10	100	-	5-10

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**Senior Management Remuneration continued – Executive Members (Table Audited)**

Name	2015/16				2014/15			
	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
Chief Executive V Watts (Appointed 01/07/14)	150-155	3,700	45,000	200-205	115-120	200	-	115-120
Director of Social Care F McAndrew (Acting Chief Executive 01/04/14 - 30/06/14) (1)	85-90	200	(22,000)	60-65	90-95	500	49,000	140-145
Director of Finance P Cummings (Seconded to NHSCT 22/05/13 – 31/05/14)	105- 110	3,200	3,000	110-115	90-95	400	27,000	115-120
Director of Integrated Care S Harper	120-125	200	44,000	165-170	115-120	500	29,000	145-150
Director of Commissioning D Sullivan	105-110	400	16,000	120-125	105-110	600	38,000	145-150
Head of Corporate Services & Acting Director of PMSI M Bloomfield (since 19/11/12)	90-95	200	18,000	105-110	90-95	300	10,000	100-105
Director of e-Health S Donaghy	125-130	100	3,000	130-135	125-130	400	30,000	155-160
Director of TYC P McCreedy (seconded to NHSCT from May 2015, subsequently resigned HSCB post) (2)	5-10	100	-	-	75-80	0	18,000	90-95
O Harkin (Acting Director of Finance from 22/05/13 until 31/05/14)	-	-	-	-	10-15	300	-	10-15

*For notes (1-2) relating to Senior Management Remuneration please refer to the Pensions of Senior Management table which follows below.*

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

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.

#### Pensions of Senior Management – Executive Members (Table Audited)

Name	2015/16				
	Total accrued pension at age 60 and related lump sum £000s	Real increase in pension and related lump sum at age 60 £000s	CETV at 31/03/16 £000s	CETV at 31/03/15 £000s	Real increase in CETV £000s
Chief Executive V Watts (Appointed 01/07/14)	0-5 pension	2.5-5 pension	65	20	45
Director of Social Care F McAndrew (Acting Chief Executive 01/04/14 – 30/06/14) (1)	20-25 pension 60-65 lump sum	0-(2.5) pension 0-(2.5) lump sum	-	508	-
Director of Finance P Cummings (Seconded to NHSCT 22/05/13 – 31/05/14) (3a)	40-45 pension 125-130 lump sum	0-2.5 pension 2.5-5 lump sum	815	771	18
Director of Integrated Care S Harper (3b)	50-55 pension 150-155 lump sum	2.5-5 pension 7.5-10 lump sum	1046	959	55
Director of Commissioning D Sullivan (3c)	45-50 pension	0-2.5 pension	565	534	16
Head of Corporate Services & Acting Director of PMSI M Bloomfield (since 19/11/12) (3d)	30-35 pension 90-95 lump sum	0-2.5 pension 0-(2.5) lump sum	536	505	14
Director of e-Health S Donaghy (3e)	40-45 pension 130-135 lump sum	0-2.5 pension 2.5-5 lump sum	886	839	19
Director of TYC P McCreedy (seconded to NHSCT from May 2015, subsequently resigned HSCB post) (2)	-	-	-	74	-



## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### *Notes – Executive Members Tables*

- (1) *CETV calculation not applicable for this post holder.*
- (2) *No pension figures shown as these are annual calculations; postholder was employed by NHSCT at 31/03/16.*
- (3) *CETV at 31/03/15 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:*
  - (a) *816 to 771*
  - (b) *975 to 959*
  - (c) *539 to 534*
  - (d) *516 to 505*
  - (e) *859 to 839*

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 or 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 include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSS 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 column market valuation factors for the start and end of the year up to normal pension age.

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.

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### Staff Report

The following tables set out the HSCB's staff costs and numbers for the 2015/16 financial year.

#### Staff Costs

The following tables set out the HSCB's staff costs and numbers for the 2015/16 financial year.

	2016			2015
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	22,240	945	23,185	24,519
Social security costs	1,925	82	2,007	2,122
Other pension costs	3,321	141	3,462	3,012
<b>Total staff costs reported in Statement of Comprehensive Expenditure</b>	<b>27,486</b>	<b>1,168</b>	<b>28,654</b>	<b>29,653</b>
Less recoveries in respect of outward secondments			(534)	(559)
<b>Total net costs</b>			<b>28,120</b>	<b>29,094</b>

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 DHSSPS. 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

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

	2016			2015
	Permanently employed staff	Others	Total	Total
Commissioning of Health and Social Care	550	29	579	594
Less average staff number relating to capitalised staff costs	0	0	0	0
Less average staff number in respect of outward secondments	(10)	0	(10)	(10)
<b>Total net average number of persons employed</b>	<b>540</b>	<b>29</b>	<b>569</b>	<b>584</b>

#### Staff Composition

At 31 March 2016 the HSCB's headcount is 586 employees which equates to 526.44 WTE. Of this figure, 495 are permanent staff members with 91 temporary staff. The ratio of female to male employees is 437 women to 149 men.

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

There were 75 senior staff who earn over £67k or would earn over £67k if they were 1 WTE, of these 29 are women and 46 men.

#### Reporting of early retirement and other compensation scheme – exit packages

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2016	2015	2016	2015	2016	2015
<£10,000	0	0	0	0	0	0
£10,000-£25,000	0	0	10	0	10	0
£25,000-£50,000	0	0	14	0	14	0
£50,001-£100,000	0	0	15	0	15	0
£100,001-£150,000	0	0	5	0	5	0
<b>Total number of exit packages by type</b>	<b>0</b>	<b>0</b>	<b>44</b>	<b>0</b>	<b>44</b>	<b>0</b>
<b>Total resource cost £000s</b>	<b>£0</b>	<b>£0</b>	<b>£2,504</b>	<b>£0</b>	<b>£2,504</b>	<b>£0</b>

Redundancy and other departure costs have been paid in accordance with the provisions of the 2015/16 Voluntary Exit Scheme and the HSC Pension Scheme Regulations where appropriate. 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 employing authority 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 2015/16 or 2014/15.

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### Management Costs

	<b>2016</b>	<b>2015</b>
	<b>£000s</b>	<b>£000s</b>
HSCB management costs	35,599	35,065
<b>Income:</b>		
RRL	4,424,086	4,251,874
Less non cash RRL excluding element to cover clinical negligence provision	(17,767)	(12,709)
Income per Note 4	52,299	53,579
Less interest receivable	0	0
<b>Total Income</b>	<b>4,458,618</b>	<b>4,292,744</b>
<b>% of total income</b>	<b>0.80%</b>	<b>0.82%</b>

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 2015-16 there were 2 early retirements from the Board, agreed on the grounds of ill-health, where individuals made a decision to commute their pension.

#### Sickness Absence Data

The corporate cumulative annual absence level for the HSCB for the period from 1 April 2015 – 31 March 2016 is 3.92%.

There were 41,227 hours lost due to sickness absence, or the equivalent of 70.8 hours lost per employee. Based on a 7.5 hour working day, this is equal to 9.44 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, flexibility is given in respect of interview times, location of interview and any requested use of interpreters to applicants who require such arrangements.

Following a staff survey, the Board along with other HSC organisations has established a Disability Forum which launched in March 2016. The Board along with several other organisations is also participating 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.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

Staff who become disabled during the course of their employment will be assessed by the Occupational Health Service provided to the organisation under a SLA. Their recommendations in respect of reasonable adjustments required 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 both Induction and Selection and Recruitment training for Board staff. All staff have access to a range of organisational policies and procedures in respect of flexible working arrangements which have been equality screened.

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 expended £6k on one consultancy project during 2015/16, this was considered and approved under the extant guidance and related to the provision of independent advice and assurance regarding the consultation process for the Making Choices document, which set out the criteria to be used to make decisions regarding statutory residential care homes for older people.

#### **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 2015/16 there were no such 'off-payroll' engagements (2014/15 – none).

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### ASSEMBLY ACCOUNTABILITY AND AUDIT REPORT

#### 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 2015/16 there has been no evidence of irregular expenditure.

##### Losses and Special Payments

Type of loss and special payment		2015-16		2014-15
		Number of Cases	£	£
<b>Cash losses</b>				
	Cash Losses - Theft, fraud etc.	3	562	0
	Cash Losses - Exchange Rate Fluctuations	0	0	510
		<b>3</b>	<b>562</b>	<b>510</b>
<b>Fruitless payments</b>				
	Late Payment of Commercial Debt	0	0	292
		<b>0</b>	<b>0</b>	<b>292</b>
<b>Special Payments</b>				
	Compensation payments:			
	- Clinical Negligence	30	915,930	6,320,188
	- Public Liability	0	0	0
	- Employers Liability	8	46,389	25,167
	- Other	0	0	0
		<b>38</b>	<b>962,319</b>	<b>6,345,355</b>
<b>TOTAL</b>		<b>41</b>	<b>962,881</b>	<b>6,346,157</b>

##### **Special Payments**

There were no other special payments or gifts made during the year (2014/15 – none).

##### **Other Payments and Estimates**

There were no other payments made during the year (2014/15 – none).

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### Estimate of Patient Exemption Fraud and Error

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

1. The BSO on behalf of the Board handles payments to contractors providing family practitioner services. The Counter Fraud and Probity Service within the BSO is responsible for checking patient exemption entitlement and for taking follow-up action where a patient's claim to exemption from statutory charges has not been confirmed.
2. Given the volume of Dental and Ophthalmic claims each year, sampling is used to establish an estimate of the total annual potential loss due to 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 Business Services Authority to provide independent verification of entitlement across a number of exemption categories. Where entitlement to exemptions claimed is not confirmed for individual patients as part of this process, such instances are referred as cases to Electronic Prescribing and Eligibility System (EPES) case management system for further investigation.
3. To estimate the total annual loss due to patient exemption fraud and error in the population, the BSO applies the estimate rate of loss for each exemption category in the sample to the volumetric and average liability for that category in the population.

The best estimate of total fraud and error loss for the NI region in 2015/16 is £3.6m rounded (£2.9m Dental, £0.8m Ophthalmic). If comparative figures for 2014/15 are uplifted to 2015/16 activity levels, then the estimated combined figure is £3.8m.

#### **Losses and Special Payments over £250,000**

<b>Losses and Special Payments over £250,000</b>	<b>Number of Cases</b>	<b>2015-16 £</b>	<b>2014-15 £</b>
<b>Special Payments</b>			
Prior year total (4 cases)	0	0	5,783,598
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>5,783,598</b>

#### **Remote Contingent Liabilities**

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 21 of the Annual Accounts, the Board 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 2016, the Board is not aware of any remote contingent liabilities.

**HEALTH AND SOCIAL CARE BOARD**

**ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

**Accounting Officer Signature – approval of individual sections within Accountability Report**



**Mrs Valerie Watts  
Chief Executive**

Date 9 June 2016



## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **Glossary of Terms**

**Bamford Report** – a major study commissioned by the Department of Health, Social Services and Public Safety in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

**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.

**DEXA scan** - a DEXA scan is a special type of X-ray that measures bone density and is most commonly used to diagnose osteoporosis.

**DHSSPS** – Department of Health, Social Services and Public Safety

**ECG** - electrocardiogram

**ED** – Emergency Department

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

**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

**IMROC** - Implementing Recovery through Organisational Change

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

**ICATS** – Integrated Clinical Assessment and Treatment Services

**Local Commissioning Groups** – committees of the regional 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.

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

**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.

**MRI** – Magnetic Resonance Imaging

**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.

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

**TYC** – Transforming Your Care

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016**

#### **HEALTH AND SOCIAL CARE BOARD**

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

I certify that I have audited the financial statements of the Health and Social Care Board for the year ended 31 March 2016 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 Remuneration and Staff Report and Accountability and Audit Report within the Accountability Report that is described in that report as having been audited.

#### **Respective responsibilities of the Accounting Officer and auditor**

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. 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 conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

#### **Scope of the audit of the financial statements**

An audit involves obtaining 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. This includes an assessment of: whether the accounting policies are appropriate to the Health and Social Care Board's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Health and Social Care Board; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

#### **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.

## HEALTH AND SOCIAL CARE BOARD

### ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2016

#### Opinion on financial statements

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 2016 and of the net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health (formerly the Department of Health, Social Services and Public Safety) directions issued thereunder.

#### Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Accountability and Audit 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 for the financial year for which the financial statements are prepared is consistent with the financial statements.

#### 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 Remuneration and Staff Report and the Accountability and Audit 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 Department of Finance's (formerly Department of Finance and Personnel) 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

13 June 2016

**HEALTH AND SOCIAL CARE BOARD**  
**ANNUAL ACCOUNTS**  
**FOR THE YEAR ENDED 31 MARCH 2016**

## **HEALTH AND SOCIAL CARE BOARD**

### **ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

#### **FOREWORD**

These accounts for the year ended 31 March 2016 have been prepared in a form determined by the Department of Health, Social Services and Public Safety (DHSSPS) based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FRM) 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 2016

#### 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 146 to 180) 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 DHSSPS.



Simon Christie

**Acting Director of Finance**

Date 9 June 2016

I certify that the annual accounts set out in the financial statements and notes to the accounts (page 146 to 180) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.



Ian Clements

**Chairman**

Date 9 June 2016



Valerie Watts

**Chief Executive**

Date 9 June 2016

## HEALTH and SOCIAL CARE BOARD

### STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2016

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.

<b>Income</b>	<b>NOTE</b>	<b>2016 £000</b>	<b>2015 £000</b>
Income from activities	4.1	50,803	52,167
Other income (excluding interest)	4.2	1,398	1,412
Deferred income	4.3	97	0
<b>Total operating income</b>		<u>52,298</u>	<u>53,579</u>
<b>Expenditure</b>			
Staff costs	3	(28,654)	(29,653)
Purchase of goods and services	3	(973,454)	(946,891)
Depreciation, amortisation and impairment charges	3	(2,815)	(3,008)
Provision expense	3	(14,780)	(9,591)
Other expenditures	3	(23,553)	(22,999)
<b>Total operating expenditure</b>		<u>(1,043,256)</u>	<u>(1,012,143)</u>
<b>Net Expenditure</b>		<u>(990,958)</u>	<u>(958,563)</u>
Finance income	4.2	2	0
Finance expense	3	0	0
<b>Net expenditure for the year</b>		<u>(990,956)</u>	<u>(958,563)</u>
<b>Revenue Resource Limits (RRLs) issued (to)</b>			
Belfast Health & Social Care Trust		(1,181,868)	(1,137,664)
South Eastern Health & Social Care Trust		(529,523)	(499,429)
Southern Health & Social Care Trust		(533,644)	(510,383)
Northern Health & Social Care Trust		(591,648)	(577,546)
Western Health & Social Care Trust		(531,044)	(500,022)
NIAS Health & Social Care Trust		(63,490)	(59,943)
NI Medical & Dental Training Agency		(1,316)	(1,290)
NI Social Care Council		0	(6)
<b>Total RRL issued</b>		<u>(3,432,533)</u>	<u>(3,286,283)</u>
<b>Total Commissioner resources utilised</b>		(4,423,489)	(4,244,846)
Revenue Resource Limit (RRL) received from DHSSPS	24.1	4,424,086	4,251,874
<b>Surplus / (Deficit) against RRL</b>		<u>597</u>	<u>7,028</u>
<b>OTHER COMPREHENSIVE EXPENDITURE</b>			
	<b>NOTE</b>	<b>2016 £000</b>	<b>2015 £000</b>
<b>Items that will not be reclassified to net operating costs:</b>			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	183	1,109
<b>TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2016</b>		<u>(990,773)</u>	<u>(957,454)</u>

The notes on pages 150 to 180 form part of these accounts.



## HEALTH and SOCIAL CARE BOARD


### STATEMENT of FINANCIAL POSITION as at 31 March 2016

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

	NOTE	2016 £000	2015 £000
<b>Non Current Assets</b>			
Property, plant and equipment	5.1/5.2	14,897	15,889
Intangible assets	6.1/6.2	1,569	905
Financial assets	7	348	0
<b>Total Non Current Assets</b>		<u>16,814</u>	<u>16,794</u>
<b>Current Assets</b>			
Trade and other receivables	12	6,106	6,611
Other current assets	12	37	128
Financial assets	7	41	0
Cash and cash equivalents	11	10,095	2,315
<b>Total Current Assets</b>		<u>16,279</u>	<u>9,054</u>
<b>Total Assets</b>		<u>33,093</u>	<u>25,848</u>
<b>Current Liabilities</b>			
Trade and other payables	13	(163,033)	(150,937)
Provisions	15	(8,313)	(7,307)
<b>Total Current Liabilities</b>		<u>(171,346)</u>	<u>(158,244)</u>
<b>Total assets less current liabilities</b>		<u>(138,253)</u>	<u>(132,396)</u>
<b>Non Current Liabilities</b>			
Provisions	15	(33,929)	(36,299)
<b>Total Non Current Liabilities</b>		<u>(33,929)</u>	<u>(36,299)</u>
<b>Total assets less total liabilities</b>		<u>(172,182)</u>	<u>(168,695)</u>
<b>Taxpayers' Equity and other reserves</b>			
Revaluation reserve		8,157	8,004
SoCNE reserve		(180,339)	(176,699)
<b>Total equity</b>		<u>(172,182)</u>	<u>(168,695)</u>

The financial statements on pages 146 to 180 were approved by the Board on 9 June 2016 and were signed on its behalf by:

Signed  (Chairman) Date 9 June 2016

Signed  (Chief Executive) Date 9 June 2016

The notes on pages 150 to 180 form part of these accounts.

## HEALTH and SOCIAL CARE BOARD

### STATEMENT of CASH FLOWS for the year ended 31 March 2016

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	2016 £000	2015 £000
<b>Cash flows from operating activities</b>			
Net surplus after interest/Net operating cost	SoCNE	(990,956)	(958,563)
Adjustments for non cash costs	3	17,767	12,709
(Increase)/decrease in trade and other receivables	12	596	850
Increase/(decrease) in trade payables	13	12,096	5,446
<i>Less movements in payables relating to items not passing through the NEA</i>			
Movements in payables relating to the purchase of property, plant and equipment	13	(17)	398
Movements in payables relating to the purchase of intangibles	13	(595)	71
Use of provisions	15	(16,145)	(10,241)
<b>Net cash outflow from operating activities</b>		<b>(977,254)</b>	<b>(949,330)</b>
<b>Cash flows from investing activities</b>			
(Purchase of property, plant & equipment)	5	(1,505)	(2,504)
(Purchase of intangible assets)	6	(409)	(310)
(FTC loans issued to GPs)	7	(498)	0
FTC loans returned by GPs	7	13	0
<b>Net cash outflow from investing activities</b>		<b>(2,400)</b>	<b>(2,814)</b>
<b>Cash flows from financing activities</b>			
Grant in aid		987,434	951,057
<b>Net financing</b>		<b>987,434</b>	<b>951,057</b>
<b>Net increase (decrease) in cash &amp; cash equivalents in the period</b>		<b>7,780</b>	<b>(1,087)</b>
<b>Cash &amp; cash equivalents at the beginning of the period</b>	11	<b>2,315</b>	<b>3,402</b>
<b>Cash &amp; cash equivalents at the end of the period</b>	11	<b>10,095</b>	<b>2,315</b>

The notes on pages 150 to 180 form part of these accounts.

## HEALTH and SOCIAL CARE BOARD

### STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2016

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, Social Services and Public Safety) and the Revaluation Reserve which reflects the change in asset values that have not been recognised as income or expenditure. The SoCNE Reserve represents the total assets less liabilities of the 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
<b>Balance at 31 March 2014</b>		<b>(169,245)</b>	<b>6,895</b>	<b>(162,350)</b>
<b>Changes in Taxpayers' Equity 2014/15</b>				
Grant from DHSSPS		951,057	0	951,057
(Comprehensive expenditure for the year)		(958,563)	1,109	(957,454)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	52	0	52
<b>Balance at 31 March 2015</b>		<b>(176,699)</b>	<b>8,004</b>	<b>(168,695)</b>
<b>Changes in Taxpayers' Equity 2015/16</b>				
Grant from DHSSPS		987,434	0	987,434
(Comprehensive expenditure for the year)		(990,956)	183	(990,773)
Transfer of asset ownership		(170)	(30)	(200)
Non cash charges - auditors remuneration	3	52	0	52
<b>Balance at 31 March 2016</b>		<b>(180,339)</b>	<b>8,157</b>	<b>(172,182)</b>

The notes on pages 150 to 180 form part of these accounts.

# HEALTH AND SOCIAL CARE BOARD

## NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

### NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

#### 1 Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel'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.

#### 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;

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

- 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 and Personnel. 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**

DFP 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

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

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 2015/16 or 2014/15.

#### **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.

## HEALTH AND SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

The following asset lives have been used.

<b>Asset Type</b>	<b>Asset Life</b>
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:

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

- 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 2015/16 or 2014/15.

#### **1.9 Inventories**

The HSCB had no inventories as at 31 March 2016 or 31 March 2015.

#### **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.



## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

#### **Grant in aid**

Funding received from other entities, including the Department of Health, Social Services and Public Safety are accounted for as grant in aid and are reflected through the Statement of Comprehensive Net Expenditure Reserve.

#### **1.11 Investments**

The HSCB did not hold any investments in either 2015/16 or 2014/15.

#### **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.

##### The HSCB as lessee

The HSCB held no finance leases during 2015/16 or 2014/15.

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

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

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

##### The HSCB as lessor

The HSCB did not have any lessor agreements in either 2015/16 or 2014/15.

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

#### **1.15 Private Finance Initiative (PFI) transactions**

The HSCB had no PFI transactions during 2015/16 or 2014/15.

#### **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 2015/16 or 2014/15.

- 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 DHSSPS, 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.

## HEALTH AND SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

- Credit and liquidity risk

Since the HSCB receives the majority of its funding from the Department of Health, Social Services and Public Safety, 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 DFP's discount rates of -1.55% (1-5 years), -1.00% (5-10 years), -0.80% (>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.

During 2015/16 the HSCB has settled the inherited legacy Board pension provision with the HSC Pension Scheme and fully utilised the provision previously held (please refer to note 15 of the accounts).

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.

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

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 2016. 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 DHSSPS. 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, Social Services and Public Safety.

The costs of early 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.

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

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 2012 valuation for the HSC Pension Scheme will be used in 2015/16 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 2015/16 or 2014/15.

#### **1.23 Government Grants**

The HSCB had no government grants in 2015/16 or 2014/15.

#### **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 and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

## **HEALTH AND SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

#### **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 2016. 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 2016

#### NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

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

<b>Summary</b>	<b>NOTE</b>	<b>2016 £000</b>	<b>2015 £000</b>
Commissioning	2.1	3,503,348	3,350,336
FHS	2.2	851,491	829,952
Board Administration	2.3	68,650	64,558
<b>Total Commissioner Resources utilised</b>		<b>4,423,489</b>	<b>4,244,846</b>

#### 2.1 Commissioning

<b>Expenditure</b>	<b>NOTE</b>	<b>2016 £000</b>	<b>2015 £000</b>
Belfast Health & Social Care Trust		1,181,868	1,137,664
South Eastern Health & Social Care Trust		529,523	499,429
Southern Health & Social Care Trust		533,644	510,383
Northern Health & Social Care Trust		591,648	577,546
Western Health & Social Care Trust		531,044	500,022
NIAS Health & Social Care Trust		63,490	59,943
NI Medical & Dental Training Agency		1,316	1,290
NI Social Care Council		0	6
Other Providers	3.2	96,481	93,086
		<b>3,529,014</b>	<b>3,379,369</b>
<b>Income</b>			
Income from activities	4.1	25,666	29,033
<b>Commissioning Net Expenditure</b>		<b>3,503,348</b>	<b>3,350,336</b>

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

##### 2.2 FHS

		<b>2016</b>	<b>2015</b>
<b>Expenditure</b>	<b>NOTE</b>	<b>£000</b>	<b>£000</b>
General Medical Services	3.2	249,426	238,597
General Dental Services	3.2	126,599	125,559
General Pharmaceutical Services	3.2	478,162	466,506
General Ophthalmic Services	3.2	22,538	22,424
		<u>876,725</u>	<u>853,086</u>
<b>Income</b>			
FHS receipts & recovery of charges	4.1	<u>25,234</u>	<u>23,134</u>
<b>FHS Net Expenditure</b>		<u><b>851,491</b></u>	<u><b>829,952</b></u>

##### 2.3 Board Administration

		<b>2016</b>	<b>2015</b>
<b>Expenditure</b>	<b>NOTE</b>	<b>£000</b>	<b>£000</b>
Salaries and wages	3.1	28,654	29,653
Operating expenditure	3.3	23,629	23,608
Non-cash costs	3.4	14,952	9,701
Depreciation	3.4	2,815	3,008
		<u>70,050</u>	<u>65,970</u>
<b>Income</b>			
Staff secondment recoveries	4.2	534	559
Operating income	4.2	864	853
FTC interest	4.2	2	0
		<u>1,400</u>	<u>1,412</u>
<b>Board Administration Net Expenditure</b>		<u><b>68,650</b></u>	<u><b>64,558</b></u>



## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 3 - STAFF COSTS

	<b>2016</b>	<b>2015</b>
<b>3.1 Staff Costs:</b>	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Wages and salaries	23,185	24,519
Social security costs	2,007	2,122
Other pension costs	3,462	3,012
<b>Total staff costs reported in Statement of Comprehensive Net Expenditure</b>	<b>28,654</b>	<b>29,652</b>
Less recoveries in respect of outward secondments	534	559
<b>Total net costs</b>	<b>28,120</b>	<b>29,093</b>

A breakdown of the above costs into permanent staff and others can be found in the Remuneration and Staff Report within the Accountability Report.

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 3 - OPERATING EXPENSES

<b>3.2 Commissioning:</b>	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
General Medical Services	249,426	238,597
General Dental Services	126,599	125,559
General Pharmaceutical Services	478,162	466,506
General Ophthalmic Services	22,538	22,424
NHS Trusts	29,210	30,613
Other providers of healthcare and personal social services	66,845	62,368
Capital grants to voluntary organisations	426	105
<b>Total Commissioning</b>	<b>973,206</b>	<b>946,172</b>
<b>3.3 Operating expenses are as follows:</b>		
Supplies and services - general	248	719
Establishment	21,336	20,465
Transport	17	18
Premises	2,028	2,406
<b>Total Operating Expenses</b>	<b>23,629</b>	<b>23,608</b>
<b>3.4 Non cash items:</b>		
Depreciation	2,476	2,601
Amortisation	339	407
Impairments relating to FTC	96	0
Loss on disposal of property, plant & equipment (including land)	24	58
Provisions provided for in year	14,719	9,490
Cost of borrowing of provisions (unwinding of discount on provisions)	61	101
Auditors remuneration	52	52
<b>Total non cash items</b>	<b>17,767</b>	<b>12,709</b>
<b>Total</b>	<b>1,014,602</b>	<b>982,489</b>

During the year the HSCB purchased no non audit services from its external auditor (NIAO).

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 4 - INCOME

<b>4.1 Income from Activities</b>	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Income from Department of Education	24,394	26,509
CAWT	952	2,075
Family Health Services Receipts	25,234	23,134
Other income	223	449
<b>Total</b>	<b>50,803</b>	<b>52,167</b>

<b>4.2 Other Operating Income</b>	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Accommodation	650	638
Canteen	214	215
Seconded Staff	534	559
FTC interest receivable	2	0
<b>Total</b>	<b>1,400</b>	<b>1,412</b>

<b>4.3 Deferred income</b>	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Income released from conditional grants	97	0
<b>Total</b>	<b>97</b>	<b>0</b>

<b>TOTAL INCOME</b>	<b>52,300</b>	<b>53,579</b>
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**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 5.1 - Property, plant & equipment - year ended 31 March 2016**

	<b>Land £000</b>	<b>Buildings (excluding dwellings) £000</b>	<b>Plant and Machinery (Equipment) £000</b>	<b>Information Technology (IT) £000</b>	<b>Furniture and Fittings £000</b>	<b>Total £000</b>
<b>Cost or Valuation</b>						
At 1 April 2015	3,150	6,782	6	17,577	164	27,679
Indexation	147	43	0	(3)	0	187
Additions	0	107	0	1,416	0	1,523
Transfers	(200)	2	0	0	0	(198)
Disposals	0	0	0	(2,460)	0	(2,460)
<b>At 31 March 2016</b>	<b>3,097</b>	<b>6,934</b>	<b>6</b>	<b>16,530</b>	<b>164</b>	<b>26,731</b>

**Depreciation**

At 1 April 2015	0	49	6	11,571	164	11,790
Indexation	0	4	0	0	0	4
Disposals	0	0	0	(2,436)	0	(2,436)
Provided during the year	0	301	0	2,175	0	2,476
<b>At 31 March 2016</b>	<b>0</b>	<b>354</b>	<b>6</b>	<b>11,310</b>	<b>164</b>	<b>11,834</b>

**Carrying Amount**

At 31 March 2016	<b>3,097</b>	<b>6,580</b>	<b>0</b>	<b>5,220</b>	<b>0</b>	<b>14,897</b>
At 31 March 2015	<b>3,150</b>	<b>6,733</b>	<b>0</b>	<b>6,006</b>	<b>0</b>	<b>15,889</b>

**Asset financing**

Owned	3,097	6,580	0	5,220	0	14,897
<b>Carrying Amount</b>	<b>3,097</b>	<b>6,580</b>	<b>0</b>	<b>5,220</b>	<b>0</b>	<b>14,897</b>
At 31 March 2016						

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 (2015 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2015 - £nil).

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 5.2 - Property, plant & equipment - year ended 31 March 2015**

	<b>Land £000</b>	<b>Buildings (excluding dwellings) £000</b>	<b>Plant and Machinery (Equipment) £000</b>	<b>Information Technology (IT) £000</b>	<b>Furniture and Fittings £000</b>	<b>Total £000</b>
<b>Cost or Valuation</b>						
At 1 April 2014	2,722	7,208	6	18,511	164	28,611
Additions	0	52	0	2,055	0	2,107
Reclassifications	0	0	0	(2)	0	(2)
Revaluation	428	(478)	0	0	0	(50)
Disposals	0	0	0	(2,987)	0	(2,987)
At 31 March 2015	<b>3,150</b>	<b>6,782</b>	<b>6</b>	<b>17,577</b>	<b>164</b>	<b>27,679</b>

**Depreciation**

At 1 April 2014	0	934	6	12,173	164	13,277
Indexation	0	0	0	0	0	0
Revaluation	0	(1,159)	0	0	0	(1,159)
Disposals	0	0	0	(2,929)	0	(2,929)
Provided during the year	0	274	0	2,327	0	2,601
At 31 March 2015	<b>0</b>	<b>49</b>	<b>6</b>	<b>11,571</b>	<b>164</b>	<b>11,790</b>

**Carrying Amount**

At 31 March 2015	<b>3,150</b>	<b>6,733</b>	<b>0</b>	<b>6,006</b>	<b>0</b>	<b>15,889</b>
At 1 April 2014	<b>2,722</b>	<b>6,274</b>	<b>0</b>	<b>6,338</b>	<b>0</b>	<b>15,334</b>

**Asset financing**

Owned	3,150	6,733	0	6,006	0	15,889
<b>Carrying Amount</b> At 31 March 2015	<b>3,150</b>	<b>6,733</b>	<b>0</b>	<b>6,006</b>	<b>0</b>	<b>15,889</b>

**Asset financing**

Owned	2,722	6,274	0	6,338	0	15,334
<b>Carrying Amount</b> At 1 April 2014	<b>2,722</b>	<b>6,274</b>	<b>0</b>	<b>6,338</b>	<b>0</b>	<b>15,334</b>

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 6.1 - Intangible assets - year ended 31 March 2016**

	<b>Software Licenses £000</b>	<b>Information Technology £000</b>	<b>Total £000</b>
<b>Cost or Valuation</b>			
At 1 April 2015	1,417	3,900	5,317
Indexation	0	0	0
Additions	11	993	1,004
At 31 March 2016	<b>1,428</b>	<b>4,893</b>	<b>6,321</b>

<b>Amortisation</b>
At 1 April 2015
Indexation
Provided during the year
At 31 March 2016

	1,038	3,374	4,412
	0	0	0
	195	145	340
	<b>1,233</b>	<b>3,519</b>	<b>4,752</b>

<b>Carrying Amount</b>
At 31 March 2016
At 31 March 2015

	<b>195</b>	<b>1,374</b>	<b>1,569</b>
	<b>379</b>	<b>526</b>	<b>905</b>

<b>Asset financing</b>
Owned

	195	1,374	1,569
	<b>195</b>	<b>1,374</b>	<b>1,569</b>

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 (2015 - £nil).

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 6.2 - Intangible assets - year ended 31 March 2015**

	<b>Software Licenses £000</b>	<b>Information Technology £000</b>	<b>Total £000</b>
<b>Cost or Valuation</b>			
At 1 April 2014	1,343	3,734	5,077
Additions	74	165	239
Reclassifications	0	1	1
At 31 March 2015	<b>1,417</b>	<b>3,900</b>	<b>5,317</b>

**Amortisation**

At 1 April 2014	853	3,152	4,005
Provided during the year	185	222	407
At 31 March 2015	<b>1,038</b>	<b>3,374</b>	<b>4,412</b>

**Carrying Amount**

At 31 March 2015	<b>379</b>	<b>526</b>	<b>905</b>
At 1 April 2014	<b>490</b>	<b>582</b>	<b>1,072</b>

**Asset financing**

Owned	379	526	905
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**Carrying Amount**

At 31 March 2015	<b>379</b>	<b>526</b>	<b>905</b>
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**Asset financing**

Owned	490	582	1,072
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**Carrying Amount**

At 1 April 2014	<b>490</b>	<b>582</b>	<b>1,072</b>
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## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 7 - FINANCIAL INSTRUMENTS

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

During 2015/16 the HSCB introduced one type of financial instrument, the GP Infrastructure Loans Scheme. This scheme utilises Financial Transactions Capital (FTC) in the form of loans to GPs to enable them to undertake premises developments and improvements for health and social care purposes. The first two loans were issued in 2015/16 as shown in the note below.

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

	<b>2016</b>	<b>2015</b>
	<b>Assets</b>	<b>Assets</b>
	<b>£000</b>	<b>£000</b>
Balance at 1 April	0	0
Additions	498	0
Settlement	(13)	0
Impairments	(96)	0
Revaluations	0	0
<b>Balance at 31 March</b>	<b>389</b>	<b>0</b>

#### Analysis of expected timing of discounted flows

	<b>2016</b>	<b>2015</b>
	<b>Assets</b>	<b>Assets</b>
	<b>£000</b>	<b>£000</b>
Not later than one year	41	0
Later than one year and not later than five years	193	0
Later than five years	155	0
	<b>389</b>	<b>0</b>



## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 8 - IMPAIRMENTS

	<b>2016</b>	<b>2015</b>
	<b>Financial</b>	<b>Financial</b>
	<b>Assets</b>	<b>Assets</b>
	<b>£000</b>	<b>£000</b>
Total value of impairments for the period	96	0
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0
<b>Impairments charged / (credited) to Statement of Comprehensive Net Expenditure</b>	<b>96</b>	<b>0</b>

The HSCB had no other impairments in 2015/16 in relation to Property, Plant & Equipment or intangible assets.

#### NOTE 9 - ASSETS CLASSIFIED AS HELD FOR SALE

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

The HSCB did not hold any assets classified as held for sale in 2015/16 or 2014/15.

#### NOTE 10 - INVENTORIES

The HSCB did not hold any inventories as at 31 March 2016 or 31 March 2015.

#### NOTE 11 - CASH AND CASH EQUIVALENTS

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Balance at 1st April	2,315	3,402
Net change in cash and cash equivalents	7,780	(1,087)
<b>Balance at 31st March</b>	<b>10,095</b>	<b>2,315</b>

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
<b>The following balances at 31 March were held at</b>		
Commercial banks and cash in hand	10,095	2,315
<b>Balance at 31st March</b>	<b>10,095</b>	<b>2,315</b>

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS**

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
<b>Amounts falling due within one year</b>		
Trade receivables	5,338	5,589
VAT receivable	678	780
Other receivables - not relating to fixed assets	90	242
<b>Trade and other receivables</b>	<b>6,106</b>	<b>6,611</b>
Prepayments and accrued income	37	128
<b>Other current assets</b>	<b>37</b>	<b>128</b>
<b>Amounts falling due after more than one year</b>		
<b>Trade and other receivables</b>	<b>0</b>	<b>0</b>
Prepayments and accrued income		
<b>Other current assets falling due after more than one year</b>	<b>0</b>	<b>0</b>
<b>TOTAL TRADE AND OTHER RECEIVABLES</b>	<b>6,106</b>	<b>6,611</b>
<b>TOTAL OTHER CURRENT ASSETS</b>	<b>37</b>	<b>128</b>
<b>TOTAL INTANGIBLE CURRENT ASSETS</b>	<b>0</b>	<b>0</b>
<b>TOTAL RECEIVABLES AND OTHER CURRENT ASSETS</b>	<b>6,143</b>	<b>6,739</b>

The balances are net of a provision for bad debts of £nil (2015 £nil).

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 13 - TRADE PAYABLES AND OTHER CURRENT LIABILITIES**

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
<b>Amounts falling due within one year</b>		
Other taxation and social security	0	335
Trade capital payables - property, plant and equipment	340	323
Trade capital payables - intangibles	716	121
Trade revenue payables	51,034	50,907
Payroll payables	957	1,696
Clinical negligence payables	545	1,018
BSO payables	4,382	5,481
Other payables	14,953	2,114
Accruals and deferred income	90,106	88,942
<b>Trade and other payables</b>	<b>163,033</b>	<b>150,937</b>
<b>Total payables falling due within one year</b>	<b>163,033</b>	<b>150,937</b>
<b>Total non current other payables</b>	<b>0</b>	<b>0</b>
<b>TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES</b>	<b>163,033</b>	<b>150,937</b>

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### 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:

	<b>2016</b>	<b>2016</b>	<b>2015</b>	<b>2015</b>
	<b>Number</b>	<b>Value £000s</b>	<b>Number</b>	<b>Value £000s</b>
Total bills paid	20,846	115,897	22,024	118,439
Total bills paid within 30 day target or under agreed payment terms *	<u>18,823</u>	<u>106,402</u>	<u>18,624</u>	<u>103,636</u>
% of bills paid within 30 day target or under agreed payment terms	<u><b>90.3%</b></u>	<u><b>91.8%</b></u>	<u><b>84.6%</b></u>	<u><b>87.5%</b></u>
Total bills paid within 10 day target	<u>15,372</u>	<u>91,020</u>	<u>12,477</u>	<u>82,020</u>
% of bills paid within 10 day target	<u><b>73.7%</b></u>	<u><b>78.5%</b></u>	<u><b>56.7%</b></u>	<u><b>69.3%</b></u>

##### 14.2 The Late Payment of Commercial Debts Regulations 2002

The HSCB did not pay any compensation or interest for payments made late in 2015/16 (2014/15 £nil).

\* New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

A regional review of the BSO calculation, supported by legal advice has resulted in an adjustment to the prior year comparator figures.

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2016**

	<b>Pensions relating to other staff £000</b>	<b>Clinical negligence £000</b>	<b>Other £000</b>	<b>2016 £000</b>
Balance at 1 April 2015	15,710	17,546	10,350	43,606
Provided in year	359	17,000	342	17,701
(Provisions not required written back)	(2,405)	(405)	(171)	(2,981)
(Provisions utilised in the year)	(13,868)	(1,761)	(516)	(16,145)
Cost of borrowing (unwinding of discount)	204	(263)	120	61
At 31 March 2016	<b>0</b>	<b>32,117</b>	<b>10,125</b>	<b>42,242</b>

<b>Comprehensive Net Expenditure Account charges</b>	<b>2016 £000</b>	<b>2015 £000</b>
Arising during the year	17,701	11,851
Reversed unused	(2,981)	(2,361)
Cost of borrowing (unwinding of discount)	61	101
<b>Total charge within Operating expenses</b>	<b>14,781</b>	<b>9,591</b>

**Analysis of expected timing of discounted flows**

	<b>Pensions relating to other staff £000</b>	<b>Clinical negligence £000</b>	<b>Other £000</b>	<b>2016 £000</b>
Not later than one year	0	7,269	1,044	8,313
Later than one year and not later than five years	0	4,287	1,764	6,051
Later than five years	0	20,561	7,317	27,878
At 31 March 2016	<b>0</b>	<b>32,117</b>	<b>10,125</b>	<b>42,242</b>

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2015

	<b>Pensions relating to other staff £000s</b>	<b>Clinical negligence £000s</b>	<b>Other £000s</b>	<b>2015 £000s</b>
Balance at 1 April 2014	16,721	18,657	8,878	44,256
Provided in year	1,274	8,697	1,880	11,851
(Provisions not required written back)	(1,957)	(343)	(61)	(2,361)
(Provisions utilised in the year)	(629)	(9,111)	(501)	(10,241)
Cost of borrowing (unwinding of discount)	301	(354)	154	101
At 31 March 2015	<b>15,710</b>	<b>17,546</b>	<b>10,350</b>	<b>43,606</b>

Provisions have been made for 4 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement, and Injury Benefit. The provision for Early Retirement and 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.

#### Analysis of expected timing of discounted flows

	<b>Pensions relating to other staff £000s</b>	<b>Clinical negligence £000s</b>	<b>Other £000s</b>	<b>2015 £000s</b>
Not later than one year	629	5,742	936	7,307
Later than one year and not later than five years	2,600	4,257	1,742	8,599
Later than five years	12,481	7,547	7,672	27,700
At 31 March 2015	<b>15,710</b>	<b>17,546</b>	<b>10,350</b>	<b>43,606</b>

## **HEALTH and SOCIAL CARE BOARD**

### **NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

#### **NOTE 16 - CAPITAL COMMITMENTS**

The HSCB did not have any capital commitments as at 31 March 2016 or 31 March 2015.

#### **NOTE 17 - COMMITMENTS UNDER LEASES**

##### **17.1 Operating Leases**

The HSCB had no operating leases in 2015/16 or 2014/15.

##### **17.2 Finance Leases**

The HSCB had no finance leases in 2015/16 or 2014/15.

##### **17.3 Commitments under Lessor Agreements**

The HSCB had no lessor obligations in either 2015/16 or 2014/15.

#### **NOTE 18 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION**

The HSCB had no commitments under PFI or service concession arrangements in either 2015/16 or 2014/15.

#### **NOTE 19 - OTHER FINANCIAL COMMITMENTS**

The HSCB did not have any other financial commitments at either 31 March 2016 or 31 March 2015.

#### **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 2016, please refer to Note 7.

## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### NOTE 21 - CONTINGENT LIABILITIES

##### Clinical negligence

The HSCB has contingent liabilities of £183k.

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Total estimate of contingent clinical negligence liabilities	180	213
Amount recoverable through non cash RRL	(180)	(213)
	<u>0</u>	<u>0</u>
Net Contingent Liability	<u>0</u>	<u>0</u>

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:

	<b>2016</b>	<b>2015</b>
	<b>£000</b>	<b>£000</b>
Employers' liability	3	0
Amount recoverable through non cash RRL	(3)	0
Total	<u>0</u>	<u>0</u>

The HSCB did not have any unquantifiable contingent liabilities as at 31 March 2016 or 31 March 2015.

#### NOTE 22 - RELATED PARTY TRANSACTIONS

The HSCB is an arms length body of the Department of Health, Social Services and Public Safety 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 had various material transactions with the Business Services Organisation for which the DHSSPS is regarded as the parent.

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 parties assets in 2015/16 or 2014/15.



## HEALTH and SOCIAL CARE BOARD

### NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016

#### 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:

	<b>2016</b>	<b>2015</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
DHSSPS (excludes non cash)	4,405,893	4,239,060
Non cash RRL (from DHSSPS)	17,767	12,709
Ajustment for CRL grants received for Brightstart	426	105
<b>Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure</b>	<b>4,424,086</b>	<b>4,251,874</b>

##### 24.2 Capital Resource Limit

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

	<b>2016</b>	<b>2015</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Gross capital expenditure by HSCB	2,527	2,346
FTC issued to third parties	499	0
(FTC received from third parties)	(13)	0
Net capital expenditure	3,013	2,346
Capital Resource Limit	3,019	2,354
<b>Overspend/(Underspend) against CRL</b>	<b>(6)</b>	<b>(8)</b>

##### 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.

	<b>2015-16</b>	<b>2014-15</b>
	<b>£000</b>	<b>£000</b>
Net Expenditure	(4,423,489)	(4,244,846)
RRL	4,424,086	4,251,874
Surplus / (Deficit) against RRL	597	7,028
Break Even cumulative position(opening)	7,788	760
<b>Break Even cumulative position (closing)</b>	<b>8,385</b>	<b>7,788</b>

##### Materiality Test:

	<b>2015-16</b>	<b>2014-15</b>
	<b>%</b>	<b>%</b>
Break Even in year position as % of RRL	0.01%	0.17%
Break Even cumulative position as % of RRL	0.19%	0.18%

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

**HEALTH and SOCIAL CARE BOARD**

**NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2016**

**NOTE 25 - POST BALANCE SHEET EVENTS**

There are no post balance sheet events having a material effect on the accounts.

**NOTE 26 - DATE AUTHORISED FOR ISSUE**

The Accounting Officer authorised these financial statements for issue on 30 June 2016