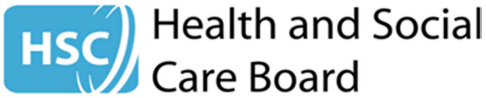

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2017

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ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2017

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.

On 23 June 2017

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This publication is also available for download from our website at:
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For an alternative format, please contact:
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HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017

PERFORMANCE REPORT

Welcome to the Health and Social Care Board's Annual Report covering the financial year 2016/17.

About the Health and Social Care Board

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

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

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

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

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

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

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

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

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

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

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

Objectives for 2016/17

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

The five themes are:

> Theme 1: Ensure high quality, safe, accessible and integrated health and social care services, and performance manage delivery to achieve quality outcomes;
>
> Theme 2: Improve the health and social wellbeing of the population of NI with a focus on prevention and health inequalities, promoting equality, human rights and diversity in all the HSCB's functions;
>
> Theme 3: Provide value for money through the effective use of resources ensuring robust financial management;
>
> Theme 4: Effectively engage with key stakeholders in an open and transparent manner, particularly service users and carers, benefiting from their personal experiences; and
>
> Theme 5: Maintain and develop effective internal systems and processes and maximise the potential of our staff by ensuring that they are skilled, motivated and valued.

Overview from Chief Executive and Chair of Board

2016/17 was a year which signalled major change for the Health and Social Care Board and the wider system in terms of restructuring and reform.

Minister Hamilton announced in November 2015, and this was confirmed by Minister O'Neill in 2016, that the HSCB would close.

We also had a major report from Professor Bengoa and the Expert Panel 'Systems Not Structures' and a Ministerial vision 'Health and Wellbeing 2026 Delivering Together' which has set the direction for health and social care reform for the next ten years. These reforms are vital in addressing the ever increasing demands on the system which are putting significant pressures on the whole system and out stripping the budgets available.

Therefore, in the ever-changing world of health and social care, it makes sense that the structures, and enablers, also change to ensure we put patient and service users at the heart of what we do, that we can focus on prevention, on supporting communities, reducing health inequalities and on delivering the highest standard of care.

The work to ensure an effective and smooth transition of the HSCB's functions will continue in 2017/18 and into 2018/19.

It will be important during this change process to ensure that our staff are appropriately supported to make the transition into the new structures and to continue taking forward the important work set out in the Minister's vision.

The Voluntary Exit Scheme which operated during 2015/16 and 2016/17 has had an impact on business continuity, and to address this, the HSCB has continued to prioritise resources towards areas of greatest impact and to be innovative in the way we deliver improvements to support health and wellbeing.

Some of the highlights of the year include the opening of the North-West Cancer Centre in November 2016 which will provide comprehensive oncology and treatment services, including radiotherapy to patients in the West, North Coast and Donegal.

We continue to support projects which help reduce unnecessary admissions to hospitals. For example, the 'Acute Care at Home' service in the Belfast and Southern Trust areas resulted in 1,787 frail elderly people receiving enhanced, or acute care at home services avoiding more than 8,935 days in hospital. Our priority is to ensure that patient centred initiatives like this continue right across our health and social care system.

The Department of Health approved a £17m funding initiative to enable practice-based pharmacy support for GP practices across Northern Ireland. Pharmacists in GP practices will allow GPs more time to spend with patients and improve patient outcomes.

It will also improve the safety of prescribing, reduce the level of errors and waste through managing prescribing systems, medical reviews and reconciliation. It is anticipated that there will be 351 pharmacists in post by June 2017.

The Northern Ireland Electronic Care Record (NIECR) was recognised by a UK-wide award at the 'Building Better Healthcare' Awards in November 2016. The quality and scope of information on the NIECR has been growing since its launch in June 2013 and it is reducing the need for tests and repeat appointments, improving the quality and safety of care for patients. During 2016/17, the number of care professionals using the NIECR reached over 18,500, supporting safer, faster care.

This year, we launched a Diabetes Network for Northern Ireland to design and deliver better diabetes services. Over 88,000 people currently live with diabetes and this rises annually by more than 3,000 with an estimated 2,000 undiagnosed yet.

Meanwhile, over 3,600 individuals currently benefit from Self Directed Support (SDS), an initiative which represents a transformation in the way social care is delivered. SDS has made a real difference to the lives of these individuals, providing them with greater opportunities, choice and flexibility to live fulfilling independent lives.

The Controlled Drugs Reconciliation Project (CDRP), developed by our pharmacy team won a Safety Forum award and is currently being used as a model for developing similar processes in other parts of the UK.

The constrained financial environment has, however, presented significant challenges to improving or maintaining performance across a number of service areas. Elective waiting times continue to rise in the face of increasing demand and uncertainty over budgets, and the GP shortage is affecting small rural practices in particular.

The following report aims to highlight the breadth of our work across primary, community and acute care, and also acknowledges the challenges and opportunities that lie ahead.

Overview of Organisational Performance

Corporate Objectives

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

Financial Management

In 2016/17, the Health and Social Care Board received funding of £4.6bn from the Department of Health to commission health and social care services for the population of Northern Ireland.

With careful financial management at the end of 2016/17 the HSC achieved a breakeven position of £143k surplus against its Revenue Resource Limit (RRL).

In addition to this, the HSCB also received £53m income from other sources which amounted to £26m for the delivery of services such as Early Years Children's Services and £27m of Family Health Service receipts for dental and ophthalmic services.

Non-recurrent funding of £72m was secured through the June 2016 Monitoring Round, of which £67m was used to address a range of front line pressures across health and social care and the remaining £5m for capital spend.

The £67m revenue funding was used for unscheduled care, improving patient flow through our hospitals, children's services, mental health and learning disability services and additional social care provision to help meet increasing demand.

Developing Services

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

Key Issues and Risks

During 2016/17, we have continued to drive forward improved outcomes for patients and service users in line with Departmental direction. We remain committed to creating a modern 'patient centred' system that is able to respond to increasing demand whilst ensuring the best and most effective use of resources for the population. A number of risks have been highlighted below. See Section 10B of the Governance Statement for full details of issues and risks.

1) Financial Position

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

1.1) Waiting times

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

1.2) General Practice (GP)

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

Northern Ireland has the lowest number of GPs per population in the UK 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. Although an investment plan has now been secured for additional GP training places and a GP retainer scheme, in the short term there remains a considerable risk to the ongoing continuity of general medical services provision to patients, particularly in smaller practices in isolated locations and out of hours services.

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

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

2) Business continuity

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

Performance Analysis

The performance analysis has been carried out under the five corporate objectives which are in line with the 2016/17 Corporate Plan and the 2016/17 Commissioning Plan.

Theme 1 - Providing high quality, safe and accessible care

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

1.1) Enhancing Unscheduled Care

Across Northern Ireland, emergency services are under pressure. Rising demand from an ageing population and pressure on general practice all contribute to increasing attendances at emergency departments and ambulance service call outs. Just over 770,000 patients attended Emergency Departments (ED) in 2016/17, an increase of 4.5% on the level of attendances in the previous year.

During 2016/17, performance against the 4-hour and 12-hour ED standards remained below the level required (the standard being that 95% of patients attending an ED are either treated and discharged home, or admitted, within four hours of their arrival; and no patient should wait longer than 12 hours).

Improving unscheduled care performance remains a priority for the HSC. During 2016/17 the HSCB and PHA, working through the regional unscheduled care structures, continued to work with HSC Trusts to support the more effective delivery of unscheduled care services across Northern Ireland.

Considerable efforts were made across the HSC to plan for the winter period with preparatory work commencing much earlier than in previous years. This was supported by a high profile public information campaign, 'Stay Well This Winter', with a particular focus on the Christmas and New Year period.

Despite significant efforts across the region to ensure effective arrangements were in place to manage winter pressures demand, all HSC Trusts experienced increased pressures over the Christmas and New Year period with an average increase of 8% in attendances across the nine larger EDs and a 5% increase in ambulance arrivals compared to the same period in 2015/16.

In 2016 /17, the HSCB Senior Nurse Review Team carried out delayed discharge audits to identify the main reasons for delays in patient pathways. The findings from this work led to HSC Trusts participating in a 'Champion Wards' initiative, focusing effort on a small number

of wards to support local interventions, improve processes and working practices in relation to inpatient stays. We expect to see improved patient outcomes and a better working environment for staff as this continues to be rolled out and best practice shared.

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

1.2) Elective Care

The increase in elective waiting times over the last year is not unexpected and is primarily as a result of patient demand continuing to exceed funded health service capacity in a number of specialties and the impact of the wider financial position.

In order to minimise the increase in waiting times, during 2016/17, the HSCB allocated the limited amount of non-recurrent funding that was available for elective care to HSC Trusts to undertake additional outpatient and inpatient/day case activity, primarily in-house, in specialties where there is a gap between funded capacity and patient demand. Trusts used the funding to target those areas where the additional elective activity would have the greatest impact in addressing patient safety issues and long waiting times.

The HSCB also allocated significant non-recurrent funding to HSC Trusts to undertake additional diagnostics activity during 2016/17 as diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place.

In order to maximise the delivery of funded core elective capacity, the HSCB required HSC Trusts to produce improvement plans for a number of specialties where there had been a continued under delivery of commissioned volumes of core capacity.

The HSCB monitored Trusts' performance against these plans on an ongoing basis to ensure that progress was being made to deliver the agreed outcomes or, where this was not the case, to agree what remedial actions the Trusts planned to take. In the main, Trusts' plans delivered the agreed outcomes, however, in a small number of areas, the forecast position was not delivered and the HSCB have raised this with the relevant Trusts to understand the reasons and agree what further actions can be taken.

In relation to the longer term approach, the Minister for Health launched a 10-year vision to transform the current health and social care system (Health and Wellbeing 2026: Delivering Together) in October 2016. As part of that vision, the Minister also published an Elective Care Plan in February 2017 to address waiting times. The Plan has six commitments which encompass a number of actions designed to reform elective care services to meet current and future demand. A key commitment is to reduce the backlog of patients waiting for elective

care, subject to the availability of funding, while continuing the longer term process to transform secondary, primary and community care services.

1.3) Cancer Services

The main challenges relate to the 14-day breast cancer and 62-day cancer waiting time standards.

In relation to the 14-day breast cancer standard, the regional position is largely as a result of performance in the Southern Trust due to a shortage of radiologists to support the breast assessment clinics. Given the seriousness of this issue, the HSCB facilitated a collaborative approach across the HSC whereby Southern Trust patients were transferred to other Trusts for assessment. This approach is continuing, subject to capacity being available in other Trusts, pending the implementation of a fourth breast clinic in the Southern Trust on a sustainable basis.

In response to the ongoing challenges with sustaining 14-day breast performance in October 2016, the HSCB and PHA organised a regional workshop to discuss the future configuration of the breast assessment service, to include breast screening. There was a clear consensus among workshop attendees that the current configuration of provision across five sites was not sustainable and that consideration needed to be given to providing the service across fewer sites. The HSCB and PHA have established a project team with representation from all the relevant disciplines, Trust management and service users to look at the future configuration of the service. The project team will report to the Transformation Implementation Group through the Chief Medical Officer's workstream on service reconfiguration. It is anticipated that the recommendations arising from this work will be subject to public consultation during 2017/18.

Given the lack of progress towards achievement of the 62-day cancer access standard regionally, the HSCB introduced Director-level cancer performance meetings with each Trust. The focus of these meetings is on the longest waits and to seek assurances from Trusts that the longest waiting patients are treated as progress is made towards improving performance to the required standard.

In particular, the regional position was impacted by a marked deterioration in performance in the South Eastern Trust during 2016/17, primarily as a result of delays in providing flexible cystoscopies for patients on the urological cancer pathway. To address this, the HSCB allocated non-recurrent funding to the Trust to undertake additional flexible cystoscopies in quarter four of 2016/17. This additional activity is expected to bring about a significant improvement in the Trust's 62-day urology performance in 2017/18.

The Cancer Forum, established in 2015/16 has continued to meet during 2016/17 and focuses on addressing the longer term strategic issues to improve cancer pathways.

In addition, over the last year, staff across the HSC have worked with suppliers to build an electronic record and prescribing system to support cancer care. This new system will be

implemented during 2017/18 and will support improved prescribing and medicine administration to further improve the safety and quality of cancer care.

1.4) Reducing Hospital Admission and Providing Person Centred Care

One of the major priorities for the HSCB and its partners, in line with 'Delivering Together' is to provide care closer to people's homes, wrapped around the needs of the patient and service user, and avoiding the need for a hospital admission.

Examples of this include:

- **Acute care at home**

Hospital at home services, which are now available across a number of Trust areas, provide people aged 75 years and over with expert medical and social care in their own home. For example, in the Southern area, in 2016/17, the service provided care for 705 older people in their homes, saving 3,525 bed days in hospitals.

- **Reablement Services**

The reablement service is a planned short term service lasting six weeks or less, providing support to a person in their own home. It is an occupational therapy led service and assessments are carried out to identify the individual needs of the user. Visits by trained support workers take place throughout the day to promote independence and enable people to regain their confidence, ability, and necessary skills to remain independent, after having experienced a health or social care crisis, such as an illness or injury.

For the period April to November 2016, 3,856 people were offered reablement services, an increase of 14% over the same period the year before.

- **Social Care Response Services**

The Rapid Access Personal Support (RAPS) service is a domiciliary, resettlement at home service, for patients who have no support to leave a hospital ward or ED and who require practical assistance with social care arrangements to settle them back in their own home. The RAPS service is currently being piloted across the Northern, South Eastern and Belfast HSC Trusts.

- **Intermediate Care Services (implemented across all HSC Trusts)**

To maximise a patient's potential for recovery following a health crisis such as fracture, stroke or general ill-health/frailty, the HSCB has worked with the five HSC Trusts to embed community multi-professional rehabilitation teams to rehabilitate patients residing in step-down bed facilities or in their own homes.

- **Nursing Home in Reach (Northern area)**

The focus of this initiative is on very frail, older people, living in nursing homes, who commonly experience a high level of attendance at Emergency Departments.

Under this initiative, staff in nursing homes in the Antrim/Ballymena area receive specialist education, training and development programmes to enable them to provide more care for their residents in the home.

This initiative has led to a 48% reduction in the number of calls to the hospital diversion team relating to feeding tube issues and a 25% reduction in the number of visits from Marie Curie out of hours staff.

By enhancing the skills of nursing home staff, the project has also reduced by one third, the numbers of older people attending Emergency Departments from nursing homes, avoiding 1,519 hospital bed days.

1.5) Local Commissioning Groups

The HSCB's commissioning processes are underpinned by the five Local Commissioning Groups (LCGs). LCGs are responsible for ensuring that the health and social care needs of local populations across Northern Ireland are addressed. A number of examples of their work during 2016/17 are detailed below:

Belfast LCG

In 2016/17, the Belfast LCG and ICPs agreed a new hub initiative to benefit 4,000 of the most vulnerable people in the city. These include those at risk of or already living with conditions such as heart disease, diabetes, respiratory conditions, cancer, dementia and stroke, as well as older people who are isolated, lonely or require practical support. Wellbeing coordinators will support each individual to manage their condition, drawing on the resources of local community and voluntary groups. A key feature will be a programme of health improvement led by the Belfast HSC Trust, the Public Health Agency and Belfast City Council who will work closely with the Hub to target those who are most at risk of developing long term conditions.

Northern LCG

In the last year, the Northern LCG has progressed the 'Living Well Moyle' initiative in Ballycastle and surrounding area. Further detail about this initiative is available under Section 2.2 (Integrated Care Partnerships).

South Eastern LCG

During 2016/17, the South Eastern LCG provided funding for the South Eastern Trust's Enhanced Care at Home service, which provides nursing care and medical support to people at home, reducing unscheduled admissions. An estimated 130 admissions were avoided, saving 1,300 hospital bed days over six months. The service, already available in Ards and North Down, will be roll out to the Down and Lisburn areas.

Southern LCG

To address increasing demand for mental health services, the Southern LCG commissioned the WelImind Hub, launched by the Minister for Health, in October 2016. The Hub offers support options for people with common mental health conditions such as anxiety, stress or

low mood at an early stage, to reduce the need for referrals to secondary health and social care services.

The Southern LCG also commissioned a nurse-led service for new entrants to Northern Ireland, offering support to new migrants, asylum seekers and refugees, not already registered with a GP and a holistic health assessment and screening for both adults and children.

Western LCG

In 2016/17, the Western LCG's funding for several projects resulted in care provided closer to or at home for a number of patients. The Acute Care at Home service provided an alternative to acute hospital care for 237 patients, and the ground-breaking Community Respiratory Team avoided 1,157 acute admissions and saved 6,938 hospital bed days for respiratory patients in the year to March 2017, i.e. 578 bed days per month on average.

Primary care talking therapies, already successfully in place in Derry, Limavady and Strabane, is due to be rolled out in the Fermanagh and Omagh area. The service received 3,040 referrals from April 2016 – March 2017.

1.6) Primary Care

Despite challenging issues with GP recruitment and retention, the HSCB has managed to secure additional investment in GP training. We provided evidence in support of the largest Ministerial investment in GP training for more than ten years, resulting in an investment of £1.2m per year to fund an additional 20 GP training places, in 2016/17.

To further support GP practices, we have recruited 110 (86 whole time equivalent) pharmacists by March 2017 to service all GP practices. These practice-based pharmacists will help improve capacity in GP practices as well as improve safety, quality and the cost effectiveness of prescribing. We expect to see the real impact of this work in 2017/18.

To enhance access to GP services, the HSCB invested in a GP online service for patients to make appointments or order prescriptions online in the majority of GP practices and have piloted the 'AskMyGP' system for online and telephone triage.

We continue to ensure that all residents in Northern Ireland have access to a GP and we worked this year to support GP practices in Bannview, Glenarm and parts of Fermanagh with recruitment challenges and encouraged more partnership working with other neighbouring practices.

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

Health and Care Centres (Hubs) in Newry and Lisburn are currently in procurement (at preferred bidder stage). New developments in Banbridge and Ballymena are now operational and improving accessibility to services for local populations.

The programme has also delivered improvements to smaller GP (spoke) facilities through both conventional investment and innovative funding streams.

We continue to work with primary care providers and the public to reduce medicine waste and to ensure more cost effective prescribing through the use of generic drugs. Although we did not meet the 2016/17 efficiency target, this is in part due to the success of the programme over the past five years and the efficiencies generated to date. Further detail is provided within the Governance Statement.

1.7) Social Care

Instability in the Residential Care and Domiciliary Care Market (Independent Sector)
The majority of care in both the residential and domiciliary care sectors is now provided by the independent sector. The non-statutory market share of domiciliary care services varies by Trust but is typically in the region of 50% to 70%. This creates a possible risk to users and carers in the event of provider failure due to business related issues. Further detail is provided in the Governance Statement.

The HSCB has allocated additional funding for a 5% uplift to the hourly rate for domiciliary care to address the implications of the introduction of the National Living Wage (April 2016). Further detail is provided within the Governance Statement.

Children's Services (Unallocated Cases)
Unallocated cases are defined as child protection, family support and disability services cases that are not allocated to a social worker within the regionally agreed time frames. The issue of unallocated cases has been a consistent challenge and although additional funding was provided in 2012 to reduce this, it has not been sustained over time.

A project approach has been developed to understand the relationship between demand, complexity, funding and to test the robustness of the threshold criteria for unallocated cases.

A project report will set out a number of recommendations and service improvement areas to reform and modernise the approach.

Child and Adolescent Mental Health Service (CAMHS)
At the end of March 2017, there were 1,056 children and young people waiting for a mental health assessment. 17% were waiting longer than the nine week target, with the majority in the Belfast and Western Trusts. This is due to a temporary loss in service capacity. It is anticipated that, subject to demand remaining stable, the number of children and young people waiting greater than nine weeks should reduce over the course of the next year.

Work is continuing on the development of an Integrated Care Pathway for CAMHS involving all HSC Trusts with representation from both parents and children. This work is expected to conclude in 2017/18. In response to the recommendations of the Independent Review of Acute CAMHS, a Managed Care for High Intensity Network has been established. This

brings together Inpatient CAMHS, Crisis Resolution and Home Treatment, Forensic CAMHS and Secure Care services into a single system of care. A bid has been submitted to the Department of Health for funding to appoint a Clinical Director and an Operations Manager which are necessary for the support network.

A review of autism services around remodelling referral, assessment, diagnostics and intervention services is nearing completion. As part of this process, a sense-maker survey was used to capture service user experiences. The CAMHS data set has also been revised and agreed by all HSC Trusts. This was published in 2016/17 capturing demand, activity, outcome and experience across all services. The overall themes and messages from the ongoing work will be used to inform the Regional draft, 'Framework for Children and Young People's Developmental and Emotional Wellbeing Services (2016)'.

Adult Mental Health

At the end of March 2017, there were 5,243 people waiting for a mental health assessment. 21% are waiting longer than the target nine weeks, with the majority in the Belfast and Southern Trusts, as a result of rising demand.

It is unlikely that without additional investment or a reduction in demand that the position will improve. Work is underway to improve the experience of people who require crisis intervention and high intensity support through the development of a new acute mental health care pathway.

The recent Sense Maker survey 'Your Experience Matters' demonstrated that there has been significant improvement in the experience of people using mental health services. Significant progress has also been made in establishing 'Recovery Colleges' which employ over 200 people with mental health experience in peer support, peer education and peer advocacy roles.

HSC Trusts have continued to develop primary care 'Talking Therapy Hubs' and to implement the regional mental health 'You in Mind' care pathway. These Hubs have helped increased the capacity for the care of people with common mental health problems. Since the Hubs were developed, over 7,000 people have benefited and subject to additional funding, it is planned to further develop the role and function of these Hubs.

Psychological Therapies

At the end of March 2017, there were 3,705 people waiting for a psychological assessment, 35% of which were waiting longer than 13 weeks, and the majority waiting in Adult Mental Health and Adult Health Psychology services.

However, without additional investment, it is unlikely that the standard of 13 weeks will be achieved in 2017. In recognition of the gap in funding, a five year investment plan of £18million has been proposed as part of the mental health reform.

An additional 50 staff are being trained in a combination of cognitive behavioural therapy, psychotherapy and family therapy, in response to NICE guidance and the need to develop the psychological therapy capacity of the existing work force.

A further 14 staff are being trained in Specialist Trauma Care in response to the ministerial announcement to establish a world class mental health trauma network. An additional 15 staff and people with mental health experience are being trained in Advanced Mental Health and Wellbeing Coaching in partnership with Mind-Wise. The purpose of this training is to improve care outcomes and to support timely recovery.

Dementia Services

In 2016/17, the Delivering Social Change (DSC) Dementia Initiative promoted public awareness of the condition by running a multi-media public information campaign. To support this awareness, the DSC Dementia programme will train 300 Dementia Champions from across all sectors of HSC by June 2017. The training will help HSC staff respond in more effective ways to the needs of people with dementia and their families. The first cohort of 59 students graduated on 1st February 2017. To improve support for people with dementia and their carers, the HSCB recruited 10 Dementia Navigators during 2015-16 (two per Trust). Navigators are qualified nurses or social workers who provide information, support and sign-posting services to people with dementia and their carers. They have worked across disciplines and departments to ensure better access and effective interventions. These posts will be evaluated in the next 15 months to secure recurrent funding after the Dementia programme concludes in March 2018.

Customised training programmes for informal carers of those living with dementia are being provided across all five Trust areas. The target is for 420 carers per Trust to receive training (during 2016/17) and a further 300 per Trust before the end of December 2017. We are also evaluating five pilot projects for short breaks support for carers which were implemented this year.

Building on this partnership, during 2016, a further funding package of approximately £8m as part of the Delivering Social Change programme was secured, funded jointly by 'Atlantic Philanthropies', the Executive Office of the Assembly and the Department of Health. This investment programme will support the delivery of new services in 2017/18 that will include a 'patient portal' for those affected by dementia, and a range of other eHealth support to those affected by dementia.

Self Directed Support

The Self Directed Support (SDS) initiative represents a key change in how social care is delivered and reflects the shifting expectations of people today. It gives service users and carers greater control, choice and flexibility.

The process of bedding in SDS and establishing operational focus across the five HSC Trusts is well underway, with many key tasks identified, scheduled and accomplished.

HSCB currently have over 3,600 individuals benefiting from Self Directed Support, across the region. The plan is, by March 2019, that anyone eligible will be assessed under the Self-Directed Support approach.

1.8) Participation in National Pandemic Influenza Exercise (Exercise Cygnus)

During October 2016, the HSCB led on the co-ordination and participation in Exercise Cygnus which was designed to test health and social care readiness for responding to an influenza pandemic across the UK. The exercise focused on responses during the early phases of a moderate to severe pandemic, as well as the wider government response, including Ministerial decision making processes, the co-ordination of messaging to the public, strategic decision making processes and communication between stakeholders.

The exercise was held over three days in October 2016, and enabled HSC organisations to consider and test their business continuity arrangements and priorities, while learning and improving their strategic responses.

Theme 2 - Improving Health and Reducing Inequalities

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

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

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

- A growing ageing population with escalating health needs. Between 2016 and 2024, the number of people aged 65+ is estimated to increase by 62,500 to 362,000 – a rise of 21%. The number of older people will represent 19% of the total population compared with 15.5% currently;
- Poor health compared to the rest of the UK. A major risk to health and wellbeing in Northern Ireland comes from lifestyle factors such as obesity, smoking and alcohol abuse;
- Excess deaths, particularly from heart disease, cancer and respiratory problems. We have increasing numbers of people living with long term conditions or multiple conditions such as COPD, diabetes, stroke, asthma and hypertension;
- An over-reliance on hospital care; and
- Health inequalities across the province.

Despite these challenges, in 2016/17 the HSCB worked with other agencies across health and social care to deliver some innovative and life changing work to improve the health and wellbeing of the population, which is highlighted within the section below.

2.1) Opening of the North-West Cancer Centre

The North-West Cancer Centre opened in November 2016 to provide comprehensive oncology and treatment services, including radiotherapy to patients in the West, North Coast and Donegal.

This service will increase capacity in Northern Ireland for radiotherapy services and cater for over half a million people living on both sides of the border. It will make a real difference to people being treated for cancer and their families, who now have cancer care and treatment closer to home.

2.2) Integrated Care Partnerships

Integrated Care Partnerships (ICPs) are collaborative networks of care providers, bringing together healthcare professionals (including doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and community sectors; local council representatives; and service users and carers; to design and coordinate local health and social care services.

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

The ICP-led Enhanced Foot Care Pathway (Northern Trust area) is one such example which has reduced the risk of amputation, the number of amputations, and emergency admissions for diabetes related foot conditions. The project reduced the number of minor amputations carried out on patients in the Causeway and Mid Ulster ICP areas by 90%, with 5% of patients treated by hospital diversion teams, saving 344 hospital bed days.

The team, including a specialist podiatrist, diabetes consultant and a diabetes nurse specialist, provide a more integrated foot care service, supporting patients to better manage their condition and their cardiovascular risk. The team also works effectively with vascular consultants across Northern Ireland.

2.3) Living Well Moyle

Living Well Moyle is a new approach to supporting people with chronic conditions to improve their health and wellbeing by reconnecting with social networks and the local community in the rural areas around Ballycastle.

It refocuses the system on what is most important to the patient by cutting through the complexity of the system to improve people's experience of care.

Launched in 2016, Living Well Moyle has improved resilience amongst older people with multiple long-term conditions by providing low-level support for daily living to improve wellbeing.

An evaluation of the initiative shows substantial improvement in a patient's own sense of health and wellbeing and more cohesive and productive working between local HSC teams. This has in turn led to a significant reduction in unscheduled care attendances and admissions and reduced reliance on other health and social care services. Living Well Moyle was taken forward under the banner of the Dalriada Pathfinder Partnership led by the Northern LCG and included NHSCT, PHA, local community representatives, Age NI, Causeway Coast and Glens Council and ICP.

2.4) NI Stroke Network

The NI Stroke Network, which is overseen and coordinated by the HSCB and the PHA, brings together a collaborative network of professionals, patients and third sector partners to drive quality improvement in the delivery of stroke services across Northern Ireland.

In 2016/17, the network improved stroke survival rates by increasing the numbers of patients admitted to a stroke ward as their first ward of admission, from 50% in 2013/14 to 63% in 2016/17.

Following an audit of 150 mini stroke cases, the network recommended eight service improvements to help prevent stroke. These recommendations are currently with the five HSC Trusts to progress.

80 patients across Northern Ireland benefited from a new innovative procedure, Mechanical Thrombectomy to remove clots at the Royal Victoria Hospital after the network developed a regional referral and patient transfer protocol.

The Stroke Network will play a leading role in shaping the modernisation and reform of stroke services in line with the Minister's vision "Health and Wellbeing 2026: Delivering Together". Whilst there has been a 50% reduction in death rates from strokes in the last 20 years, there are clear opportunities to further enhance services.

2.5) Launch of the 'Palliative Care in Partnership' Programme

In 2016/17, the new Palliative Care in Partnership Programme was launched to improve the quality of care for the 1% to 2% of individuals who are at the end of life. This is a regionally managed programme with a strong local approach partnering local palliative care providers, patients and carers.

2.6) Primary Care

The majority of the public's first interaction with the health service is through primary care providers such as GPs, dentists, pharmacists or optometrists and the HSCB is responsible for commissioning and managing these services.

As GPs are the main contact for patients living with long term health conditions, in 2016/17, we supported GPs to develop over 23,000 individual medical care-plan reviews. These reviews improve care and avoid unplanned hospital admissions for patients with long term conditions and those in residential and nursing homes.

In Northern Ireland, 64.1% of the population is registered with a dentist, representing the highest ever levels of access to dental services. We launched the 'Happy Smiles' programme this year to maintain and improve child oral health and to prevent dental decay in young children.

The HSCB also successfully delivered more than 400,000 HSC funded eye examinations through contracting arrangements with over 270 ophthalmic practices in 2016/17.

2.7) Social Care

A key priority for the Social Care Directorate was the safeguarding of both children and adults. The HSCB are continuing to address the recommendations and learning from the 2014 DoH initiated Inquiry into Child Sexual Exploitation and the Safeguarding Board NI's Thematic Review of Operation Owl.

This year, the HSCB published new regional procedures for dealing with adults at risk and in need of protection and issued a new protocol for joint investigation of adult safeguarding cases. Working with partner organisations, the HSCB aim to raise awareness of the abuse, exploitation or neglect of adults at risk and to prevent and reduce the incidence of such abuse.

As the numbers of children in care continue to increase the HSCB have provided additional financial support this year to enhance Looked After Children Therapeutic Services. The HSCB are collaborating with the HSC Trusts, the Department of Education and the Education Authority on a three year Early Intervention Transformation Programme to improve educational outcomes for looked after children in primary years.

Building on the 2015/16 initiative, the HSCB also secured additional funding to promote inclusion and integration for looked after children in sports, leisure and arts activities in collaboration with the Department for Communities, Department of Health and various voluntary sector agencies.

The recruitment of stranger foster carers remains a challenging area of work across all HSC Trusts but the number of kinship placements continues to increase.

In collaboration with the Northern Ireland Housing Executive (NIHE) and the Supporting People Programme, the HSCB have worked with the HSC Trusts to deliver on a plan for the development of accommodation and support services for young people leaving care and for the young homeless. The HSCB secured additional funding during 2016/17 to support the 'Going the Extra Mile' (Gem) Scheme which offers continued support and accommodation for young people as they leave foster care.

2.8) eHealth and Care

During the year to March 2017, further progress has been made in extending the use of the NI Electronic Care Record (NIECR). This removes reliance on paper to manage referrals in hospital and to book appointments. It complements work done to support GPs to generate electronic referrals to hospital consultants. Evidence from implementations shows that, taken together, these developments can reduce delays between referrals and booking by several days, as well as eliminating the potential for error caused by paper-based transactions.

2.9) Community Planning

Throughout the year, the HSCB has continued its support for community planning, working in partnership with the wider health and social care family, local Councils and other statutory partners to help design Community Plans. The plans will provide a shared, long term vision to improving social, health, education, economic and environmental wellbeing and will help to reduce duplication of services and create new and innovative ways of working.

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

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

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

3.1) Financial Planning

The HSCB worked closely with DoH and Trusts to prepare a Financial Plan for 2016/17, taking into account the significant budgetary constraints and varied and mounting pressures across the HSC sector. This plan was supported by the development of Trust Delivery Plans (TDPs) which were scrutinised by the HSCB and DoH. All but one was supported by HSCB and subsequently approved by the Minister.

Looking forward into 2017/18, the current financial context significantly limits the additional resources available for health and social care developments and requires HSC Trusts to deliver very challenging financial savings targets. There continues to be a risk that this will impact on the quality and safety of health and social care services which HSCB along with the sector continue to try to mitigate. In addition, the Political uncertainties and the resultant impact on budgetary uncertainty adds more pressure to the HSC sector.

3.2) HSC Financial Stability

The HSCB along with the DoH has operational responsibility to ensure the overall financial stability of the Health and Social Care system within Northern Ireland including the Trusts, HSCB and the PHA. The significant and on-going financial constraints required rigorous

planning, monitoring, management and decision making with respect to the budget by the HSCB and DoH during 2016/17.

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

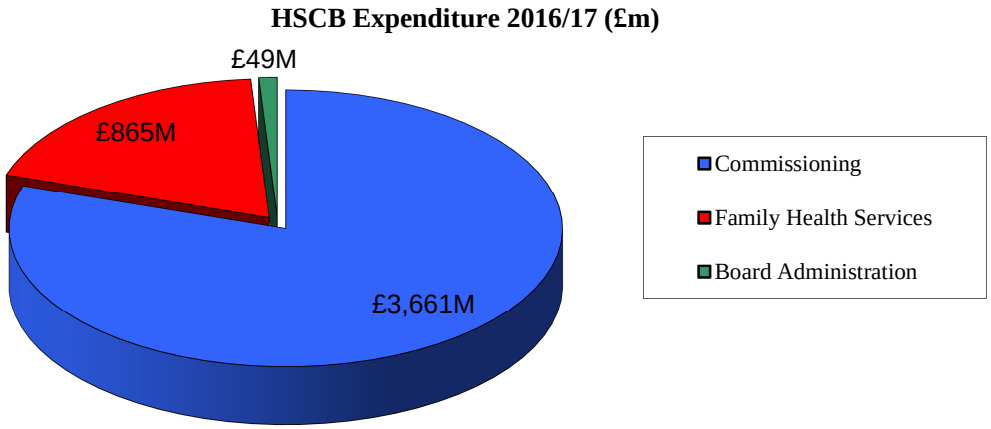
By this careful management at the end of 2016/17 the wider HSC shows a breakeven position.

3.3) HSCB Breakeven Duty

During 2016/17, the HSCB received a budget of £2.6m capital resource and £4,575m revenue resource from the DoH, along with income from other sources of £53.4m, of which the HSCB has a statutory duty to breakeven within +/-0.25% of these resources. The financial statements presented in this Annual Report and Accounts highlight a small surplus of £143k. This was achieved by significant effort on the part of the Finance Directorate and all budget holders managing the wide range of pressures and demands and delivery of significant efficiencies in both the FHS and Management and Administration budgets.

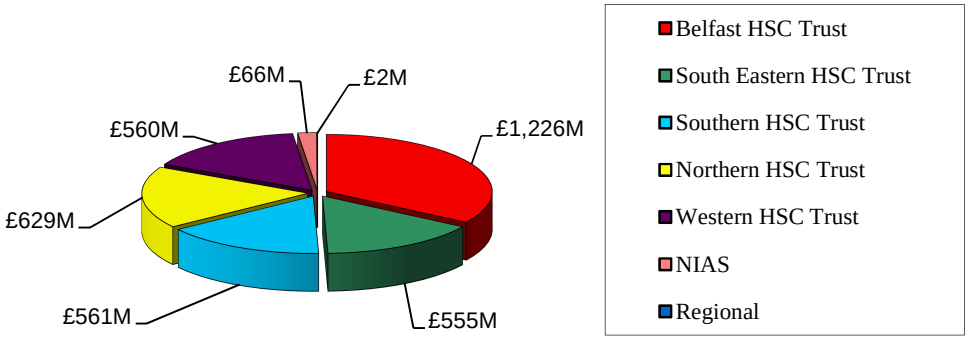
The following charts highlight how the HSCB's revenue funds have been utilised during 2016/17.

a. HSCB Net Revenue Expenditure 2016/17



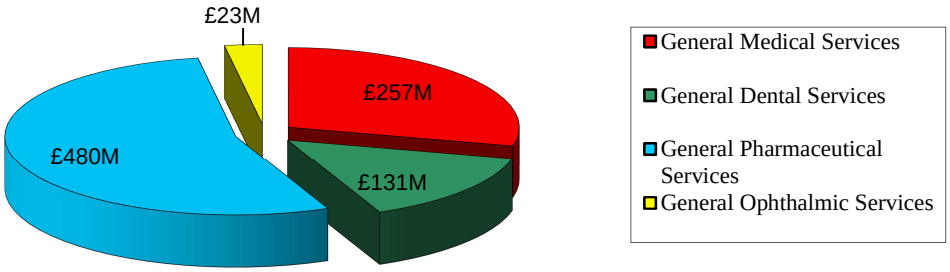
b. Commissioning Expenditure Analysis by Provider 2016/17

Commissioning Net Expenditure 2016/17



c. Family Health Services Expenditure 2016/17

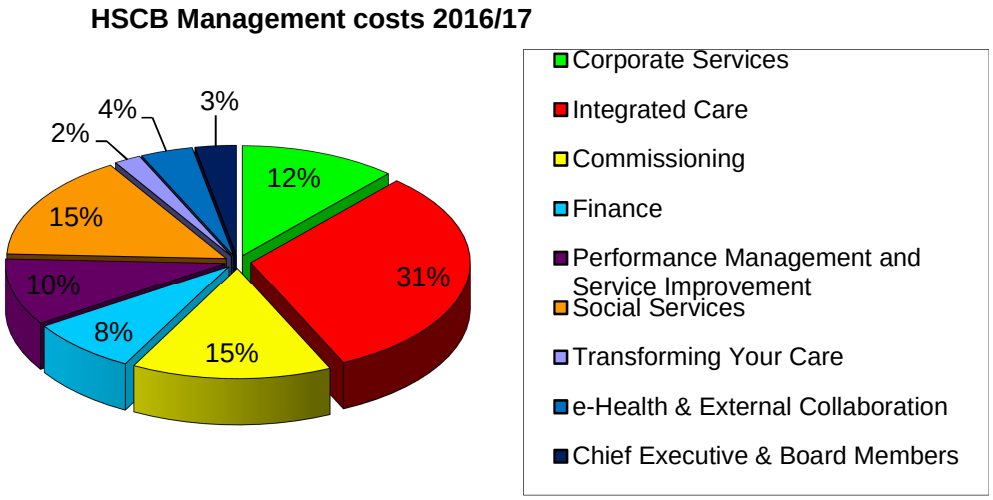
FHS Expenditure 2016/17



During the 2016/17 financial year, the HSCB continued with the difficult task of managing to successfully deliver its many and complex functions with a significantly reduced Management and Administration budget (reduction of £8.1m since 2015/16). Delivery of these savings, set in the backdrop of significant organisational uncertainty regarding the closure of the HSCB, has created a significant and ongoing challenge for the HSCB to ensure that core functions continue to be delivered to the standard that its stakeholders expect.

At the end of 2016/17, the HSCB has been successful in delivering a wide range of efficiencies to deliver the £8.1m savings on a recurrent basis. The outlook for 2017/18 is increasingly constrained – please refer to the Quality, Quantity and Financial Controls section in the Governance Statement for further detail.

d. HSCB Management Costs 2016/17



3.4) Prompt Payment Policy

The DoH requires that the HSCB 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 these principles and its measure of compliance can be found within Note 14 of the Annual Accounts within this combined document.

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

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

4.1) 10,000 Voices

The 10,000 Voices initiative is commissioned and funded by the HSCB and PHA to introduce a more person centred approach to shaping the way services are delivered and commissioned**.** It is based on the principles of Experience Led Co-Design, which have been adapted into a robust and systematic model, through which patients, clients, family members, carers and staff describe their experience of receiving and delivering health and social care in Northern Ireland.

10,000 Voices has been instrumental in ensuring services deliver better outcomes for patients, their families and carers. In 2016/17, the patients' experiences are helping to shape and enhance unscheduled care in Emergency Departments and adult safeguarding.

4.2) Regional Learnings from Serious Adverse Incidents (SAIs)

In November 2016, the HSCB and the PHA issued revised SAI procedures, following a review of the regional procedure, in consultation with DoH, Regulation and Quality Improvement Authority (RQIA), Trust professionals and Governance leads.

The revised procedure provides a system-wide perspective on serious incidents occurring in health and social care and the independent sector which provides services on behalf of the HSC.

The review produces clearer, consistent governance arrangements for reporting and learning from the most serious incidents, supporting preventative measures and reducing the risk of serious harm to patients.

The aim of investigating and learning from incidents 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 and PHA are jointly responsible for identifying and disseminating regional learning from SAIs, and during 2016/17 issued a number of learning letters and published articles in the "Learning Matters" bulletin.

In addition, two thematic reviews were carried out in 2016/17 for SAIs linked to choking and insulin. In October 2016, the HSCB held a regional workshop on SAIs relating to financial abuse.

The 3rd Annual Regional SAI Learning Workshop on 23 May 2017 provided an opportunity to share learning across the wider HSC family.

When an adverse outcome occurs, it is important that the patient, family or carer receive timely information and are fully aware of the review process.

The HSCB are responsible for monitoring the level of engagement for each SAI that is notified. The level of engagement is focused on two main issues:

- The patient, family or carer has been informed the incident was being reviewed as a SAI; and
- The review report has been shared with the patient, family or carer.

4.3) Annual Learning Event – Complaints

The HSCB has oversight of all Health and Social Care complaints, including complaints regarding Family Practitioner Services. The HSCB monitor these complaints to establish patterns, trends or areas of concern. In 2015/16, the number of complaints reduced by almost

1,000 from a high of 7,000 in 2014/15. Early indications of 2016/17 figures are that this number has further dropped to approximately 5,200 this year.

Issues of privacy, dignity and respect were the themes at this year's Annual Learning event. One of the learning outcomes was the introduction of small pouches and Moses baskets in the Emergency Obstetric Unit (EOU) for women who have miscarried or had a stillbirth. This ensured their babies were treated with dignity and respect, while staff received additional training in bereavement care.

The event was attended by staff from HSC organisations including Family Practitioner Services, RQIA, the Patient and Client Council and a number of service users.

4.4) Communications, Engagement and Digital Channels

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

In 2016, the HSCB launched a new, more user-friendly website in an effort to provide patients, the general public, staff and other stakeholders with accessible, up-to-date information about the HSCB's work.

The HSCB in partnership with the DoH, PHA, Patient Client Council, patients and service users and other key partners, are taking forward a programme of work, 'HSC Online', to establish an easily accessible, high quality, trusted health and care information source, accredited by the HSC. During 2016/17, information on over 100 conditions was published through 'nidirect'. The HSC continues to work with nidirect to extend the range of health and care information for citizens, linking the information to public health campaigns to support citizens to easily access the information they need to support the best choices for their health and wellbeing.

Digital technologies and social media are increasingly being used for campaigns and engaging with stakeholders. An example of how the HSCB have used this successfully to engage with the public was the use of Facebook to publicise Pain Management clinics across Northern Ireland. All spaces for these workshops were filled within three days of the Facebook posting, demonstrating both the effectiveness of social media as a tool for reaching stakeholders and the demand for such clinics.

Social media has proved particularly cost effective as a campaign tool and is now fully embedded in our communications planning processes. The ability to robustly monitor and evaluate social media campaigns for projects such as Dementia, Stay Well This Winter, Wasted Medicines, Living Well Moyle, Social Work Strategy and Integrated Care Partnerships has helped increase buy-in from staff and project partners.

The HSCB's Medicine Waste and prescriptions cost campaigns help raise awareness about the cost of wasting medicines or prescription costs on over-the- counter medicines. These have resonated well with audiences in Northern Ireland, with a Facebook post about the types

of health services that spending on prescription paracetamol would fund being shared over 5,000 times and reaching over almost 400,000 people. The success of this campaign has helped influence policy decisions to reduce prescriptions for treating minor and self-limiting illnesses.

The HSCB also ran the 'Stay Well This Winter', a new winter campaign in conjunction with the PHA, to encourage people to make choices to stay well over the winter. An early evaluation of the campaign suggests that it was successful in raising awareness and in encouraging behavioural trends.

4.5) Freedom of Information and Subject Access Requests

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

- 115 Freedom of Information requests were received during 2016/17;
- 87% of these requests were responded to within the target of 20 working days; and
- 6 Subject Access Requests were also submitted and responded to by the HSCB during this period. 67% of these requests were responded to within 40 calendar days.

There were no serious personal data related incidents during 2016/17.

Theme 5 - Valuing Staff

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

In light of the Minister's announcement in November 2015 regarding the future closure of the HSCB and the re-structuring of HSCB functions, the Chief Executive, the Chair and Senior Management Team have led on a series of engagement with staff and Trade Unions to ensure they are fully informed and involved in the change process. These have included sessions attended by the former Health Minister, and also the Permanent Secretary. In March 2017, two workshops, for both HSCB and PHA staff were held, giving staff the opportunity to put forward their views to help shape the future structures. This work will progress in 2017/18, and will include continued input from Human Resources (HR), provided by the Business Support Organisation (BSO), to ensure staff are supported through this time of change and that any impact is minimised.

In 2016/17 HR colleagues at BSO led on a number of work areas including pay and conditions, employee relations (both improvement of and resolution of individual cases) and retained recruitment (i.e. quality assurance role in respect of posts advertised and job evaluations). This involved working with managers, staff and Trade Union organisations. A suite of reviewed, new and amended policies and procedures will be rolled-out within HSCB

in 2017/18, following Senior Management Team approval, with subsequent appropriate training for managers and staff.

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, Voluntary Exit Scheme and the provision of business continuity, whilst awaiting the development and implementation of future models of care.

As an Equal Opportunities employer, training and development opportunities are available and offered to all staff throughout the year.

HR staff support and work with HSCB colleagues to improve the health and wellbeing of staff through a number of initiatives. This is delivered via the Organisational Workforce Development Group, Attendance Management Policy, Occupational Health Service and external support organisations, as and when required. BSO HR also assists in the provision of short information sessions to address targeted health issues identified through attendance monitoring.

During 2016/17, HSCB staff have had the opportunity to participate in the Global Corporate Challenge to improve their health, wellbeing and performance by walking 10,000 steps daily. The HSCB have also invested in new gym equipment at the offices in Belfast to support efforts to improve staff health and wellbeing.

HSCB staff also have access to workplace wellbeing services such as mental health support, counselling and other therapeutic interventions through partnership working with Inspire (formerly Carecall). The HSCB are also working with Inspire to develop a number of programmes for managers and staff to provide additional support during this time of change.

5.1) Equality, Human Rights and Diversity

During 2016/17, the HSCB conducted five equality screenings and continued to develop staff capacity through training. Diversity training, including disability awareness training is available for all our staff through the HSC Discovering Diversity e-learning platform. The HSCB supported and contributed to the development of a regional Equality Awareness Module on the eLearning platform.

Equality Impact Assessment (EQIA) training is available to staff, delivered by colleagues in the BSO Equality Unit. Five staff members also participated in Equality Screening Training.

The HSCB are sponsors of the HSC Disability Staff Network, Tapestry, which is open to all staff working in the regional HSC agencies that have an interest in disability. The staff network provides peer support to members and undertakes an ambitious range of initiatives each year.

The HSCB also continue to support and participate in the Disability Placement Scheme, taking in two new members of staff within the Scheme in 2016/17. The Scheme which

commenced in December provides six month employment opportunities for individuals with disabilities, with the opportunity, after four months on the scheme, for participants to apply for internal posts.

The HSCB are committed to making important information as accessible as possible and have committed to translating a range of information into alternative formats upfront. This year, examples of documents published in accessible formats included, the Self Directed Support Easy Read User Guide, Carers Guide to Self Directed Support and various materials for the Regional Communication Support Services Review Consultation.

Sustainability

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

The HSCB have continued to implement a number of energy saving initiatives which support the policies on Environmental Management and Waste Management. Display Energy Certification is undertaken annually and the 2016 energy performance in each HSCB office has improved on the operational rating for 2015. This information is made clearly visible to staff and visitors to increase awareness of energy usage.

Energy Performance

- Eastern Office decreased year on year
- Southern Office decreased year on year
- Northern Office decreased year on year
- Western Office – no DEC required as it is not a public building

The Multi-Functional device fleet continued to produce significant savings of up to 40% on printing costs through a reduction in paper requirements and more efficient use of fewer machines.

In an effort to lower the carbon footprint, the HSCB use environmentally suitable toners/inks; ensure printers automatically switch to standby mode, promoted the use of tele-conferencing and video-conferencing facilities to reduce the amount of staff travel to meetings.

In 2016/17, eight staff availed of the Cycle to Work Scheme and the HSCB continue to support the Sustrans workplace initiative 'Leading The Way With Active Travel' which encourages more sustainable travel by staff within Belfast. The Business Rail Translink Scheme also encouraged staff to make use of public transport to help reduce environmental pollution.

Mandatory Sustainability and Environmental requirements are also included in our tender processes for all prospective contractors and considered in the award of contracts.

Mrs Valerie Watts

Chief Executive

Date 8 June 2017

ACCOUNTABILITY REPORT - GOVERNANCE REPORT

Directors' Report

The Board of the Health and Social Care Board is made up of four 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 Health Minister.

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 2016 – 31 March 2017:

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

Executive Directors

Mrs Valerie Watts
Chief Executive

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

Mrs Fionnuala McAndrew
Director of Social Care and Children

Mr Dean Sullivan
Director of Commissioning

Mr Paul Cummings
Director of Finance

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;

Mr Sean Donaghy, Director of eHealth and External Collaboration, Health and Social Care Board;

Dr Carolyn Harper, Executive Medical Director/Director of Public Health, Public Health Agency; and

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

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

Board of Directors

Dr Ian Clements, Chairman

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

Mrs Valerie Watts, Chief Executive

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

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

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

Mr Stephen Leach CB, Non-Executive Director

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

Mrs Stephanie Lowry, Non-Executive Director

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

Independent Assessor for Public Appointments. 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 and Law at Brighton and Sussex Medical School, University of Sussex. She has been a Non-Executive Director of the Health and Social Care Board since 2009. Dr McCullough has been a visiting lecturer at the Royal College of Surgeons of Ireland since 2006 and her interests are primarily in human rights and 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 and 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 Ulster University and has undertaken work to support projects to improve the care of people with disabilities. He has written widely on these matters and continues to assist organisations that provide and develop services for users and carers. 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; is a member of the NI Research Ethics Committee and also 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 Social Services Board in a senior capacity where he assisted with the development of many services provided to patients by GPs.

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

Mrs Fionnuala McAndrew OBE, Director of Social Care and Children

Mrs McAndrew was appointed to her post when the Health and Social Care Board was established in April 2009, and previously trained and practised as a social worker. She 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).

Mr Dean Sullivan, Director of Commissioning

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

Mr Michael Bloomfield, Director of Performance and Corporate Services/Deputy Chief Executive

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

Related Parties Transactions

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

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

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

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

Register of Directors' Interests

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

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

Audit Services

The Health and Social Care Board's statutory audit was performed by ASM Chartered Accountants on behalf of the Northern Ireland Audit Office and the notional charge for the year ended 31 March 2017 was £52,000. An additional amount of £1,201 was paid to the Audit Office for the National Fraud Initiative.

Audit Disclosure

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

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health 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 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 as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated Ms 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.

*It should be noted that then Minister for Health announced in November 2015, confirmed by the subsequent Minister, the intention to close the HSCB and realign its activities across the wider HSC system. However, no formal timeframe for closure has been advised and HSCB is expected to continue as constituted for the 2017/18 financial year. The financial statements, therefore, have been prepared on a going concern basis.

Governance Statement

1. Introduction / Scope of Responsibility

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

Processes in place by which the HSCB works with partner organisations

- Public Health Agency (PHA)

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

- Business Services Organisation (BSO)

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

- Health and Social Care (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 DoH and HSCB

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

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

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

Senior HSCB officers attend bi-annual accountability reviews, with senior 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 Board of 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 no conflicts of interests declared at Board meetings. There were abstentions or dissentions from voting on a number of occasions and these are recorded in the public Board minutes.

Register of Interests

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

Gifts and Hospitality Policy

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

Performance Appraisal System

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

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

Training

"Essential Skills" refresher training was last undertaken in 2013 and was valid for 3 years. Further training was provided during the period under review, and consideration is being given to organising further training.

Self-Assessment

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

- A Board Governance Self-Assessment Tool covering the period 2016/17 was approved by the Board at its meeting on 11 May 2017. From 2015/16, ALBs are required to provide assurance, 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 2016/17 self-assessment evaluation included one mandatory case study focusing on performance issues in the area of quality, resources (finance, HR, estates) or service delivery.

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

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

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

The Board

The Board of Directors is comprised of a Non-Executive Chair, seven Non-Executive Directors, the Chief Executive and four Executive Directors – the Director of Finance, Director of Commissioning, Director of Social Care and Children and Director of Performance and Corporate Services / Deputy Chief Executive.

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

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

In the 2016/17 year, the Board met on nine occasions and, in accordance with the Board's Standing Orders, was quorate for each meeting. During this period there was over 92% attendance at each meeting, with the exception of one meeting where attendance was 69%. There were no special Board meetings held during this period.

During the period 1 April 2016 – 31 March 2017, the Board met on nine occasions.

Name	Title	Meetings attended
Dr Ian Clements	Chair	9
Mr Stephen Leach	Non Executive Director	9
Mrs Stephanie Lowry	Non Executive Director	8
Mr John Mone	Non Executive Director	9
Mr Brendan McKeever	Non Executive Director	8
Dr Robert Thompson	Non Executive Director	6
Dr Melissa McCullough	Non Executive Director	8
Mr Robert Gilmore	Non Executive Director	9
Mrs Valerie Watts	Chief Executive	9
Mr Dean Sullivan	Director of Commissioning	9
Mrs Fionnuala McAndrew	Director of Social Care & Children	8
Mr Paul Cummings	Director of Finance	6
Mr Michael Bloomfield	Director of Performance & Corporate Services	9

Role of the Audit Committee

The role of the Audit Committee is to support the Board and Accountable Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. 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 all meetings of the Committee.

The Terms of Reference of the Audit Committee are in accordance with the Good Practice Principles contained within the Audit and Risk Assurance Committee Handbook NI (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 2011) clarifies the composition and role of the Audit Committee is reflected in the HSCB Standing Orders.

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

During the 2016/17 financial year four meetings of the Audit Committee were held, along with a joint meeting with the Governance Committee to consider the mid-year Assurance Statement.

The Audit Committee assessed itself against the five good practice principles published in the Audit and Risk Assurance Committee Handbook (NI), 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; and
- communication and reporting.

Role of the Governance Committee

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

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

In the 2016/17 year, the Governance Committee met on three occasions with 100% attendance at one meeting; 75% attendance at one meeting and 50% at the remaining meeting.

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

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

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

4. Business Planning and Risk Management

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

Business Planning

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

Commissioning Plan

In line with the above statute, the HSCB is required to prepare and publish an Annual Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery. The preparation of the Commissioning Plan is done in partnership with the PHA and is implemented through a series of integrated service teams. It takes full account of the financial parameters set by the Executive and the DoH, 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 HSCB, 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 HSCB's objectives and responsibilities for the year 2016/17 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 2016/17 have been subject to bi-annual review. The first of these reviews was carried out as at 30 September 2016 and was approved by the Governance Committee at its meeting on 26 January 2017. The year end review was carried

out as at 31 March 2017 and will be approved by SMT prior to being approved by the Governance Committee at its meeting in September 2017.

Planning for 2017/18 Corporate Plan

In planning for 2017/18, the HSCB's Senior Management Team held a series of workshops to identify key priorities and corporate objectives for the coming year. The 2017/18 plan was approved by the Board on 9 February 2017 and subsequently approved by the Department of Health.

Business Continuity Plan

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

Risk Management

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

The purpose of risk management is not to remove all risk, but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss. The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004, standard (adopted by DoH) 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. Completion rates are actively monitored and verified as part of the Controls Assurance Standards programme. Training in risk management is also incorporated in the overarching corporate induction programme.

Categorisation of Risk

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

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

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

- Risk Appetite

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

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

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

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

- Embedding of risk

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

The substantive review as at 31 March 2017, 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.

The Governance Committee is currently in the process of approving the substantive review as at 31 March 2017 for onward referral to the Board for noting at its meeting in June 2017.

Stakeholder Risk

- Serious Adverse Incidents (SAIs)

The HSCB is responsible for the management and follow up of SAIs across the HSC. During 2016-17 the Procedure for the reporting and follow up of SAIs was revised and issued to the HSC. Further details can be found within section 4 of the Performance Analysis section of this report.

- Complaints

The HSCB has oversight of all HSC complaints and is responsible for the monitoring of complaints and processes and for the identification and dissemination of learning from complaints. Further details can be found within section 4 of the Performance Analysis section of this report.

- Emergency Preparedness

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

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

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

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.

2016/17 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 with updates provided as necessary at each meeting. Reports to the HSCB Governance Committee were provided from the Senior Information Risk Owner who attends both groups. Further assurances were sought via self-assessment of the Information Management Controls Assurance Standard.

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

6. Public Stakeholder Involvement

The HSCB, working collaboratively with the PHA, recognises that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of HSC services. PPI is the active and meaningful involvement of service users, carers and the public in those processes. 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, implementation of the Stroke Strategy, and the regional Carers Strategy;
- development of HSC online;
- service users actively involved in the design, implementation and roll out of both EHCR and NI direct web portal; and
- Health and Social Care Board continues to commission Personal and Public Involvement training for both staff and service users and carers.

7. Assurance

Assurance Framework

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

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

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

Quality of Board Papers

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

- documented information requirements (standing agenda items);
- evidence of challenge e.g. from Board minutes;
- Board Meeting timetable;
- process for submitting and issuing Board papers;
- content of Board papers; and
- data quality updates (performance reports).

Delegated Statutory Functions

HSC Trusts submit an annual monitoring report on the delivery of statutory functions with a mid-year return on Corporate Parenting. This is analysed by HSCB and an overview report on findings was considered by the Board at its meeting on 6 October 2016 and submitted to DoH. 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, ensures that this area is kept under constant review.

Controls Assurance Standards

The HSCB assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress was expected in 2016/17.

The HSCB achieved the following levels of compliance for 2016/17.

Standard	**DoH Expected Level of Compliance**	**HSCB Level of Compliance**	**Audited by Internal Audit**
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	83%	-
Decontamination of medical devices	75% - 99% (Substantive)	Not Applicable	-
Emergency Planning	75% - 99% (Substantive)	91%	BSO IA
Environmental Cleanliness	75% - 99% (Substantive)	Not Applicable	-
Environment Management	75% - 99% (Substantive)	82%	-
Financial Management ***(Core Standard)***	75% - 99% (Substantive)	88%	BSO IA
Fire safety	75% - 99% (Substantive)	93%	-
Fleet and Transport Management	75% - 99% (Substantive)	Not Applicable	-
Food Hygiene	75% - 99% (Substantive)	Not Applicable	-
Governance ***(Core Standard)***	75% - 99% (Substantive)	92%	BSO IA
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	84%	BSO IA
Infection Control	75% - 99% (Substantive)	Not Applicable	-
Information Communication Technology	75% - 99% (Substantive)	88%	-
Management of Purchasing	75% - 99% (Substantive)	84%	-
Medical Devices and Equipment Management	75% - 99% (Substantive)	Not Applicable	-

Standard	**DoH Expected Level of Compliance**	**HSCB Level of Compliance**	**Audited by Internal Audit**
Medicines Management	75% - 99% (Substantive)	Not Applicable	-
Information Management	75% - 99% (Substantive)	82%	-
Research Governance	75% - 99% (Substantive)	Not Applicable	-
Risk Management ***(Core Standard)***	75% - 99% (Substantive)	93%	BSO IA
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	87%	-

8. Sources of Independent Assurance

The HSCB obtains independent assurance from the following sources:

- Internal Audit;
- Regulation and Quality Improvement Authority (RQIA); and
- 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 2016/17 Internal Audit reviewed the following systems:

- Financial Transactions Capital – GP Loans;
- Management of Contracts with the Community and Voluntary (C&V) Sector, including Visits to Organisations;
- Clinical Negligence – Financial Planning;
- Financial Review;
- eHealth & External Collaboration;
- Integrated Care Partnerships;
- Family Practitioner Services – General Ophthalmic Services;
- Family Practitioner Services – Pharmaceutical Services;
- Commissioning – Contracts outside the UK, including ECRs; and
- Contract Management Arrangements – Community and Voluntary Organisations*.

(* denotes report not subject to assurance categorisation)

All received a satisfactory level of assurance*, with the exception of Integrated Care Partnerships, and three of the community and voluntary organisations visited as part of the Management of Voluntary Organisations Contracts audit which received limited assurance.

In the Annual Report, the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the HSCB's objectives. However, the following weaknesses in control (priority 1) were identified during 2016/17:

- eHealth

It was recommended that the process for securing approval for the Accelerated Access to Digital Information project be reviewed to ensure that lessons are learnt in terms of timing, planning and scoping projects. A second recommendation was made in respect of further defining relationships in relation to the governance and oversight of EU funded

projects. Management have accepted these recommendations and are working towards implementation.

- Clinical Negligence – Financial Planning

There was one Priority 1 finding in this report, however it related to BSO processes rather than HSCB processes.

- Management of Voluntary Organisations Contracts (including Visits to Voluntary Organisations)

Internal Audit identified Priority 1 weaknesses in three of the organisations visited relating to the areas of governance, financial control, and activity reported to the HSCB.

- Integrated Care Partnerships

Internal Audit recommended that the governance arrangements for the ICP's Project Board, Partnership Committee and Stakeholder Reference Group be reviewed with regards to composition, quorum, frequency and attendance which management have accepted within the context of an updated policy framework from the DoH. Further recommendations were made relating to the consistent and timely development and approval of Investment Proposals and development of the Performance Management Reporting Framework, which have been accepted by Management.

Management regularly review and are working towards the implementation of all recommendations made by internal audit.

Regulation Quality Improvement Authority (RQIA)

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

This system of assurance takes the form of a six monthly report which details the progress on implementation of RQIA recommendations. The most recent six monthly report on progress for the period ending 30 September 2016 was approved by the Governance Committee on 26 January 2017. The report for the period ending 31 March 2017 is scheduled to go to SMT for approval and for noting at Governance Committee in September 2017.

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 2016 was approved by SMT in September 2016 and noted by the Governance Committee at its meeting on 29 September 2016. The report for the period ending 31 December 2016 was approved by SMT in March 2017 and noted at the Governance Committee in April 2017.

External Audit

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2016, 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.

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

Implementation of Reform

In 2015/16 the main control issue that existed in relation to implementing the reform agenda concerned the level of funding which impacted the pace at which reform could take place. This in turn contributed to public and political perceptions that reform was failing.

To address the issue in 2015/16 reform continued to be embedded in 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 2016/17, the HSCB prioritised funds to support continuation of reform projects, and monies were made available through the Transformation Fund; however as the reform agenda is now being led by DoH under new structures to take forward "Health and Wellbeing 2026:

Delivering Together", this is no longer considered to be a control issue for which HSCB is directly responsible.

Historical Institutional Abuse Inquiry

The HSCB was a core participant to the Historical Institutional Abuse Inquiry which reported its findings on 20 January 2017. The HSCB provided records from both the legacy Boards and from HSC Trusts and their predecessor organisations. The HSCB prepared a response to each statement made by an applicant to the Inquiry. The HSCB statement described the role an HSC organisation had in the applicant's care. The HSCB's responsibility was to produce both historic file materials, and statements from relevant staff about issues raised by applicants to the Inquiry. The locating and production of historic materials and tracing staff was both challenging and difficult.

The final report consisted of ten volumes, reflecting the 15 modules of the Inquiry covering the period from 1922 to 1995.

A number of areas have been identified in the report including lengthy serious criticisms made against a number of voluntary childcare organisations. Whilst not on the same scale, criticism was also levelled against HSC legacy organisations and some individuals, a number of whom had already been subject to legal proceedings in the 1980s.

Social work safeguarding practices have moved on considerably from the time period of the HIAI providing a safer and more accountable system.

The Inquiry made a number of recommendations, including that an unconditional apology be given by all relevant bodies.

Paediatric Congenital Cardiac Services (PCCS)

In 2015 an all-island Congenital Heart Disease (CHD) Network Board was established. The Network Board includes representation from HSCB and PHA. The Network Board is developing proposals for the phased increase in capacity in Dublin to accommodate those children from Northern Ireland who require 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. A key development is that from April 2017 all urgent (in addition to emergency) paediatric surgery cases from Northern Ireland will be undertaken in Dublin. The Board is monitoring these arrangements on an on-going basis.

Statutory Residential Homes

Proposals have been submitted by the HSCB to the DoH for Ministerial consideration of recommendations for the closure of a number of facilities and the retention and reconfiguration of others. There are approximately 142 permanent residents in the 19 homes with 48 beds being used for respite care and 103 for intermediate/step down care. The HSCB has completed its tasks and is awaiting a Departmental decision on this issue.

HSC Trust Performance

Control issues in all Trusts have now been removed from this Governance Statement as they are not considered to be control issues/internal control divergences for the HSCB. All control issues/internal control divergences are however included in each of the Trust's individual Governance Statements. However, a range of performance targets are contained within the HSCB Annual Report.

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

Quality, Quantity and Financial Controls 2016/17

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

Health and Social Care (HSC) in Northern Ireland continued to face very significant financial challenges during 2016/17. The HSCB worked closely and pro-actively with all HSC Trusts and the DoH throughout the year in order to address the difficulties faced. This collaborative approach enabled the HSC system to achieve financial breakeven for the 2016/17 year.

The outlook for 2017/18 is increasingly constrained, particularly in respect of resource funding. In a statement to the House of Commons on 24 April 2017 the Secretary of State for Northern Ireland outlined an indicative Budget position for NI departments. This position was based on the advice of the Head of the NI Civil Service (NICS) in conjunction with the NICS Board. The purpose of this statement was to provide clarity to departments as to the basis for departmental allocations in the absence of an Executive, so that Permanent Secretaries can plan and prepare to take more detailed decisions in that light. The departmental allocations set out by the Secretary of State provide the basis on which departments are now planning for 2017/18. However, the Secretary of State was clear that the indicative budget position did not constrain the ability of an incoming Executive to adjust its priorities during the year. He also advised that some £42 million Resource DEL and £7 million Capital DEL was left unallocated in order to maintain flexibility for a new Executive to allocate resources to meet further priorities as they deem appropriate. Therefore, while there is the potential for an incoming Executive to adjust these plans and also to allocate the

unallocated resources, individual departments cannot anticipate any additional funding at this stage until such decisions are made.

During 2017/18, the HSCB will continue to proactively work with the DoH and HSC Trusts in order to review and develop effective solutions which will seek to maintain the integrity of services to the public and secure financial balance. Within the current budgetary constraints the HSCB will work to ensure limited resources are used to achieve the best outcomes for patients. Change and transformation is already happening, and the HSCB remains committed to that ambition and that journey, but it is inevitable that the pace of transformation and the level of service will be negatively impacted by the level of funding available.

Western Trust Financial Support

During 2016/17, financial difficulties within the Western Health and Social Care Trust continued to be disproportionately out of step with other Trusts in Northern Ireland. The Trust's final 2016/17 position of financial balance was only achieved through the provision of significant additional non-recurrent financial support of £11.2m. The interventions and additional assistance that has now been provided to the Western Trust for three consecutive years therefore remains concerning and the HSCB will continue to work with the Trust and DoH in relation to improving the Trust's financial position and performance.

Business Services Transformation Project/Shared Services

The Business Services Transformation Programme (BSTP) introduced new HSC wide computer systems in 2012/13 and implemented Shared Services for Accounts Payable, Receivable, Payroll and Recruitment.

While BSO has made significant progress in the control environment there remains priority 1 audit recommendations for Payroll and Recruitment Shared Services with unacceptable and limited levels of assurance being received from the Internal Auditor in 2016/17. The ongoing issues raised in these audit reports have the potential to impact negatively on HSCB in terms of delivery of business, budgetary management and reputation, and it is of some concern that progress on issues identified in prior years has not been made.

Additionally, during 2016/17 new system stability issues relating to the Human Resources, Payroll and Travel system have been identified which resulted in contingency measures being used to ensure staff were paid and a recalculation of employers' superannuation across the HSC. An action plan has been developed by BSO to attempt to address the control and system stability issues, which will be closely monitored by all HSC organisations throughout 2017/18.

Health Visiting

The DoH Healthy Child Healthy Future (2010-2015) Child Health Promotion Programme (CHPP) requires universal health visitor contacts to be offered to all families with pre-school children. As a result of significant workforce pressures, 30% of the CHPP in 2014 were not

being delivered. Decrease in CHPP delivery creates risk to children and families from a prevention and early intervention perspective, as well as placing undue pressure on other services such as Primary Care Teams, Paediatrics, Emergency Departments, Allied Health Professionals and Social Services.

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

The funded vacancy rate has reduced to 4.2 WTE at March 2017, however there is relatively high number of temporary vacancies. Regular workforce updates from HSC Trusts will continue to be analysed.

All health visitors from the student Health Visitor group graduating in October 2016 have been offered permanent employment contracts. These have been accepted with the exception of four who prefer to remain on temporary contracts until a position becomes available to them locally. A further 44 students are expected to graduate in October 2017.

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). A regional workshop was held in February 2017 and a revised action plan is being developed for submission to Healthy Futures Programme Board.

GP Out of Hours (OOH) Services

The Urgent Primary Care service continues to face considerable challenge due to increasing demand. Not all GP Out of Hours 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. A draft Business Case has been prepared and submitted to DoH for uplift to the recommended Regional GP OOH rates. The draft Business Case is currently in the process of being amended to reflect DoH comments and requests for additional supporting information.

In July 2015, the HSCB piloted a Regional Additional Costs Scheme whereby additional funding was made available to OOH Providers to enable them to pay a supplement to GPs. The aim was to cover the additional costs incurred by working in OOH such as indemnity, working unsocial hours and to encourage those GPs working a small number of hours to work more OOH hours. Whilst this pilot was to a large degree successful, a decision was taken to run with localised Additional Costs Schemes in each of the five areas in 2016/17 as it was considered that this would give OOH Providers greater flexibility to address local recruitment and retention issues.

Feedback from providers, together with a review of the data received to date, suggests that the localised scheme model has been effective. It is proposed to continue the localised Additional Costs Scheme model into 2017/18.

In 2017/18 it is proposed to continue to refine existing Local OOH Enhanced Services and to implement such services where none have to date existed. The OOH Locally Enhanced Service (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 similar scheme is being piloted in Limavady until the end of March 2017.

A LES in the Northern area commenced in January 2016 with a view to increasing the level of GP engagement in OOH - 16 practices have signed up to this LES.

Similar LESs were launched in July 2016 in both the South and South Eastern areas. Whilst the LES in the South East has had a limited uptake, the position in the South has been much more positive - 12 new start GPs have expressed interest in the LES and 14 OOH GPs have expressed an interest in mentoring the new GPs.

These enhanced services will be evaluated in terms of numbers of additional GP hours or sessions secured at the end of March 2017 and revised on the basis of outcomes.

The HSCB participated in the review of GP OOH Provision Working Group which had been established by the then DoH with a view to examining the current delivery of GP Out of Hours service across NI, to identify good practice and opportunities to improve service provision within existing resources.

The Working Group launched its report in March 2016 and made 11 recommendations to provide an effective OOH service. The HSCB continues to be actively involved in the implementation of these recommendations.

<u>Service and Budget Agreements</u>

Counter-signed Service and Budget Agreements (SBAs) have been received from all Trusts - South-Eastern, Southern, Northern, Western and Belfast Trust were received with caveats.

Child Sexual Exploitation (CSE)

The HSCB continues, through the HSCTs, to respond to concerns about CSE under the Protocol for Joint Investigation in conjunction with the PSNI.

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

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

The HSCB and the PSNI continue to monitor and refine the missing person's guidance. Data collection systems assist in promoting our understanding and identifying emerging trends and issues.

VOYPIC also continues to engage young people directly to ensure that their views are considered and taken into account.

The DoH has now stood down the response team which reviewed the Marshall Action Plan as most of the actions have now been addressed and associated costings where available have been identified. The only outstanding action for HSC is S6 and draft guidance on Protecting Looked after Children has been forwarded to DoH for approval. The recommendation also requires comment on protecting children with a disability which is being addressed and both elements will be completed by December 2017.

The SBNI reported on its Thematic Review in December 2015 and the HSCB / HSC Trusts completed a follow up audit in November 2016. A report outlining findings will be submitted to the DoH before the end of March 2017.

Domiciliary Care / Independent Home Care

Maintaining sufficient capacity in terms of both workforce and volume of domiciliary care service delivery remains extremely challenging. This is most acutely evidenced at times of more general, seasonal pressures on the health and social care system in addition to localised service delivery problems of an episodic or more protracted nature.

The procurement exercises carried out by the Western and Belfast Health and Social Care Trusts during 2016/17 are likely to have a major impact on the redesign and delivery of the service. This will need to be monitored and tested during 2017/18.

In order to minimise the risk of non-compliance with the Public Contract Regulations 2015, all DoH ALBs are extending CoPE cover for social and health care services in the Light

Touch Regime. This is being taken forward by the ALBs via a formally constituted project, reported to Regional Procurement Board.

HSCB is also working with DoH to look at the potential for regional contract standardisation for domiciliary care.

The ongoing registration of the social care workforce by the Northern Ireland Social Care Council (NISCC) alongside the Departmental led Domiciliary Care Workforce Review is aimed at improving the status and support needs of domiciliary care staff. Providers continue to make representations for significant enhancements to the hourly rate paid for care with Living Wage considerations being to the fore in these discussions. Sector stability is monitored via regular dialogue with providers and via the Community Services Workstream of the Regional Reform of Adult Social Care Project. The issue remains on the Corporate Risk Register.

GP Workforce

A shortage of GPs has had considerable impact on service delivery, with regard to: notably the filling of shifts and achievement of KPIs by OOH providers; the level of supply of sessional doctors available to provide day time locum sessions in practices; and on practices experiencing difficulties recruiting new partners. There is a considerable risk to on-going continuity of general medical services provision to patients, particularly in relation to sustaining out of hours services and potentially in smaller practices in more isolated locations.

The Future of GP-led Services Working Group established by DoH to consider the delivery of primary care medical services in GP surgeries by GPs or other healthcare professionals, published its report on 23 March 2016. The report made nine recommendations and 50 key actions and the HSCB is working with colleagues to address these.

GP training places are funded by DoH through the Northern Ireland Medical and Dental Training Agency (NIMDTA). In response to workforce capacity concerns the number of WTE training places has been increased from 65 which had been the intake for several years until 2015/16 to 85 in 2016/17, 95 in 2017/18 and with plans to further increase to 111 per year from 2018/19.

In a move to support retention of qualified GPs, there are 25 GPs included on a 2-year retainer scheme covering 2016/17 and 2017/18. These GPs are attached to a practice and also commit to a number of Out of Hours sessions. At present there is no identified funding to extend this scheme for a new group of GPs.

The HSCB has also sought to mitigate the GP workforce issue at operational level by providing additional funding to general practices to increase staff capacity, such as the establishment of practice based pharmacist posts. A review of General Practice nursing is ongoing.

Innovation in General Practice has been supported through piloting of an on-line triage system "Ask My GP" and increasing the number of practices providing availability of online appointment booking and prescription requests.

The review of GP nursing sits within the remit of the Public Health Agency.

HSCB Business Continuity

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

The HSCB continues to work with the DoH, and all other relevant stakeholders, to support the development of the most effective structural arrangements and ensure the smooth transition of HSCB functions. The HSCB has put in place the following controls:

- Chief Executive participation on Transformation Implementation Group
- Regular briefings provided to all staff to update on changes, including a Ministerial visit in August 2016
- Corporate approach to VES applications
- Scrutiny panel to consider request for new posts
- SMT process to identify key business priorities

Other associated issues which have been identified and will require careful management include the potential loss of the HSCB Corporate Record or Memory, Corporate Knowledge and potential loss of Corporate Record during the period of transition. To ensure this risk is appropriately addressed, a number of actions have been identified and included in the Information Governance Action Plan for 2016/17 and are expected to carry forward into the 2017/18 Action Plan.

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

Prescribing efficiency targets

Due to the limited financial resources available to Health and Social Care in 2016/17 it was necessary to deliver £30m of efficiencies from the hospital and primary care prescribing budgets. Primary care savings were set at £23m and plans were developed in order to achieve this ambitious target.

Management within the HSCB worked proactively with the DoH and Trusts throughout the year in order to deliver the plans. Unfortunately a number of elements of the plan fell short of the target set and the primary care prescribing budget overspent by £11m.

However for 2017/18, £5m of the shortfall will be recovered from existing work done but more work will be required to recover the balance, mainly due to plans to reduce cost from

medicines that can be purchased 'over the counter' and by limiting the prescribing of medicines with low or no clinical benefit to patients.

Looking ahead to 2017/18, the continuing constraints on the financial resources for Health and Social Care will require further substantial efficiency savings to be delivered from prescribing budgets regionally. The HSCB will continue to work closely with the DoH and Trusts in order to make the most effective use of the available budget without impacting patient care.

Supported Housing

Northern Ireland Housing Executive (NIHE) budget pressures have resulted in the capping of revenue funding (Supporting People Funding) thereby limiting the capacity to jointly plan and develop new supported housing schemes with HSC organisations. NIHE has removed all supported housing schemes for HSC client groups from their capital development plans for 2017/18 and beyond, unless they already have committed funding. This will limit the capacity of HSC organisations to develop appropriate housing options for vulnerable client groups. It is likely to impact negatively on the ability to discharge people with additional needs from hospital to appropriate community settings, and avoid inappropriate admissions to hospital.

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

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

The combined effect of these developments is their inclusion on the Corporate Risk Register and the situation will require careful monitoring, through redesigned Supporting People coordinating structures and Special Needs Management Allowance monitoring arrangements.

Acute Service Continuity

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

Currently this mitigation includes providing support to Southern Trust, working with other Trusts, to maintain existing ED services in Daisy Hill Hospital and develop a sustainable longer term model for the delivery of acute services.

Lakewood Secure Care Centre

Lakewood has been experiencing challenges in service delivery due to reductions in staff available to fill rotas, largely due to levels of sickness in the core team. The increased reliance on agency staff is not conducive to continuity of care. The reduced occupancy levels are challenging for the system.

The HSCB and HSC Trusts are working together to support the Centre and have agreed a number of measures to mitigate the current risks. Weekly monitoring is ongoing.

Leases

The Department of Finance (DoF) granted a "hold-over" for a Business Case in respect of renewal of a lease for office accommodation in County Hall, Ballymena which expired on 14 September 2016. As HSCB did not request an extension to the "hold-over", £214k of expenditure for the period 15 September 2016 to 31 March 2017 is therefore potentially irregular: this figure is based on the 2016/17 total expenditure of £395k and includes an annual rental charge of £124k. As the details of this arrangement were not notified to HSCB at the time, a request will be made to the DoF for a one year extension to the "hold-over" period and a Business Case for the renewal of the lease for period 1 October 2017 to 30 September 2020 will be submitted for timely approval in order to ensure no future recurrence.

11. Conclusion

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

Further to considering the accountability framework within the Body and in conjunction with assurances given to me by the Head of Internal Audit, I am content that the HSCB has operated a sound system of internal governance during the year 2016/17.

REMUNERATION AND STAFF REPORT

Remuneration Report

A Committee of Non-Executive Board members exists to advise the full Board on the remuneration and terms and conditions of service for Senior Executives employed by the Health and Social Care Board.

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

A DoH Circular on the 2016/17 Senior Executive pay award had not been received from the DoH by 31 March 2017, therefore related payments have not been made to Executive Directors.

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

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out within this report. None of the Executive or Non-Executive Directors of the HSCB received any other bonus or performance related pay in 2016/17. It should be noted that Non-Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non-Executive members.

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

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

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to current or past Senior Executives during 2016/17.

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).

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 2015/16.

	2017	**2016**
Highest Earner's Total Remuneration (band in £'000) (a)	155-160	150-155
Median Salary (£)	34,875	37,291
Median Total Remuneration Ratio	**4.4**	**4.1**

Senior Employee's Remuneration

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows (it should be noted that there were no bonuses paid to any Director during 2016/17 or 2015/16):

Non Executive Members (Table Audited)

	2016/17				**2015/16**			
Name	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £'000**	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £'000**
I Clements	30-35	100	-	30-35	30-35	100	-	30-35
S J Leach	5-10	0	-	5-10	5-10	-	-	5-10
M McCullough	5-10	0	-	5-10	5-10	100	-	5-10
R Gilmore	5-10	0	-	5-10	5-10	100	-	5-10
B McKeever	5-10	0	-	5-10	5-10	-	-	5-10
J Mone	5-10	200	-	5-10	5-10	100	-	5-10
W R Thompson	5-10	0	-	5-10	5-10	-	-	5-10
S Lowry	5-10	0	-	5-10	5-10	100	-	5-10

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

Executive Members (Table Audited)

	2016/17				2015/16			
Name	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £'000**	**Salary £000s**	**Benefits in Kind (Rounded to nearest £100)**	**Pension Benefits (to nearest £1000)**	**Total £'000**
Chief Executive V Watts (1)	155-160	200	36,000	190-195	150-155	3,700	45,000	200-205
Director of Social Care F McAndrew (2)	85-90	200	10,000	95-100	85-90	200	(22,000)	60-65
Director of Finance P Cummings	105-110	2,100	35,000	145-150	105-110	3,200	3,000	110-115
Director of Integrated Care S Harper	125-130	300	16,000	140-145	120-125	200	44,000	165-170
Director of Commissioning D Sullivan	105-110	400	21,000	125-130	105-110	400	16,000	120-125
Head of Corporate Services & Acting Director of PMSI (since 19/11/12) & Deputy Chief Executive (since 01/11/16) M Bloomfield (3)	90-95	200	54,000	145-150	90-95	200	18,000	105-110
Director of e-Health S Donaghy	125-130	200	18,000	145-150	125-130	100	3,000	130-135
Community Planning L McMahon (5)	25-30	0	6,000	30-35	-	-	-	-
Director of TYC P McCreedy (seconded to NHSCT from May 2015, subsequently resigned HSCB post) (4)	-	-	-	-	5-10	100	-	-

For notes (1-5) relating to Senior Management Remuneration please refer to the Pensions of Senior Management table which follows below.

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.

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

Pensions of Senior Management – Executive Members (Table Audited)

	2016/17				
Name	**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 31/03/17 £000s**	**CETV at 31/03/16 £000s**	**Real increase in CETV £000s**
Chief Executive V Watts (1)	5-10 pension	2.5-5 pension	107	65	39
Director of Social Care F McAndrew (2)	20-25 pension	0-2.5 pension 2.5-5 lump sum	-	-	-
Director of Finance P Cummings (3a)	45-50 pension 135-140 lump sum	0-2.5 pension 5-7.5 lump sum	915	839	48
Director of Integrated Care S Harper (3b)	50-55 pension 155-160 lump sum	0-2.5 pension 2.5-5 lump sum	1140	1072	32
Director of Commissioning D Sullivan (3c)	45-50 pension	0-2.5 pension	626	587	20
Head of Corporate Services & Acting Director of PMSI (since 19/11/12) & Deputy Chief Executive (since 01/11/16) M Bloomfield (3d)	35-40 pension 95-100 lump sum	2.5-5 pension 2.5-5 lump sum	617	557	43
Director of e-Health S Donaghy (3e)	45-50 pension 145-150 lump sum	0-2.5 pension 2.5-5 lump sum	1038	971	34
Community Planning L McMahon (5)	5-10 pension	0-2.5 pension	159	-	-

Notes

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

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

(3) CETV at 31/03/16 has been adjusted by Pensions branch, based on the current framework prescribed by the Institute and Faculty of Actuaries as follows:
- (a) 815 to 839
- (b) 1046 to 1072
- (c) 565 to 587
- (d) 536 to 557
- (e) 886 to 971

(4) No pension figures shown in year as these are annual calculations; postholder was employed by NHSCT from May 2015.

(5) Postholder returned to HSCB from 01/01/17, CETV figures are available at 31/03/17 only, equivalent full time equivalent cost for the post is £110k.

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

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

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

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

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

Staff Costs Comprise:

	2017			2016
	Permanently employed staff	**Others**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Wages and salaries	21,050	508	21,558	23,185
Social security costs	2,238	54	2,292	2,007
Other pension costs	3,131	76	3,207	3,462
Total staff costs reported in Statement of Comprehensive Expenditure	**26,419**	**638**	**27,057**	**28,654**
Less recoveries in respect of outward secondments			(418)	(534)
Total net costs			**26,639**	**28,120**

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

Average Number of Persons Employed

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

	2017			2016
	Permanently employed staff	**Others**	**Total**	**Total**
Commissioning of Health and Social Care	533	18	**551**	**579**
Less average staff number relating to capitalised staff costs	0	0	**0**	**0**
Less average staff number in respect of outward secondments	(7)	0	**(7)**	**(10)**
Total net average number of persons employed	**526**	**18**	**544**	**569**

Staff Composition

At 31 March 2017 the HSCB's headcount is 526 employees which equates to 472.35 WTE. Of this figure, 447 are permanent staff members with 79 temporary staff. The ratio of female to male employees is 391 women to 135 men.

There were 85 senior staff who earn over £67k or would earn over £67k if they were 1 WTE, of these 37 are women and 48 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	
	2017	**2016**	**2017**	**2016**	**2017**	**2016**
<£10,000	0	0	0	0	0	0
£10,000-£25,000	0	0	1	10	1	10
£25,000-£50,000	0	0	5	14	5	14
£50,001-£100,000	0	0	3	15	3	15
£100,001-£150,000	0	0	1	5	1	5
Total number of exit packages by type	**0**	**0**	**10**	**44**	**10**	**44**
Total resource cost £000s	**£0**	**£0**	**£593**	**£2,504**	**£593**	**£2,504**

Redundancy and other departure costs have been paid in accordance with the provisions of the 2016/17 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 HSCB and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The HSCB had no staff benefits in 2016/17 or 2015/16.

HSCB Management Costs

	2017	2016
	£000s	£000s
HSCB management costs	30,815	35,599
Income:		
RRL	4,574,708	4,424,086
Less non cash RRL excluding element to cover clinical negligence provision	(3,059)	(17,767)
Income per Note 4	53,446	52,299
Less interest receivable	0	0
Total Income	**4,625,095**	**4,458,618**
% of total income	**0.67%**	**0.80%**

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 2016/17 there were 2 early retirements from the Board, agreed on the grounds of ill-health. These costs are borne by HSC pension scheme and not included in HSCB Accounts.

Sickness Absence Data

The corporate cumulative annual absence level for the HSCB for the period from 1 April 2016 – 31 March 2017 is 3.27% (2015/16 3.92%)

There were 30,872 hours lost due to sickness absence (2015/16 41,227 hours), or the equivalent of 58.9 (2015/16 70.8 hours) hours lost per employee. Based on a 7.5 hour working day, this is equal to 7.85 (2015/16 9.44 days) 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.

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 had no expenditure on consultancy projects during 2016/17. However, when the post project evaluation was being completed for Transforming Your Care, it was noted that a further amount of expenditure should have been classified as consultancy, rather than Staff Substitution in 2015/16. The work completed was to support the Congenital Heart Defect Network and Commissioning Stocktake, which had been approved by the DoH in advance under the extant guidance. The total expenditure in 2015/16 was therefore £193k, rather than £6k as previously reported.

Off-Payroll Engagements

The HSCB is required to disclose whether there were any staff or public sector appointees contracted through employment agencies or self-employed with a total cost of over £58,200 during the financial year, which were not paid through the HSCB Payroll. In 2016/17 there were no such 'off-payroll' engagements (2015/16 – none).

Funding Report

Regularity of Expenditure

The Board has robust internal controls in place to support the regularity of expenditure. These are supported by procurement experts (BSO PaLS), annually reviewed Standing Orders, Standing Financial Instructions and Scheme of Delegated Authority and the dissemination of new Departmental guidance where appropriate. Expenditure and the governing controls are independently reviewed by Internal and External Audit and are self-assessed in controls assurance standards. During 2016/17 there has been no evidence of irregular expenditure.

Losses and Special Payments

Type of loss and special payment		2016/17		2015/16
		Number of Cases	£	£
Administrative write-offs				
	Bad Debts	1	139	0
Cash losses				
	Cash Losses - Theft, fraud etc.	0	0	562
Special Payments				
	Compensation payments:			
	- Clinical Negligence	11	3,113,846	915,930
	- Employers Liability	4	11,511	46,389
TOTAL		**16**	**3,125,496**	**962,881**

Special Payments

There were no other special payments or gifts made during the year (2015/16 – none).

Other Payments and Estimates

There were no other payments made during the year (2015/16 – none).

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 2016/17 is £3.5m rounded (£2.8m Dental, £0.8m Ophthalmic). If comparative figures for 2015/16 are uplifted to 2016/17 activity levels, then the estimated combined figure is £3.5m.

Losses and Special Payments over £250,000

Losses and Special Payments over £250,000	**Number of Cases**	**2016/17 £**	**2015/16 £**
Special Payments			
Prior year total (0 cases)	2	2,777,596	0
TOTAL	**2**	**2,777,596**	**0**

Remote Contingent Liabilities

In addition to contingent liabilities reported within the meaning of IAS37 shown in Note 21 of the Annual Accounts, the HSCB also considers liabilities for which the likelihood of a transfer of economic benefit in settlement is considered too remote to meet the definition of contingent liability. As at 31 March 2017, the Board is not aware of any remote contingent liabilities.

Mrs Valerie Watts

Chief Executive

Date 8 June 2017

Glossary of Terms

ALB – Arm's Length Body

BSO – Business Services Organisation

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

CoPE – Centre of Procurement Expertise

DoH – Department of Health

ED – Emergency Department

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

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

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

GP – General Practitioner

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

HRPTS – Human Resources, Payroll, Travel and Subsistence

HSC – Health and Social Care

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

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

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

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

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

NIAS – Northern Ireland Ambulance Service

NIASP - Northern Ireland Adult Safeguarding Partnership

NISAT - Northern Ireland Single Assessment Tool

OFMDFM - Office of the First Minister and Deputy First Minister

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

PHA – Public Health Agency

PPI – Patient and public involvement

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

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

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

RQIA - Regulation and Quality Improvement Authority

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

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

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

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 2017 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. The financial statements comprise the Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows 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.

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 2017 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 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 and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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 guidance.

Report

I have no observations to make on these financial statements.

K J Donnelly

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

14 June 2017

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS
FOR THE YEAR ENDED 31 MARCH 2017

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

FOREWORD

These accounts for the year ended 31 March 2017 have been prepared in a form determined by the Department of Health (DoH) based on guidance from the Department of Finance's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

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 86 to 118) which I am required to prepare on behalf of the Health and Social Care Board have been compiled from, and are in accordance with, the accounts and financial records maintained by the Health and Social Care Board and with the accounting standards and policies for HSC bodies approved by the DoH.

Paul Cummings

Director of Finance

Date 8 June 2017

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 86 to 118) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Ian Clements

Chairman

Date 8 June 2017

Valerie Watts

Chief Executive

Date 8 June 2017

HEALTH and SOCIAL CARE BOARD

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2017

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.

		2017	2016
Income	**NOTE**	**£000**	**£000**
Income from activities	4.1	52,230	50,803
Other income (excluding interest)	4.2	1,209	1,398
Deferred income	4.3	0	97
Total operating income		53,439	52,298
Expenditure			
Staff costs		(27,057)	(28,654)
Purchase of goods and services	3	(979,885)	(973,454)
Depreciation, amortisation and impairment charges	3	(2,516)	(2,815)
Provision expense	3	(360)	(14,780)
Other expenditures	3	(19,903)	(23,553)
Total operating expenditure		(1,029,721)	(1,043,256)
Net Expenditure		**(976,282)**	**(990,958)**
Finance income	4.2	7	2
Finance expense	3	0	0
Net expenditure for the year		(976,275)	(990,956)
Revenue Resource Limits (RRLs) issued (to)			
Belfast Health & Social Care Trust		(1,225,599)	(1,181,868)
South Eastern Health & Social Care Trust		(554,899)	(529,523)
Southern Health & Social Care Trust		(561,431)	(533,644)
Northern Health & Social Care Trust		(628,827)	(591,648)
Western Health & Social Care Trust		(560,107)	(531,044)
NIAS Health & Social Care Trust		(65,891)	(63,490)
NI Medical & Dental Training Agency		(1,531)	(1,316)
NI Social Care Council		0	0
Patient and Client Council		(5)	0
Total RRL issued		(3,598,290)	(3,432,533)
Total Commissioner resources utilised		(4,574,565)	(4,423,489)
Revenue Resource Limit (RRL) received from DoH	24.1	4,574,708	4,424,086
Surplus / (Deficit) against RRL		**143**	**597**

OTHER COMPREHENSIVE EXPENDITURE		2017	2016
	NOTE	**£000**	**£000**
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment	5.1/8/5.2/8	196	183
Net gain/(loss) on revaluation of intangibles	6.1/8/6.2/8	20	(0)
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2017		**(976,059)**	**(990,773)**

The notes on pages 90 to 118 form part of these accounts.

HEALTH and SOCIAL CARE BOARD

STATEMENT of FINANCIAL POSITION as at 31 March 2017

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

	NOTE	2017 £000	£000	2016 £000	£000
Non Current Assets					
Property, plant and equipment	5.1/5.2	14,659		14,897	
Intangible assets	6.1/6.2	1,355		1,569	
Financial assets	7	866		348	
Total Non Current Assets			16,880		16,814
Current Assets					
Trade and other receivables	12	4,454		6,106	
Other current assets	12	3		37	
Financial assets	7	110		41	
Cash and cash equivalents	11	1,041		10,095	
Total Current Assets			5,608		16,279
Total Assets			**22,488**		**33,093**
Current Liabilities					
Trade and other payables	13	(145,388)		(163,033)	
Provisions	15	(5,277)		(8,313)	
Total Current Liabilities			(150,665)		(171,346)
Total assets less current liabilities			**(128,177)**		**(138,253)**
Non Current Liabilities					
Provisions	15	(32,485)		(33,929)	
Total Non Current Liabilities			(32,485)		(33,929)
Total assets less total liabilities			**(160,662)**		**(172,182)**
Taxpayers' Equity and other reserves					
Revaluation reserve		8,373		8,157	
SoCNE reserve		(169,035)		(180,339)	
Total equity			**(160,662)**		**(172,182)**

The financial statements on pages 86 to 118 were approved by the Board on 8 June 2017 and were signed on its behalf by:

Signed  (Chairman) Date 8 June 2017

Signed  (Chief Executive) Date 8 June 2017

The notes on pages 90 to 118 form part of these accounts.

HEALTH and SOCIAL CARE BOARD

STATEMENT of CASH FLOWS for the year ended 31 March 2017

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	2017 £000	2016 £000
Cash flows from operating activities			
Net surplus after interest/Net operating cost	SoCNE	(976,275)	(990,956)
Adjustments for non cash costs	3	3,059	17,767
(Increase)/decrease in trade and other receivables	12	1,686	596
Increase/(decrease) in trade payables	13	(17,647)	12,096
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment	13	(71)	(17)
Movements in payables relating to the purchase of intangibles	13	595	(595)
Use of provisions	15	(4,840)	(16,145)
Net cash outflow from operating activities		(993,493)	(977,254)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	5	(1,614)	(1,505)
(Purchase of intangible assets)	6	(767)	(409)
(FTC loans issued to GPs)	7	(750)	(498)
FTC loans returned by GPs	7	43	13
Net cash outflow from investing activities		(3,088)	(2,400)
Cash flows from financing activities			
Grant in aid		987,527	987,434
Cap element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net financing		987,527	987,434
Net increase (decrease) in cash & cash equivalents in the period		(9,054)	7,780
Cash & cash equivalents at the beginning of the period	11	10,095	2,315
Cash & cash equivalents at the end of the period	11	**1,041**	**10,095**

The notes on pages 90 to 118 form part of these accounts.

HEALTH and SOCIAL CARE BOARD

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2017

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

	NOTE	SoCNE Reserve £000	Revaluation Reserve £000	Total £000
Balance at 31 March 2015		**(176,699)**	**8,004**	**(168,695)**
Changes in Taxpayers' Equity 2015/16				
Grant from DoH		987,434	0	987,434
Transfers between reserves		0	0	0
(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
Balance at 31 March 2016		**(180,339)**	**8,157**	**(172,182)**
Changes in Taxpayers' Equity 2016/17				
Grant from DoH		987,527	0	987,527
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(976,275)	216	(976,059)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	3	52	0	52
Balance at 31 March 2017		**(169,035)**	**8,373**	**(160,662)**

The notes on pages 90 to 118 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 1 - STATEMENT OF ACCOUNTING POLICIES

1 Authority

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

The accounting policies follow International Financial Reporting Standards (IFRS) to the extent that it is meaningful and appropriate to the Health and Social Care Board (HSCB). Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the HSCB for the purpose of giving a true and fair view has been selected. The HSCB's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

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

1.1 Accounting convention

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

1.2 Currency and Rounding

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

1.3 Property, Plant and Equipment

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

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;

- it is probable that future economic benefits will flow to, or service potential will be supplied to, the HSCB;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, irrespective of their individual or collective cost.

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

Valuation of Land and Buildings

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (Statement of Asset Valuation Practice) Appraisal and Valuation Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard. Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

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

Fair values are determined as follows:

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

Modern Equivalent Asset

DoF has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service

being provided, an alternative site can be valued. Land and Property Services (LPS) have included this requirement within the latest valuation.

Assets under Construction (AUC)

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use. The HSCB had no AUC in either 2016/17 or 2015/16.

Short Life Assets

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

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

Revaluation Reserve

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

1.4 Depreciation

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

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

The following asset lives have been used.

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

1.5 Impairment loss

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

1.6 Subsequent expenditure

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

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

1.7 Intangible assets

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

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

Recognition

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

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

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

1.8 Non-current assets held for sale

The HSCB had no non-current assets held for sale in either 2016/17 or 2015/16.

1.9 Inventories

The HSCB had no inventories as at 31 March 2017 or 31 March 2016.

1.10 Income

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

Grant in aid

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

1.11 Investments

The HSCB did not hold any investments in either 2016/17 or 2015/16.

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 or operating leases during 2016/17 or 2015/16.

The HSCB as lessor

The HSCB did not have any lessor agreements in either 2016/17 or 2015/16.

1.15 Private Finance Initiative (PFI) transactions

The HSCB had no PFI transactions during 2016/17 or 2015/16.

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 2016/17 or 2015/16.

- Financial risk management

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

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

- Currency risk

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

- Interest rate risk

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

- Credit and liquidity risk

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

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

1.17 Provisions

In accordance with IAS 37, provisions are recognised when the HSCB has a present legal or constructive obligation as a result of a past event, it is probable that the HSCB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure

required to settle the obligation at the end of the reporting year, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using DoF's discount rates of -2.70% (1-5 years), -1.95% (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.

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

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

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

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

1.18 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly. Under IAS 37, the HSCB discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the HSCB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.19 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2017. Untaken flexi leave is estimated to be immaterial to the HSCB and has not been included.

Retirement benefit costs

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

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2012 valuation for the HSC Pension Scheme will be used in 2016/17 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 2016/17 or 2015/16.

1.23 Government Grants

The HSCB had no government grants in 2016/17 or 2015/16.

1.24 Losses and Special Payments

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

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

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

Under IAS 8 there is a requirement to disclose those standards issued but not yet adopted.

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

1.26 Changes in accounting policies/Prior year restatement

There were no changes in accounting policies during the year ended 31 March 2017. Due to changes in the template, there have been amendments to the layout and display of some figures.

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

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

Summary	NOTE	2017 £000	2016 £000
Commissioning	2.1	3,660,935	3,503,348
FHS	2.2	864,802	851,491
Board Administration	2.3	48,828	68,650
Total Commissioner Resources utilised		**4,574,565**	**4,423,489**

2.1 Commissioning

Expenditure	NOTE	2017 £000	2016 £000
Belfast Health & Social Care Trust		1,225,599	1,181,868
South Eastern Health & Social Care Trust		554,899	529,523
Southern Health & Social Care Trust		561,431	533,644
Northern Health & Social Care Trust		628,827	591,648
Western Health & Social Care Trust		560,107	531,044
NIAS Health & Social Care Trust		65,891	63,490
NI Medical & Dental Training Agency		1,531	1,316
Patient and Client Council		5	0
Other Providers	3.1	88,254	96,481
		3,686,544	3,529,014
Income			
Income from activities	4.1	25,609	25,666
Commissioning Net Expenditure		**3,660,935**	**3,503,348**

NOTE 2 - ANALYSIS of NET EXPENDITURE by SEGMENT

2.2 FHS

Expenditure	NOTE	2017 £000	2016 £000
General Medical Services	3.1	256,653	249,426
General Dental Services	3.1	131,033	126,599
General Pharmaceutical Services	3.1	480,286	478,162
General Ophthalmic Services	3.1	23,451	22,538
		891,423	876,725
Income			
FHS receipts & recovery of charges	4.1	26,621	25,234
FHS Net Expenditure		**864,802**	**851,491**

2.3 Board Administration

Expenditure	NOTE	2017 £000	2016 £000
Salaries and wages		27,057	28,654
Operating expenditure	3.2	19,928	23,629
Non-cash costs	3.3	543	14,952
Depreciation	3.3	2,516	2,815
		50,044	70,050
Income			
Staff secondment recoveries	4.2	418	534
Operating income	4.2	791	864
FTC interest	4.2	7	2
		1,216	1,400
Board Administration Net Expenditure		**48,828**	**68,650**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 3 - OPERATING EXPENSES

3.1 Commissioning:	**2017**	**2016**
	£000	**£000**
General Medical Services	256,653	249,426
General Dental Services	131,033	126,599
General Pharmaceutical Services	480,286	478,162
General Ophthalmic Services	23,451	22,538
NHS Trusts	27,432	29,210
Other providers of healthcare and personal social services	60,348	66,845
Capital grants to voluntary organisations	474	426
Total Commissioning	979,677	973,206
3.2 Operating expenses are as follows:		
Staff costs[1]:		
Wages and salaries	21,558	23,185
Social security costs	2,292	2,007
Other pension costs	3,207	3,462
Supplies and services - general	208	248
Establishment	18,171	21,336
Transport	11	17
Premises	1,538	2,028
Total Operating Expenses	46,985	52,283
3.3 Non cash items:		
Depreciation	2,110	2,476
Amortisation	406	339
Impairments relating to FTC	121	96
Loss on disposal of property, plant & equipment (including land)	10	24
Provisions provided for in year	737	14,719
Cost of borrowing of provisions (unwinding of discount on provisions)	(377)	61
Auditors remuneration	52	52
Total non cash items	3,059	17,767
Total	**1,029,721**	**1,043,256**

[1] Further detailed analysis of staff costs is located in the Staff Report on page 73 within the Accountability Report.

During the year the HSCB paid its share of regional audit services (£1,201) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and is included in operating costs above.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 4 - INCOME

4.1 Income from Activities	2017	2016
	£000	£000
Income from Department of Education	24,735	24,394
Co-operation & Working Together (CAWT)	294	952
Family Health Services Receipts	26,621	25,234
Other income	580	223
Total	**52,230**	**50,803**

4.2 Other Operating Income	2017	2016
	£000	£000
Accommodation	604	650
Canteen	187	214
Seconded Staff	418	534
FTC interest receivable	7	2
Total	**1,216**	**1,400**

4.3 Deferred income	2017	2016
	£000	£000
Income released from conditional grants	0	97
Total	**0**	**97**

TOTAL INCOME	**53,446**	**52,300**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 5.1 - Property, plant & equipment - year ended 31 March 2017

	Land £000	Buildings (excluding dwellings) £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 2016	3,097	6,934	6	16,530	164	26,731
Indexation	153	16	0	37	0	206
Additions	0	171	0	1,514	0	1,685
Transfers	0	0	0	0	0	0
Disposals	0	0	0	(1,002)	0	(1,002)
At 31 March 2017	**3,250**	**7,121**	**6**	**17,079**	**164**	**27,620**
Depreciation						
At 1 April 2016	0	354	6	11,310	164	11,834
Indexation	0	3	0	7	0	10
Disposals	0	0	0	(993)	0	(993)
Provided during the year	0	311	0	1,799	0	2,110
At 31 March 2017	**0**	**668**	**6**	**12,123**	**164**	**12,961**
Carrying Amount						
At 31 March 2017	**3,250**	**6,453**	**0**	**4,956**	**0**	**14,659**
At 31 March 2016	**3,097**	**6,580**	**0**	**5,220**	**0**	**14,897**
Asset financing						
Owned	3,250	6,453	0	4,956	0	14,659
Carrying Amount						
At 31 March 2017	**3,250**	**6,453**	**0**	**4,956**	**0**	**14,659**

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 (2016 - £nil).

The fair value of assets funded from donations, government grants or lottery funding during the year was £nil (2016 - £nil).

NOTE 5.2 - Property, plant & equipment - year ended 31 March 2016

	Land £000	Buildings (excluding dwellings) £000	Plant and Machinery (Equipment) £000	Information Technology (IT) £000	Furniture and Fittings £000	Total £000
Cost or Valuation						
At 1 April 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)
At 31 March 2016	**3,097**	**6,934**	**6**	**16,530**	**164**	**26,731**
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
At 31 March 2016	**0**	**354**	**6**	**11,310**	**164**	**11,834**
Carrying Amount						
At 31 March 2016	**3,097**	**6,580**	**0**	**5,220**	**0**	**14,897**
At 1 April 2015	**3,150**	**6,733**	**0**	**6,006**	**0**	**15,889**
Asset financing						
Owned	3,097	6,580	0	5,220	0	14,897
Carrying Amount						
At 31 March 2016	**3,097**	**6,580**	**0**	**5,220**	**0**	**14,897**
Asset financing						
Owned	3,150	6,733	0	6,006	0	15,889
Carrying Amount						
At 1 April 2015	**3,150**	**6,733**	**0**	**6,006**	**0**	**15,889**

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 6.1 - Intangible assets - year ended 31 March 2017

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

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 (2016 - £nil).

HEALTH and SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 6.2 - Intangible assets - year ended 31 March 2016

	Software Licenses £000	Information Technology £000	Total £000
Cost or Valuation			
At 1 April 2015	1,417	3,900	5,317
Indexation	0	0	0
Additions	11	993	1,004
At 31 March 2016	**1,428**	**4,893**	**6,321**
Amortisation			
At 1 April 2015	1,038	3,374	4,412
Indexation	0	0	0
Provided during the year	195	145	340
At 31 March 2016	**1,233**	**3,519**	**4,752**
Carrying Amount			
At 31 March 2016	**195**	**1,374**	**1,569**
At 1 April 2015	**379**	**526**	**905**
Asset financing			
Owned	195	1,374	1,569
Carrying Amount			
At 31 March 2016	**195**	**1,374**	**1,569**
Asset financing			
Owned	379	526	905
Carrying Amount			
At 1 April 2015	**379**	**526**	**905**

NOTE 7 - FINANCIAL INSTRUMENTS

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

During 2015/16 the HSCB introduced one type of financial instrument, the GP Infrastructure Loans Scheme. This scheme utilises Financial Transactions Capital (FTC) in the form of loans to GPs to enable then to undertake premises developments and improvements for health and social care purposes. The first two loans were issued in 2015/16, with a 3rd loan issued in 2016/17 as shown in the note below.

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

	2017 Assets £000	2016 Assets £000
Balance at 1 April	389	0
Additions	750	498
Settlement	(43)	(13)
Impairments	(121)	(96)
Balance at 31 March	**975**	**389**

Analysis of expected timing of discounted flows

	2017 Assets £000	2016 Assets £000
Not later than one year	109	41
Later than one year and not later than five years	415	193
Later than five years	451	155
	975	**389**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 8 - IMPAIRMENTS

	2017 Financial Assets £000	2016 Financial Assets £000
Total value of impairments for the period	121	96
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**121**	**96**

The HSCB had no other impairments in 2016/17 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 2016/17 or 2015/16.

NOTE 10 - INVENTORIES

The HSCB did not hold any inventories as at 31 March 2017 or 31 March 2016.

NOTE 11 - CASH AND CASH EQUIVALENTS

	2017 £000	2016 £000
Balance at 1st April	10,095	2,315
Net change in cash and cash equivalents	(9,054)	7,780
Balance at 31st March	**1,041**	**10,095**

The following balances at 31 March were held at	**2017 £000**	**2016 £000**
Commercial banks and cash in hand	1,041	10,095
Balance at 31st March	**1,041**	**10,095**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 12 - TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

	2017 £000	2016 £000
Amounts falling due within one year		
Trade receivables	3,628	5,338
VAT receivable	646	678
Other receivables - not relating to fixed assets	180	90
Trade and other receivables	**4,454**	**6,106**
Prepayments and accrued income	3	37
Other current assets	**3**	**37**
Amounts falling due after more than one year		
Trade and other receivables	**0**	**0**
Prepayments and accrued income		
Other current assets falling due after more than one year	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**4,454**	**6,106**
TOTAL OTHER CURRENT ASSETS	**3**	**37**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**4,457**	**6,143**

The balances are net of a provision for bad debts of £nil (2016 £nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 13 - TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2017 £000	2016 £000
Amounts falling due within one year		
Trade capital payables - property, plant and equipment	412	340
Trade capital payables - intangibles	120	716
Trade revenue payables	41,167	51,034
Payroll payables	629	957
Clinical negligence payables	228	545
BSO payables	9,379	4,382
Other payables	2,289	14,953
Accruals and deferred income	91,162	90,106
Trade and other payables	**145,386**	**163,033**
Total payables falling due within one year	**145,386**	**163,033**
Total non current other payables	**0**	**0**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**145,386**	**163,033**

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:

	2017 Number	2017 Value £000s	2016 Number	2016 Value £000s
Total bills paid	19,701	126,401	20,846	115,897
Total bills paid within 30 day target or under agreed payment terms	17,796	119,193	18,823	106,402
% of bills paid within 30 day target or under agreed payment terms	**90.3%**	**94.3%**	**90.3%**	**91.8%**
Total bills paid within 10 day target	14,410	107,055	15,372	91,020
% of bills paid within 10 day target	**73.1%**	**84.7%**	**73.7%**	**78.5%**

14.2 The Late Payment of Commercial Debts Regulations 2002

The HSCB did not pay any compensation or interest for payments made late in 2016/17 (2015/16 £nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2017

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

Comprehensive Net Expenditure Account charges	**2017 £000**	**2016 £000**
Arising during the year	4,833	17,701
Reversed unused	(4,096)	(2,981)
Cost of borrowing (unwinding of discount)	(377)	61
Total charge within Operating expenses	**360**	**14,781**

Analysis of expected timing of discounted flows

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

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

NOTE 15 - PROVISIONS FOR LIABILITIES AND CHARGES 2016

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2016 £000s
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	**0**	**32,117**	**10,125**	**42,242**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2016 £000s
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	**0**	**32,117**	**10,125**	**42,242**

NOTE 16 - CAPITAL COMMITMENTS

The HSCB did not have any capital commitments as at 31 March 2017 or 31 March 2016.

NOTE 17 - COMMITMENTS UNDER LEASES

17.1 Operating Leases

The HSCB had no operating leases in 2016/17 or 2015/16.

17.2 Finance Leases

The HSCB had no finance leases in 2016/17 or 2015/16.

17.3 Commitments under Lessor Agreements

The HSCB had no lessor obligations in either 2016/17 or 2015/16.

NOTE 18 - COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION

The HSCB had no commitments under PFI or service concession arrangements in either 2016/17 or 2015/16.

NOTE 19 - OTHER FINANCIAL COMMITMENTS

The HSCB did not have any other financial commitments at either 31 March 2017 or 31 March 2016.

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 2017, please refer to Note 7.

NOTE 21 - CONTINGENT LIABILITIES

Clinical negligence

The HSCB has contingent liabilities of £357k.

	2017	2016
	£000	£000
Total estimate of contingent clinical negligence liabilities	348	180
Amount recoverable through non cash RRL	(348)	(180)
Net Contingent Liability	**0**	**0**

In addition to the above contingent liability, provision for clinical negligence is given in Note 15. Other clinical litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

Contingencies not relating to clinical negligence are as follows:	2017	2016
	£000	£000
Employers' liability	9	3
Amount recoverable through non cash RRL	(9)	(3)
Total	**0**	**0**

A new discount rate which courts must consider when awarding compensation for future financial losses in the form of a lump sum in personal injury cases came into effect in England and Wales on 20 March 2017. The Department of Justice has power to prescribe the discount rate for Northern Ireland (in consultation with the Government Actuary and Department of Finance). The discount rate is under active consideration by the Department but will require Ministerial consideration once a Minister is in post and any change would require secondary legislation. As such, it has not been possible at this time to quantify the potential impact on the Health and Social Care Board of any change in the discount rate.

NOTE 22 - RELATED PARTY TRANSACTIONS

The HSCB is an arms length body of the Department of Health and as such the Department is a related party with which the HSCB has had various material transactions during the year. In addition, the HSCB has had various material transactions with the Business Services Organisation for which the DoH 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 party assets in 2016/17 or 2015/16.

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:

	2017 Total £000	2016 Total £000
DoH (excludes non cash)	4,571,175	4,405,893
Non cash RRL (from DoH)	3,059	17,767
Adjustment for CRL grants received for Brightstart	474	426
Total Revenue Resource Limit to Statement of Comprehensive Net Expenditure	**4,574,708**	**4,424,086**

24.2 Capital Resource Limit

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

	2017 Total £000	2016 Total £000
Gross capital expenditure by HSCB	1,858	2,527
FTC issued to third parties	750	499
(FTC received from third parties)	(43)	(13)
Net capital expenditure	2,565	3,013
Capital Resource Limit	2,565	3,019
Overspend/(Underspend) against CRL	**(0)**	**(6)**

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.

	2016/17 £000	2015/16 £000
Net Expenditure	(4,574,565)	(4,423,489)
RRL	4,574,708	4,424,086
Surplus / (Deficit) against RRL	143	597
Break Even cumulative position(opening)	8,385	7,788
Break Even cumulative position (closing)	**8,528**	**8,385**

Materiality Test:	2016/17 %	2015/16 %
Break Even in year position as % of RRL	0.00%	0.01%
Break Even cumulative position as % of RRL	0.19%	0.19%

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

NOTE 25 - POST BALANCE SHEET EVENTS

There are no post balance sheet events having a material effect on the accounts.

DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 14 June 2017.