Health and Social Care Board

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2015

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On 01 July 2015

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

Health and Social Care Board
12/22 Linenhall Street
Belfast
BT2 8BS

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ANNUAL REPORT

FOR THE YEAR ENDED 31 MARCH 2015

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Chairman's Overview

I am pleased to present the Annual Report of the Health and Social Care Board for 2014/15. This report highlights the key achievements over the past year. The Board is committed to progressing reform across Health and Social Care in Northern Ireland and ensuring that the patient, service user and the family are at the centre of all health care decision making.

2014/15 has, however, seen significant challenges across Health and Social Care as we continue to operate under a climate of decreasing budgets and increasing pressure on resources.

The recently released Sir Liam Donaldson Report *'The Right Time, the Right Place'* reaffirms our belief that *Transforming Your Care* is the right approach and direction although difficult decisions will have to be made to ensure the system is fit for purpose in the long term. We continue to discuss with the DHSSPS the availability of funding required to deliver the transformation of Health and Social Care envisaged in *Transforming Your Care*.

Integrated Care Partnerships (ICPs), a *Transforming Your Care* initiative, will invest over £5m this coming year to fund initiatives such as community-based Chronic Disease Hubs to identify and prevent long term conditions like diabetes, and the extension of rapid response teams for palliative end of life care.

ICPs play a pivotal role in delivering changes by bringing together doctors, nurses, pharmacists, social workers, hospital specialists, the community and voluntary sector and service users to reconfigure and coordinate local health and social care services that will ultimately benefit patients and service users.

Our 'Choose Well' campaign, in its second year, now includes a mental health component. This public awareness campaign is aimed at encouraging people to think about the service that best meets their healthcare needs and to choose the most appropriate service. By choosing well – people will help to ensure emergency care services such as our Emergency Departments and 999 services are available for those who need to use them.

Our new Chief Executive, Valerie Watts joined in July 2014, at a very demanding time for the health and public sector as a whole in Northern Ireland. I am confident with over 30 years' experience leading large public service organisations, Valerie will play a vital role in leading the change and transformation agenda at the Board.

Looking ahead, 2015/16 will bring many fresh challenges for the Board and I look forward to working with Valerie and the wider team to commission high quality, safe health and social care services for the population of Northern Ireland.

Dr Ian Clements
Chairman

Chief Executive's Overview

This annual report for the financial year 2014/15 provides an overview of the work of the Board as a commissioner of health and social care services for the population of Northern Ireland. It highlights key achievements delivered against a background of increasing health and social care demands, changing demographics with many people living longer and a challenging financial environment.

The Board has a clear vision of a patient and client centred service built on safety, best clinical practice and improved outcomes as outlined in *Transforming Your Care*. The reform and modernisation agenda is already delivering better outcomes for patients; supporting and enabling many individuals who use our services to lead more independent lives, and to remain in their own homes as long as possible.

We now have better outcomes for patients suffering a heart attack through the development of a regional primary Percutaneous Coronary Intervention (PCI) model which has shown to save lives. June 2014 saw the opening of a catheterisation laboratory centre in Altnagelvin for patients living in the West which will now complement the centre in the Royal Victoria Hospital. The two regional centres are providing the procedure 24 hours a day, seven days a week, 365 days a year. The Northern Ireland service benchmarks favourably with services in England and Wales, and better in most cases.

Last year, the number of live kidney transplants in Northern Ireland exceeded the Ministerial target to deliver 80 transplants by March 2015.

The Transforming Cancer Follow-Up Programme introduced individually tailored follow up care with key interventions improving outcomes for people living with and beyond cancer. Under the Breast Programme, 58% of all new patients have been allocated to a self-directed aftercare pathway – 1,971 patients as at January 2015, which was the final evaluation of the Programme carried out by Price Waterhouse Coopers (PWC). This has resulted in more timely mammograms and a significant reduction in waiting lists across breast surgery and oncology review, leading to a 28% reduction (2,724 appointments) in breast surgical review and a 4% reduction (228 appointments) in breast oncology review. New follow-up pathways for prostate cancer are being introduced and similar arrangements are being put in place for people with colorectal cancer.

Through Reablement services, we are supporting people to gain or regain their confidence, ability and necessary skills to live independently in their own home as long as possible, especially after experiencing a health or social care crisis, such as illness or injury. Reablement is designed to be a short term service to help people get back to living independently. Working closely with Trusts and the community and voluntary sector, this service has made great progress with over 4,000 people receiving reablement between April and December 2014. Over 75% of people using this service were discharged within 6 weeks, many of whom did not need any on-going care.

Implementation of the Dementia Strategy has continued, with particular emphasis on awareness raising, information and support, training, delirium and short breaks and support to carers; with funding assistance from Atlantic Philanthropies.

Funding has been provided to assist with transformative change in how services are delivered at an early stage to promote best outcomes for children and young people. The Early Intervention and

Transformation Programme is providing new services for adolescents on the edge of care, custody or exclusion from education.

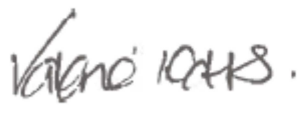
New technology is also transforming how we work and ultimately improving patient care and experience. The Northern Ireland Electronic Care Record (NIECR) continues to help frontline staff to provide safer, faster, better care, and has been used to support the care of more than 500,000 people. Over 90% of the medical workforce, across all of primary and secondary care, have access to the system for their patients, with the roll out of training and access to NIECR three years ahead of schedule due to the demand from clinicians. NIECR has reduced unnecessary laboratory tests by 27% and imaging by 8% through timely access to patient information. The transformational benefits have been recognised nationally, with NIECR winning the eHealth Insider Award for 'Best use of IT to support Integrated Healthcare Services' and the Health Service Journal Award for 'Enhancing Care by Sharing Data and Information'.

These are just a few examples of the many innovations that the Board has led on and which will help to transform the lives of many in our communities. Further examples are highlighted across the various Directors' reports within this Annual Report.

The Board remains committed to creating a modern and sustainable health and social care system which meets the changing needs of our population. The Department of Health Social Services and Public Safety (DHSSPS) has announced a Review of Commissioning and we are currently undertaking our own stocktake as part of our continual drive for improvement and excellence against a background of increasing demands and a challenging financial position. The DHSSPS also announced a Review of Health and Administrative Structures with a key focus on the roles and relationships between the regional organisations aimed at ensuring effective and efficient commissioning and delivery of services.

These appraisals together with the recommendations arising from the Sir Liam Donaldson Report *'The Right Time, the Right Place'* will provide a valuable opportunity for us to refocus and strengthen commissioning as we drive forward the reform programme at scale and pace and in partnership with health and social care professionals working across primary, secondary and community care and the statutory, voluntary and community sectors.

Finally, I would like to pay tribute to the dedication, commitment and work of all staff across the organisation. It is only with their enthusiasm and desire to reform and modernise services that we can commission and deliver an effective and sustainable health and care system that supports patients and service users.



Valerie Watts
Chief Executive

Membership of the Health and Social Care Board

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

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

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

The Non-Executive Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The Chair is accountable to the Minister for Health, Social Services and Public Safety (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 period 1 April 2014 – 31 March 2015:

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 Paul Cummings
Director of Finance

Mrs Fionnuala McAndrew
Director of Social Care and Children

Mr Dean Sullivan
Director of Commissioning

Mr Michael Bloomfield
Director of Performance and Corporate Services

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

Dr Sloan Harper	**Director of Integrated Care**, Health and Social Care Board
Mrs Pamela McCreedy	**Director of Transforming Your Care**, Health and Social Care Board
Mr Sean Donaghy	**Director of eHealth and External Collaboration**, Health and Social Care Board
Dr Carolyn Harper	**Executive Medical Director/Director of Public Health**, Public Health Agency
Mrs Pat Cullen	**Acting 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.

The role of 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 Health and Social Care Board is broadly contained in three functions:

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

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

3. To effectively deploy and manage its annual funding from the Northern Ireland Executive – currently around £4 billion – to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

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

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

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

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

The Local Commissioning Groups incorporate a range of professional interests such as GPs, nurses, dentists, pharmacists and social workers, as well as voluntary and elected representatives, to ensure that the work of the Board has genuine sensitivity and influence at a local level.

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

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

DIRECTORS' REPORTS

REPORT OF THE DIRECTOR OF COMMISSIONING

Dean Sullivan is the Board's Director of Commissioning. The role of the Board's Directorate of Commissioning is to consider the needs of the entire population of Northern Ireland and to plan and arrange for health and social care services to meet those needs.

Regional Commissioning

The Board is committed to securing high quality health and social care services which meet the needs of the Northern Ireland population. Over the last number of years, continuing to meet these needs within the budget available has become increasingly challenging.

A number of factors, including a growing and ageing population, the rising prevalence of long-term conditions, and advances in medical technology, have resulted in growing demand for increasingly costly services. In this context, a draft Commissioning Plan for 2014/15 was submitted to the Department of Health, Social Services and Public Safety (DHSSPS) in March 2014, which identified pressures of £160m required to meet the priorities, standards and targets set out in the Commissioning Plan Direction 2014.

In the months following submission of the initial draft Plan, the Board and the Public Health Agency (PHA) worked closely with the DHSSPS and the various health and social care providers to resolve this funding gap and develop a financial plan, which will deliver financial balance across the Health and Social Care (HSC) system, while minimising the impact on direct patient care. This has included the development of contingency plans by Trusts.

Additional funding secured through the monitoring rounds enabled a number of critical service developments / initiatives to proceed including normative nursing, work to improve capacity within unscheduled care, and developments within primary PCI and radiotherapy. Despite this additional injection of funds, a number of planned service developments had to be curtailed and the Board has had to take the difficult decision to withdraw referrals from the independent sector, which has had an inevitable impact on elective waiting times.

Challenges in 2015/2016

The draft budget for 2015/16 issued by the DHSSPS currently makes no provision for any new service developments. The focus of commissioning during 2015/16 will therefore, be to undertake a review of baseline funding by programme of care, to ensure that we are getting best value for money, and to identify opportunities for innovation and improvement and to enhance productivity or help us to better manage demand. In particular, Local Commissioning Groups (LCGs) will be working with Integrated Care Partnerships (ICPs) to commission new care pathways to further improve the care of patients that fall within the clinical priority areas. Throughout this process, the Board will work closely with PHA colleagues to ensure that the quality and safety of care remains at the forefront of all our decisions.

Performance against Ministerial targets will continue to be challenging in 2015/16. Local Commissioning Groups will work closely with their Performance Management and Service

Improvement colleagues to ensure that Trusts keep waiting times as short as possible through the delivery of core volumes and effective waiting list management approaches.

Key Commissioning Achievements 2014/15

Regional Achievements

- Belfast Local Commissioning Group led the regional commissioning of a Primary Care Talking Therapies service, delivered in partnership between local GPs, the Belfast Health and Social Care Trust, and voluntary and community sector organisations. Following a successful pilot in Belfast, the model, which means that patients who experience common mental health problems now have alternatives to medication, is being rolled out regionally.

- The establishment of a radiotherapy service at Altnagelvin will provide treatment for patients both north and south of the border. This project facilitates extensive collaborative cross border work with colleagues from the Republic of Ireland. Consultant oncologists and a medical physics lead have been appointed for the service which is expected to open in mid-2016 and will offer increased training places.

- In March, former Health Minister Edwin Poots formally launched the expansion of the Northern Ireland Specialist Transport and Retrieval Services (NISTAR) for critically ill neonates and children. The new service is staffed 24/7 by specialists who are experts in the transport and care of critically ill children. In addition to funding clinical staffing for the transport and retrieval team, the Board has also commissioned an additional four Paediatric Intensive Care (ICU) beds in the Royal Belfast Hospital for Sick Children increasing the unit from 8 to 12 beds, along with the purchase of a dedicated ambulance and response car. The expert project team set up to implement the service expansion took full account of specialist clinical and technical advice to ensure a future service model which is consistently safe, timely and effective and which secures the best clinical outcome for the patient. The expert project team had input from parents groups, senior Trust clinical staff, the Northern Ireland Ambulance Service and the Northern Ireland Critical Care Network.

- A new contract for the air ambulance and transfer service was agreed in 2014 for three years, to support the transfer and retrieval of patients from Northern Ireland accessing specialist care outside Northern Ireland. A dedicated air ambulance is provided for the appropriate management of critically ill patients with life threatening conditions. The vast majority of journeys undertaken are between locations in Northern Ireland and hospitals elsewhere in the UK. The service is available for journeys to and from the Republic of Ireland, however, the majority of journeys on the island of Ireland are undertaken using road transport. The new dedicated aircraft for the service was commissioned in June 2014.

- The rate of live donor kidney transplants in Northern Ireland remains the highest in the UK. More than 50 NI residents have received live donor kidneys in each of the last three years. There has been an increase in the number of kidneys retrieved and transplanted in NI that are kidneys donated after circulatory death (DCD).

- The 24/7 Primary Percutaneous Coronary Intervention (pPCI) service for the west of the Province commenced in September 2014. Primary PCI is a service which benefits patients suffering the most severe form of heart attack, known as ST Elevation Myocardial Infarction (STEMI). Approximately 40% of hospitalised heart attack patients have a STEMI. This type of heart attack happens when the blood supply to one of the heart's arteries is cut off completely as a result a blood clot. High quality care for these patients includes early diagnosis and rapid treatment. The pPCI programme requires a prompt ECG diagnosis followed by activation of a highly specialised team including consultant cardiologist, nursing, clinical physiology and radiography staff who are on call 24/7. Suitable patients bypass emergency departments and are taken directly to the closest pPCI centre. Patients stay in hospital for an average of three days.

Ministerial Targets 2014/15

- The Board also achieved all the Ministerial Targets for 2014/15 and all the commissioning themes as set out in the commissioning plan for 2014/15.

Local Achievements

<u>Belfast Local Commissioning Group</u>

- The appointment of three additional consultants has facilitated a Consultant of the Week arrangement at the Royal Belfast Hospital for Sick Children (RBHSC). The service will see an increase in the senior clinical presence and decision making in and out of hours and facilitate more regular reviews of children on wards. A dedicated eight bed Short Stay Paediatric Assessment Unit will ensure appropriate capacity is available at the hospital for children requiring observation and ensure the virtual elimination of transfers to other hospitals when RBHSC's main capacity is fully occupied.

- Belfast Local Commissioning Group has led the development of a comprehensive new service for people with Chronic Fatigue Syndrome / ME. This has involved close cooperation between the Condition Management teams in each of the Trusts and a successful pilot programme. The new service closely follows the evidence based guidelines issued by NICE and was designed in conjunction with users and carers.

- The Belfast Local Commissioning Group has implemented a comprehensive approach to commissioning Frail Elderly services in Belfast which will re-shape urgent care services for older people and support them back to independence. Investment in District Nursing will enable them to work more closely with GPs in eight localities in a Hub and Spoke arrangement across Belfast, to jointly identify, review and manage older people at risk of emergency

admission to hospital. They will be supported by investment in specialist Integrated Care Partnership teams for Coronary Obstructive Pulmonary Disease (COPD), Acute Care at Home and the NI Ambulance Service which will provide specialist expertise and a rapid response to avoid unnecessary hospital admissions. They, in turn, will be supported by direct access to specialist assessment at home or at hospital.

Northern Local Commissioning Group

- A Community Navigator has been appointed in the Causeway area to act as bridge between statutory, voluntary and community services. The Community Navigator will provide support to older people in the area ensuring that they know about services provided to address issues such as social isolation.

- Work has continued within the area of diagnostics in order to increase the numbers of patients who can be referred for direct access by GPs. Referrals have risen significantly. For example, the rapid reporting of x-rays has increased from 1,478 in 2012 to 4,356 in 2014. During a trial of direct access to audiology, 79% of patients assessed required support and/or hearing aid fitting within Audiology, with no further referrals necessary. A further 13% did not require any intervention and were discharged back to the care of their GP, 8% of the referrals were directed by Audiology to ENT for medical opinion. Without these initiatives, many of these patients would have gone to outpatients or Emergency Departments for further investigation or management of their condition.

- The Northern Local Commissioning Group has worked in partnership with the Northern Health and Social Care Trust to introduce a dedicated assessment area on the Antrim Hospital site. This assessment area is staffed by an Acute Medical Team who assess and diagnose patients referred directly by GPs, following a telephone conversation. The service currently operates between 9am and 6pm, Monday to Friday and incorporates the full range of medical specialities. Use of the assessment area by GPs continues to expand, with approximately ten contacts per day, of which eight go to Assessment Service and two to the rapid access medical clinics. The discharge rate (those not needing admission to a ward) from the Assessment Service is approximately 60%. Further enhancements and additions are being planned for this model over the coming months.

- The Northern Local Commissioning Group has continued to support the development of short breaks for carers of people with dementia. This has been provided by the short break/sitting service, including overnight stays, group activities which included advice sessions and small grants. These services have all helped to sustain carers and to assist them in dealing with crisis situations which might, in some instances, have prevented them from continuing in their caring role.

- A pathway for suspected and confirmed sleep apnoea has been established in the Northern area. This pathway enables patients to have a diagnostic test done within 9 weeks. Appropriate

referrals are then made for Continuous Positive Airway Pressure (CPAP) and on-going reviews by a sleep physiologist.

- Work has commenced on the development of emotional well-being hubs at two sites in Causeway and East Antrim. These will ensure an integrated service to support people diagnosed with mild to moderate mental health issues.

Southern Local Commissioning Group

- The Southern Local Commissioning Group has recently invested over £250,000 in additional frontline foster care placements for children, including 5 placements for children aged 12-17, who would otherwise be admitted to residential care and 5 additional placements for children aged 12–17 with complex needs.

- Phase one of a new Rapid Response service commenced in September 2014 to provide acute care at home for people over 65. A multi-disciplinary team, led by a Geriatrician, has been established in the Craigavon locality to support older people with medical and nursing needs, enabling them to be cared for at home, thus avoiding un-necessary attendances at Emergency Department and admissions to hospital. The team also provides this support to older people in half the residential and nursing homes in the southern area. Initial feedback is very positive, with a full evaluation of the service planned. If successful, it is hoped to roll this out across the southern area.

- In 2014/15 the SLCG invested in additional specialist nursing for children with epilepsy. This will increase the Southern Trust's staffing resource in terms of children's epilepsy nursing from 1.47 WTE to 2.45 WTE. Currently, there are 368 children on caseloads in the Southern Trust with epilepsy, equating to over 1,200 contacts each year in a range of settings. In 2013/14, there were 101 unplanned admissions to local hospitals for children as a result of epilepsy. This investment will enhance the care of children with epilepsy, ensuring that NICE guidelines are met. The LCG also invested in additional psychology sessions for children with long term conditions.

- The Trauma and Orthopaedic service in the southern area has benefitted from a £4 million investment to enable the expansion of the current 6 Consultant team to a new 10 consultant model. This will enable more patients to receive their elective and trauma in-patient treatments locally.

- Capital investments at both Craigavon Area and Daisy Hill hospitals have resulted in refurbished and new state of the art operating theatres and recovery wards being developed on both sites during 2014/15.

South Eastern Local Commissioning Group

- The South Eastern Local Commissioning Group invested in a direct access referral system for GPs in the North Down and Ards area so patients can be immediately referred to the dual

energy X-ray absorptiometry (DEXA) scanning service at Bangor Hospital, which determines bone strength and assists with the identification and management of osteoporosis. The service will help patients receive a faster diagnosis and reduce the need to go to an Emergency Department for an urgent X-ray. The service, which is expected to benefit 540 patients annually, will be piloted until July 2015.

- During 2014/15, the South Eastern Local Commissioning Group confirmed additional funding for a second MRI scanner at the Ulster Hospital and developments in Gynaecology, Cardiology, General Surgery, Oral Surgery and Plastic Surgery. There was also significant investment in the Trust's Fracture service to ensure that more hip fracture patients receive treatment within the Ministerial target.

- Mental Health Carers Support Service – an innovative new pilot project to provide support to carers of those with mental health difficulties, has been commissioned by the South Eastern Local Commissioning Group in the Down area. Pharmacists in the Down area will help identify carers for people with mental health difficulties who are not already known to services and link them with existing support services. The pilot service ended on 31 March 2015, and there are plans to extend the scheme to cover all carers across the Trust in partnership with the South Eastern Health & Social Care Trust, the South Eastern LCG, local pharmacists in the down area, and voluntary sector organisations.

- A range of other services and initiatives commenced this year including services to improve pain management for patients in partnership with Arthritis Care, enhanced training for GPs in Dermatology and integrating the Sexual and Reproductive Health service across the South Eastern Trust.

Western Local Commissioning Group

- Western Local Commissioning Group has commissioned pilot services across the Western Integrated Care Partnerships (ICPs) clinical priorities. Of particular success has been the agreement and roll out of integrated care pathways to support patients with respiratory conditions, including the introduction of community-based Pulmonary Rehabilitation programme and the commencement of virtual clinics where GPs can get advice from hospital respiratory physicians to manage care in their area, avoiding secondary care referral whenever possible.

- The Local Commissioning Group has also commissioned the ICPs to establish diabetic foot care with a dedicated specialist podiatrist assessing all diabetic patients in Altnagelvin Hospital, providing early identification of foot care problems and, in turn, preventing poor foot health that can lead to amputation.

- Now fully operational in the Western Trust, the Local Commissioning Group driven Musculoskeletal (MSK) Pathway has reduced multiple and duplicate referrals and improved

patient journey across orthopaedics, rheumatology, pain management and physiotherapy through coordinated triage and earlier assessment by the most appropriate MSK specialty.

- Building on the successful service available in Omagh, the Local Commissioning Group has commissioned the introduction of the second Clinical Intervention Centre (CIC) in Derry. Run as part of the Rapid Response Nursing service, the CIC provides treatments, such as IV antibiotics, in an ambulatory community setting which would otherwise be provided in hospital and enables specialist nursing to see up to four patients at a time.

- The Local Commissioning Group agreed investment of £516,000 in Western Trust diagnostics capacity, closing the demand/capacity gaps. The Trust is now achieving Ministerial waiting times and is delivering considerable additional MRI, CT, ultrasound and X-ray scans.

- As part of its Patient and Public Involvement (PPI) programme, the Local Commissioning Group heard the views of 1,020 older people on unscheduled care and mental health services. The commissioned local community networks elicit the views of patients and service users. This work was further complemented by a Local Commissioning Group-led conference in Enniskillen (April 2014) discussing the experiences of people living in rural areas and access to health and social care services in the Western area.

REPORT OF THE DIRECTOR OF PERFORMANCE AND CORPORATE SERVICES

PERFORMANCE MANAGEMENT AND SERVICE IMPROVEMENT

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

Overview of service performance

Good progress has been made across a range of standards and targets during 2014/15 including:

- A continued reduction in the number of patients waiting longer than 12 hours in Emergency Departments (ED) compared with 2013/14. However, further improvement is required, in particular in relation to 4 hour performance. The Board is continuing to work with Trusts to further improve ED waiting times.

- Performance remains strong against the 31-day cancer standard (98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat).

- A high level of performance in the waiting times for commencement of National Institute for Clinical Excellence (NICE) approved specialist drug therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

However, continuing performance challenges include:

- The need for further significant improvement in 4-hour performance for Emergency Department waiting times. The Board is working with Trusts to support the implementation of Emergency Department Improvement Plans.

- Waiting times for access to elective care services. In view of the current HSC financial position, the Board has been unable to fund Trusts to undertake additional activity in the second half of 2014/15 in elective care specialties, where there is an agreed recurrent capacity gap and this has regrettably led to increased waiting times. The Board will continue to closely monitor performance through regular meetings with Trusts and has emphasised the need for Trusts to ensure the full delivery of commissioned volumes of core

elective activity in all specialties along with strict chronological management of waiting lists.

- Waiting times in relation to the 62-day cancer standard. The Board will continue the dedicated performance and service improvement work with Trusts to deliver further improvements which is showing evidence of progress.

- Waiting times in relation to patients accessing psychological therapies. The Board is working with relevant Trusts to ensure that the best possible waiting time outcomes are achieved on the basis of additional investment.

- The Board will continue to work with Trusts to ensure that any remaining long stay patients in learning disability and psychiatric hospitals at 31 March 2015 are resettled.

- Reducing the incidence of C.*difficile* and MRSA.

- Waiting times from referral to commencement of Allied Health Professional (AHP) treatment. The Board is working with Trusts and Public Health Agency (PHA) to explore the findings of the regional review of AHP demand and capacity, to agree the steps to be taken to address the waiting time position going forward.

Service Improvements in 'Scheduled Care'

Scheduled Care describes pre-arranged services for patients such as hospital treatment, diagnostic tests or surgery. Service improvement work seeks to improve the patient pathway so that patients are seen in a timely manner and the services they receive are the key ones for the most effective diagnosis and treatment. Examples of this work during 2014/15 include:

- Completed regional review of Vascular Services to ensure a sustainable model and achievement of Vascular Society National Standards.

- Working with the Southern Trust to expand Trauma and Orthopaedic capacity in the Southern Local Commissioning Group area which will provide access for Newry and Mourne residents.

- Established a Modernising Radiology Clinical Network to progress the Regulation and Quality Improvement Authority Radiology Report recommendations.

- Developed regional capacity plan for the four main imaging modalities, including the planning for additional scanners to ensure the introduction of extended day and 7-day access across the region.

- Working closely on the Department of Health, Social Services and Public Safety (DHSSPS) Review of Imaging Services to deliver a strategy for the future provision of imaging services in NI.

- Developed regional capacity plan for Cardiac MRI with a hub and spoke model for regional service delivery.

- Completed a regional capacity model for cardiac diagnostics.

Service Improvements in 'Unscheduled Care'

Unscheduled Care describes those services that patients use unexpectedly or in times of emergency. Discussion at the Board's performance meetings with the HSC Trusts has focused on the range of issues which support the effective and timely flow of patients and improved 4 and 12 hour performance. There has been an increased emphasis on quality indicators within Emergency Departments and actions required by Trusts to improve on the overall quality of the patient experience.

The Unscheduled Care Service Improvement Team has also worked with the Northern Ireland Ambulance Service (NIAS) to develop a dashboard of nine key indicators that facilitate the NIAS to more effectively manage demand particularly during times of system wide pressures; this is now embedded in daily practice.

The Senior Nurse Review Team continues to carry out on-going audits in Trusts in relation to the implementation of agreed key actions and bed utilisation to improve the unscheduled care pathway. In addition, the Team has carried out several 'ad hoc' audits at the request of Trusts to help identify opportunities for service improvement and potential re-profiling.

During 2014/15, the Unscheduled Care Service Improvement Team has been increasingly involved in Emergency Planning and Preparedness to ensure health and social care business continuity.

Information Management

The Information Management Team provides an information and analysis service that supports the Performance Management, Service Improvement and Delivery, Commissioning and Financial Management agendas of the Board.

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

- Leading the further development of a real-time Emergency Department Pressures web-based dashboard which displays information around key emergency service pressure indicators. This has been expanded to include additional performance measures, with wider access and use of the dashboard among key health and social care (HSC) personnel.

- Development of access to a much broader suite of HSC Performance and Service Improvement Targets, Standards and Indicators.

- The Board regularly monitors performance against agreed volumes of elective activity. During the 2014/15 year, this process has been refined and enhanced to improve the quality of the analysis and expanded to include a range of other services including diagnostic activity.

- Working towards the provision of more timely, consistent and accurate information on Community Information Services through the establishment of six business-led work streams to extend and improve the extent of community information across the following areas: Domiciliary Care; Day Care; Social Work; Residential & Nursing Home Care; Community Nursing and Health Visiting and Allied Health Professionals.

- Leading the expansion of the Regional Data Warehouse to access datasets across a broader range of acute and community-based services.

- Continuing to provide clinical coding support and advice to the Board through helpdesk advice and guidance (responding to over 230 queries); delivering training to approximately 140 coding staff across Trusts through a variety of courses and workshops including foundation, refresher and conversion; and conducting audits to evaluate the level of accuracy and quality of coding for a range of services.

- The development and formal establishment of an Information Standards and Data Quality Service responsible for new data definitions and standards, providing a data definitions advice helpdesk to the Board, maintaining the NI HSC Data Dictionary and producing System Technical Guidance.

- Enabling collaboration networks across local health and social care organisations involving professional staff as necessary and maintaining effective linkages with data standards colleagues in the rest of the UK.

REPORT OF THE DIRECTOR OF INTEGRATED CARE

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

Addressing the needs of older people and the growing prevalence of long term conditions, demands improvements in the coordination of care between multiple providers of health and social care in the community. As regional commissioning organisations, the Board along with the Public Health Agency are ideally placed to use the commissioning process to reflect the need for greater integration.

General Medical (GP) Services

The GP Practice continues to be central to delivering enhanced care to those with long term conditions, including care of older people and patients with mental health problems. During 2014/15 the Board, through negotiation with the GP profession, invested in additional services designed to cover enhanced clinical care in the community.

Recognising the increased activity which GP practices are currently experiencing, important changes to the General Medical Services Contract 2014/15 were negotiated and agreed between the Department of Health, Social Services and Public Safety (DHSSPS) and the NI GP Committee. Funding to assist practices in the day to day care of patients was increased by £13m through a reduction in administrative activities.

The Northern Ireland Electronic Care Record (NIECR) is now operational and shares electronic information between General Practices, hospitals and clinics throughout Northern Ireland; (e.g. lab tests, x-rays, appointments, discharge letters, medications, allergies). As we continue to expand the scope of the Electronic Care Record, in 2014/15 approval was granted for the Key Information Summary (KIS). KIS will enable clinical staff to record and extract data that can be used in the direct care of the patient, in or out of hospital.

The Board continues to promote safety and quality within General Medical Services by monitoring practices' achievement through the Quality and Outcomes Framework, a UK wide set of mainly clinical outcomes covering long term conditions. Using this evidence, the Board discusses with practices how patient outcomes can be improved.

New drugs and other treatments are important to improving clinical standards. To support these developments, the Board funds and contributes to on-going education and learning for GPs and other members of the practice team through access to regular educational sessions, as well as providing updated information through letters, newsletters and our Primary Care site.

Medical revalidation, a process of relicensing all doctors on a regular basis, and introduced by the General Medical Council in 2012, has completed the second year of a five year cycle. Approximately 796 General Practitioners have now successfully revalidated.

As the importance of good quality patient data in supporting better integration of care becomes ever more apparent, so does the need for more robust methods of assessing the level of quality data

within general practice. In 2014/15 the Board invested in computer software for all GP Practices to assist practices improve data quality within their clinical electronic records. This will ultimately ensure better care for patients. It will also facilitate further new developments such as the transfer of records between GPs when a patient moves to a new practice.

As for many health and social care services, rising demand means that providers of care need to constantly review their working arrangements to make them as efficient as possible, so that patients can be provided with timely care. General Practice is no exception and the majority of practices across NI have been actively looking at how their capacity (e.g. phone lines, staffing numbers and alternatives to seeing a GP) matches the demand over various days of the working week.

During 2014/15, Self-Care Awareness Week was promoted as part of a national public awareness campaign aimed at providing patients with a better understanding of minor illnesses which can be safely managed at home. Through this initiative, patients are encouraged to take more responsibility for their own health, identifying ailments that do not always need the opinion of a healthcare professional.

GP Out of Hours Services

The Strategic Direction for GP Out of Hours has been established, following approval of the Strategic Framework for GP Out of Hours, in January 2014 by the Health Minister. It aims to simplify access, improve operational efficiency and improve alignment with other services.

In recognition of the additional pressures being experienced by the five GP Out of Hours services, the Board provided funding to enable clinical capacity for both GPs and nurses during the winter period to be increased. To enhance recruitment, the Board has supported a scheme to encourage experienced local GPs, essential to the safe and effective provision of these important services, to return to working in the out of hours period.

Funding has also been provided to improve the skill mix in GP Out of Hours services for a range of initiatives such as the nurse triage computer system, training new triage nurses and pharmacist prescribers. The consolidated GP Out of Hours computer system implemented in the regional data centres has enabled electronic communication of calls between GP Out of Hours services. Further improvements to IT will continue to enhance the overall service to patients.

Pharmacy and Medicines Management

During 2014/15, over thirty eight million prescription items were prescribed by GPs and dispensed in community pharmacies. The Board continues to provide leadership to raise standards of safety, quality, efficacy and efficiency of medicines used across Northern Ireland. The Board's Pharmacy and Medicines Management Team has sought to improve the safe, effective and efficient use of medicines through the commissioning of applied pharmaceutical services.

Objectives delivered in 2014/15 include:

- The maintenance and further development and application of the NI Formulary to influence the choice of effective, quality prescribing of first and second line medicines in primary care and secondary care.

- The review and advice delivered to all prescribers in primary care to continue to improve the effectiveness of prescribing.

- The Managed Entry mechanism has been fully established by the Board in 2014/15 which provides an assurance that clinically and cost effective medicines are available to the population of Northern Ireland, based on up-to-date, independent and evaluated evidence.

- The delivery of further cost efficiencies while at the same time raising the quality and safety of prescribing through the Pharmaceutical Clinical Effectiveness (PCE) programme. A key project implemented under the PCE programme was the award winning Medicines Management Dietetics project which focuses on the optimisation of dietary supplements for patients in the community. During 2014/15, over £1.2m has been saved through active clinical review, together with improvements in the quality of care that patients are receiving.

- The promotion of community pharmacy within the 'Choose Well' campaign as the first port of call for common or minor ailments and to encourage the self-care message.

- The provision of community pharmacy services to patients has been enhanced in 2014/15 with the roll out of the Medicines Use Review service to the significant clinical area of diabetes.

- 2014/15 saw the roll-out of the Home Oxygen service in a number of areas and it is encouraging to see patients being provided with a wider range of oxygen devices appropriate to their needs. This has led to improvements in their quality of life as well as overall efficiencies.

- The Board has been working closely with the Public Health Agency in the development of the 'Health and Pharmacy' concept and the first cohort of pharmacies continue to go through the accreditation processes in 2015. It is anticipated that this quality mark will make health improvement through community pharmacy more available across Northern Ireland.

- Medicines safety continues to be a focus of activity. The Board's adverse incident reporting informs regional learning, and initiatives that were taken forward include improving the calculation of doses of opiates; improvements in the management of insulin by patients with diabetes and their carers, and improved prescription security. Dissemination of learning has improved through the use of a dedicated website:
  http://www.medicinesgovernance.hscni.net/

- A number of pilot projects commissioned by the Board aimed at improving medicines use by patients (and in particular the issues of non-adherence) reached a conclusion. Final reports from these projects will be published in due course. Early indications from these projects highlight the need for formal assessment of medicines adherence/compliance followed by careful design and delivery of compliance support. The learning gained is informing the development of a business case which will set out options for future commissioning. The pilots that focussed specifically on medicines management within mental health have identified the potential for improvements for patients in this area. A key supportive tool has been the Choices and Medication website which the Board will continue to commission into 2015/16 (http://www.choiceandmedication.org/hscni/).

The challenges will be to build on 2014/15 successes and continue to improve safety, quality and cost-effectiveness in how medicines are used to improve care for patients.

General Ophthalmic Services

The Board has contracts with 267 ophthalmic practices regionally, and commissions enhanced services to help manage increasing demand for eye services for people with suspect glaucoma and acute red eye.

Between them, these 267 practices carried out in excess of 430,000 sight tests, and issued in excess of 200,000 vouchers to help towards the costs of spectacles and contact lenses in the period relating to this annual report.

This performance is now being delivered and managed more efficiently and effectively by the introduction and roll out this year of a new Ophthalmic Claims System (OCS).

Looking forward, the Board intends to build on the success of the OCS platform to commission a facility for eReferral of patients into secondary care. This streamlining of communications will improve patient safety, reduce duplication and waste and allow for eHealth virtual triage. This will enable images and scans to be viewed remotely, removing the need for some patients to attend unnecessary hospital appointments.

Building on the outcomes from 'Developing Eye Care Partnerships', the regional strategy for eye care services, the Board intends to raise the profile of Ophthalmic Public Health; in particular, the relationship between smoking and eye health, and adopt primary care optometrists into the family of practitioners offering advice on smoking cessation.

A key challenge will be to embed eye health indicators into public policy and to raise awareness of the importance of routine eye examinations in the early detection of ophthalmic and systemic disease, whilst managing the budget in a demand-led general ophthalmic service.

Other challenges are to build quality indicators into contractual change, and to work relentlessly to encourage ophthalmic contractors to fully engage with the adverse incident reporting system.

Successes this year include the piloting of a 'red eye' scheme in the Southern Local Commissioning Group area, aimed at reducing attendances in secondary care eye departments by 15%. This year also witnessed Board approval of the first cohort of Optometry Non-Medical (Independent) prescribers. These skilled practitioners are equipped with HS21 prescribing rights and will help to manage a range of eye conditions in primary care, freeing up GP capacity. In addition, the pathway approach to chronic disease management continues to transform how and where services are delivered. This has led to the commissioning of primary care optometrists to reduce, by over 60%, hospital referrals of people suspected as having ocular hypertension.

General Dental Services

The final evaluation of the primary care based Oral Surgery pilot which ran in the Southern Local Commissioning Group area in 2013/14 has been completed. The results show that satisfaction levels with the care received by patients were very high and 95% of patients were seen and treated within 4 weeks of referral. However, the new arrangements for primary care Oral Surgery appeared

to have had little impact on waiting times for Trust Oral Surgery services and were not as cost effective as anticipated. The Board is currently working with DHSSPS and the BDA to develop alternative contracting arrangements for primary care Oral Surgery services in Northern Ireland.

The first wave of pilots to test the new General Dental Services contract for Northern Ireland began in November 2014. Feedback received at this stage from both patients and practitioners is very positive. The success of wave one has led to considerable interest among dentists for the second wave of pilots which are due to commence in the summer of 2015. Funding to the value of £500K has been secured from the National Institute of Health Research to evaluate the pilots.

Oral health improvement schemes across Northern Ireland continue to be refined and developed. The Board has worked closely with Trusts to ensure that all schemes are evidence-based and learning is shared between Trusts so that efficiency is maximised. After many years when Northern Ireland was known for its poor oral health, initial findings from the 2014 UK Children's Dental Health Survey show that oral health among the province's school children has improved markedly over the last 10 years.

Integrated Care Partnerships

The development of Integrated Care Partnerships (ICPs) is central to the improvement of services and transforming how care is delivered.

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

The Integrated Care Partnership (ICP) priority is to make sure each person gets the care they need, in the right place, at the right time. To achieve this, ICPs are supporting the Risk Stratification, Information Sharing, Care Planning and Evaluation (RICE) agenda. This involves identifying patients in 'at risk' groups and focusing on prevention or managing existing conditions to stop a problem becoming an emergency; sharing information and thinking ahead to plan care around the individual; helping people to stay out of hospital unless absolutely necessary; and coordinating care in the community. The year 2014/15 has seen considerable progress. Partnership Committees have been fully populated and meet on a regular basis, to agree priorities for improvement in line with commissioning specifications issued by Local Commissioning Groups (LCGs).

Through multidisciplinary professional teams, care pathways for the Integrated Care Partnership clinical condition areas (diabetes, respiratory, stroke and services for the frail elderly) have been drawn up and agreed. This crucially also involved full engagement with service users and carers, offering opportunities for integration and improvements to be identified; leading to a more joined up service for the user across sectors and professional groupings. Business cases have been submitted to Local Commissioning Groups and investment of over £5m has been agreed for 2015/16 to fund initiatives such as the extension of rapid response teams, primary prevention of long term conditions through community based Chronic Disease Hubs, prevention and early identification of diabetic patients, an expansion of respiratory services, falls prevention and end of life services. Locally enhanced GP services have facilitated the introduction of risk stratification

and proactive care management of individuals with chronic conditions; extending multidisciplinary care planning to better integrate peoples' care.

A range of capability building and development support has been delivered and continues to be available to ensure that committee members can be effective in their roles and that there are learning and sharing opportunities across Integrated Care Partnerships. Invitations have also been extended to the Chief Executives of the eleven new local councils asking for a nomination of one council officer with a remit for community planning or health and wellbeing to join their local Integrated Care Partnership.

Monitoring and measuring the impact of Integrated Care Partnership work over the next year is crucial. Progress will be evaluated through regional evaluation measures agreed with the Department of Health, Social Services and Public Safety. Local commissioning teams and Integrated Care Partnerships are also working together to agree a range of local metrics to form part of the monitoring and accountability process. Joining up health and social care and support services is a key lever to achieving a balance between reform and sustainability. Health system integration must occur alongside continuous improvement in quality, productivity and efficiency. Integrated Care Partnerships have a key role in this.

Primary Care Infrastructure Development Programme

The Primary Care Infrastructure Development (PCID) Programme continues to undertake work to deliver infrastructure which can support the agenda of integrating services and providing more care closer to home, in line with the recommendations of Transforming Your Care. The Programme focuses on investment in health and care centres across Northern Ireland through a 'hub and spoke' model.

Two pathfinder projects have been identified in Newry and Lisburn. Competitive dialogue with bidders for each project is currently on-going and is due to complete in the coming months. Construction of both hubs is expected to commence in early 2016 and it is anticipated that they will open to the public in 2017/18, providing co-located GP and Trust services to the local community.

The Strategic Implementation Plan (SIP), which outlines proposals for the future development of primary care infrastructure, funding options and timescales for implementation, has been produced and submitted to the Health Minister for approval.

With the aim of advancing investment in primary care infrastructure using alternatives to traditional public funding methods, the Board has been successful in securing access to an initial £2.5m of Financial Transactions Capital (FTC). This is a type of capital funding that can be issued by the public sector as a loan to private contractors. The Board plans to issue this funding in the form of a low interest loan to GPs for the development of infrastructure for health and social purposes. It is anticipated that further such loan funding will be available in 2015/16 and beyond, if there is sufficient demand. The application process for the £2.5m is underway, and expressions of interest for future FTC loan schemes are also being sought to provide the Primary Care Infrastructure Development Team with information which will support any future bids to the Department of Finance and Personnel for funding.

REPORT OF THE DIRECTOR OF SOCIAL CARE AND CHILDREN

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

Services for Children and Families

- In partnership with the Northern Ireland Housing Executive, funding was secured to establish two new dedicated supported accommodation projects for young people at risk of homelessness in the Southern and South Eastern Trust areas; and a new model of supported living for young people, supported lodgings, in the Northern and Western areas.

- 250 young people chose to continue to live with their carers under the GEM Scheme, which provides for young people in foster care to continue to reside with their carers beyond the age of 18. Additional funding provided has allowed young people extended time in care, which is proven to promote better outcomes in post care life.

- Funding has been provided for three years to assist with transformative change in how services are delivered at an early stage to promote best outcomes for children and young people. The Early Intervention and Transformation Programme is providing new services for adolescents on the edge of care, custody or exclusion from education.

- Another innovative project is the Home on Time scheme, which aims to secure permanence for very young children in care as soon as possible.

- An Intensive Family Support Service, successfully tendered at end of 2013/14, and delivered by Extern in the Belfast Trust as a pilot project for three years is well established and initial evaluations show encouraging outcomes for families engaging with the service.

- A dedicated residential facility to meet the needs of separated/unaccompanied children entering Northern Ireland became operational in October 2014. The unit provides specialist support and expertise to respond to the myriad of needs presented by this group of children. The Human Trafficking and Exploitation (Criminal Justice and Support for Victims) Act (Northern Ireland) 2015 requires the establishment of a new Independent Guardianship Service and discussions will progress with DHSSPS on how this should progress.

- A new Family Support app will provide easier access to online details for a wide range of family support services provided by the community/voluntary and statutory sectors so that professionals can signpost individuals to support services.

- A new purpose built information system ensures that all Sure Start projects can collect, input and report on data in a consistent format across Northern Ireland. The system enables the Board and the Department of Education to set out a range of outcomes and indicators aimed at improving the life chances for those children aged 0-3 living in the most deprived areas in Northern Ireland.

- A new website enables staff employed in early years' facilities to apply for training courses on-line. This has resulted in encouraging more applications and increasing the level of training qualifications held by staff.

- The Inquiry into Child Sexual Exploitation in Northern Ireland has concluded and a report has been launched. The Board is working closely with DHSSPS, Trusts and other stakeholders to take forward recommendations as appropriate.

- An independent review has been completed of Beechcroft, the regional in-patient unit for child and adolescent mental health, and the acute CAMHS care pathways. The purpose of the review was to consider early intervention and how we can have a greater focus on integration across children's services. An Action Plan has been formulated to implement the recommendations which will be undertaken throughout the 2015/16 year.

Services for People with a Learning Disability

- Resettlement of long stay patients continued and will be completed in 2015.

- Implementation of the Day Opportunities model commenced in all Trusts.

- The Learning Disability Service Framework was approved and the Year 1 baseline assessment completed.

- The learning disability specific Health Improvement Group commenced its work which aims to reduce health inequalities.

- Improvement in Community Services aimed at preventing inappropriate hospital admissions were made.

Services for People with Mental Health Needs

- Resettlement of long stay patients continued and will be completed in 2015.

- Tier 4 addictions services were re-configured following consultation. This has resulted in 3 hospital sites operating a consistent 7 day per week evidence based model.

- The Mental Health Care Pathway was developed and launched. During 2015, this will replace Promoting Quality Care.

- A Care Pathway for Personality Disorder was introduced.

- Recovery Colleges were opened in each Trust under the programme to promote Recovery Approaches in Mental Health Services.

- Liaison Psychiatry Services into emergency departments were enhanced to reduce the waiting time for people who present requiring a mental health assessment.

- The Mental Health and Wellbeing Service Framework fundamental review commenced.

- A Psychological Therapies Framework with condition specific recommended treatments, inputs and duration was developed and implemented.

- Psychological Therapy Hubs in primary care were further developed in all Local Commissioning Group areas.

Services for Older People and Adults

- Development and publication of the Northern Ireland Adult Safeguarding Partnership Communication Strategy which sets out how we will improve public awareness and understanding of adult safeguarding.

- The electronic single assessment tool (eNISAT) has been rolled out and is operational in all 5 HSC Trusts. A review of the current NISAT version is underway, this includes the Carers component. The revised NISAT is being piloted in a number of multidisciplinary settings across all HSC Trusts. eNISAT will be amended to reflect the new version.

- In May 2014, the HSCB established a Domiciliary Care Project Group to review the range of challenges facing providers of domiciliary care. This will include an analysis of current models of delivery and options for service redesign. A preliminary report was delivered in April 2015 and is being considered.

- Implementation of the Dementia Strategy has continued, with particular emphasis on awareness raising, information and support, training, delirium and short breaks and support to carers; with funding assistance from Atlantic Philanthropies.

- Although diagnosis rates (dementia) in NI are among the best across the UK, there is an acknowledgement that rates can be improved and Integrated Care Partnership (ICP) Leads are working on the development of models of working that will assist this development.

- Also, building on investments made by the HSCB over the past two years to develop and enhance memory services, the HSCB Service Improvement Team has developed a five stage model to examine current models of out-patient provision. The outcome of this work will inform the further development of service specification and pathways into memory services.

- In the Western Health and Social Care Trust, a 'Guide to Communication' by Speech and Language Therapists has been published and a therapeutic hub established at Waterside Hospital.

- Progress has been made on the implementation of the Physical Disability and Sensory Impairment Strategy. Investment has been made in a wide range of initiatives including deaf blind needs assessment; and the roll-out of the Northern Ireland Single Assessment Tool within Physical Disability and Sensory Impairment Programme of Care.

REPORT OF THE DIRECTOR OF PERFORMANCE AND CORPORATE SERVICES

CORPORATE SERVICES

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

Governance and Information Management

Information Governance is the collective title for the structures, policies, procedures and controls needed by the Board to help meet its regulatory, legal, risk and operational requirements for the information it holds and processes on a daily basis.

During 2014/15 work has focused on the maintenance of an effective and organisation wide Information Governance Framework ensuring requirements for areas such as Freedom of Information, Data Protection and Records Management have been met.

Work continued during the year to develop the Board's Records Management processes with the continued implementation of Meridio, a dedicated system to manage and control the ever increasing volume of electronic documents and records generated by the organisation.

Governance Framework

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

Serious Adverse Incidents (SAIs)

The Board has continued to monitor and learn from the reporting and follow up of SAIs in line with the revised 2013 procedure, seeing a marked increase in numbers being reported across the wider HSC during 2014/15. During the year the arrangements for appropriate communication and involvement of service users, families and carers, were further enhanced and new guidance was developed for HSC staff, on effective Engagement/Communication with Service Users/ Family/ Carers following a SAI.

During the year a number of SAI learning letters have been issued, two SAI bi-annual learning reports and two editions of Learning Matters newsletter.

The Board is currently reviewing the 2013 procedure, with a revised procedure to be issued for implementation in early 2015/16.

Safety and Quality Alerts

The Board and PHA continue to monitor and co-ordinate the implementation of regional safety and quality alerts, letters and guidance via the Safety and Quality Alerts Team. This provides the mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is a robust system in place to ensure implementation across the wider HSC.

Freedom of Information and Subject Access Requests

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

- 125 Freedom of Information requests were received during 2014/15.
  - 95% of these requests were answered within 20 working days.
- 3 Subject Access Requests were also submitted and responded to by the Board during this period.
  - 100% of these requests were answered within 40 calendar days.
- There were no major Data Protection incidents during 2014/15.

Corporate Business

During 2014/15 Corporate Business staff continued to provide secretarial services to the Board and its 14 committees, including the five Local Commissioning Groups, and also supported public meetings of the Board and Local Commissioning Groups held in venues throughout Northern Ireland.

Corporate Business undertook the annual review of the Board's Standing Orders, reserved and delegated powers which, together with Standing Financial Instructions, provide a comprehensive business framework to enable the organisation to discharge its functions. An annual review of the Board's Register of Interests for Directors, Local Commissioning Groups and Committee members who are not members of the Board was also completed. Corporate Business established a Register of Staff Interests which was implemented in February 2015.

A new Board Corporate Induction Programme was established in September 2014 which will be delivered each quarter to staff. The programme was facilitated through teleconferencing arrangements between each of the four main offices of the Board.

Corporate Business produced the Board Property Asset Management (PAM) Plan for the year 2014/15 to 2019/20 and has been incorporated into the DHSSPS annual PAM Plan which has received Ministerial approval. The purpose of the Plan is to demonstrate effective asset management of public assets as required by Managing Public Money Northern Ireland.

Sustainability

The Board has a commitment to Sustainability, Environmental, Social and Community issues and to support this, a number of key policies and documents were produced in line with Controls Assurance Standards. The principles are also embedded within the business of the Board and highlighted throughout this document.

The Board participates in the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme which aims to reduce carbon emissions through delivering energy efficiencies. A range of initiatives were taken forward during the year to support the implementation of the Board's Environmental Management Policy and complementary Waste Management Policy which included the installation of low energy lighting schemes and recycling initiatives in all offices.

The Multi-Functional device fleet encompasses energy efficient models which enter sleep mode when not in use and reduces the carbon footprint by using fewer machines more efficiently, resulting in a significant savings on printing costs. The Board has set double-sided printing as default to reduce the amount of printed pages which, in turn, reduces the amount of paper required and ordered. Display Energy Certification (as defined in NI SR2008/170) is undertaken annually and is made clearly visible to staff and visitors to increase awareness of energy usage.

A new Voice-Over IP telephone system has been rolled out to include three of the four main offices and completed by 2014/15.
. The Board continues to promote the use of teleconferencing and videoconferencing facilities to reduce staff travel, costs and carbon emissions.

The Board is a participant in a new workplace initiative 'Leading the Way with Active Travel' which is a programme to encourage and support staff to walk, cycle and take public transport to work.

Equality, Human Rights and Diversity

During 2014/15, the Board continued its work to equality screen new and revised policies and develop staff capacity through training. Diversity Training, including disability awareness training is available for all Board staff through the HSC Discovering Diversity e-learning platform.

Equality Impact Assessment (EQIA) training was developed by colleagues in the Business Services Organisation (BSO) Equality Unit and some Board staff participated and completed this course. We also saw a rise in the number of Equality Impact Assessments being carried out across business areas, namely in the eHealth and Care Strategy and Self Directed Support.

The Board continues to develop and enhance our capacity around Human Rights based approaches to Health and Social Care; sponsoring and participating in a HSC wide conference themed 'The Business Benefits of Equality, Diversity and Human Rights'. This year, we also undertook significant reviews into our Disability Action Plan and Inequalities Action Plan, ensuring that they remain robust, resilient and relevant in an ever changing environment. At the beginning of the next financial year, we plan to consult on these new plans, engaging stakeholders and communities, both internally and externally.

Human Resources

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

This includes the now well embedded use of the HRPTS system in respect of pay and conditions, individual and new post job evaluations, working with managers, staff and Trade Unions organisations to improve Employee Relations and resolve individual issues. BSO have also assisted in the introduction of a comprehensive Board Induction Programme, workforce planning including a planned workshop and a review of organisational policies and procedures which is on-going.

HR staff will continue to be involved with and work closely with Board Senior Management Team, staff and in consultation with Trade Unions on the identification and implementation of initiatives to meet the financial cost reduction targets required by the DHSSPS. One such initiative to date has been the establishment of the Recruitment Scrutiny Group. Other future challenges include the Review of Administrative Services and the potential impact of the recommendations outlined within the Donaldson report.

The Board is an Equal Opportunities employer and our Recruitment and Selection Policy allows for adjustments to interview procedures if a candidate has indicated he or she has a disability during the application process.

The Board has also implemented an Attendance Management Policy which outlines our commitment to make reasonable adjustments where an employee becomes disabled. This may include redeployment to an alternative post.

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

The Board also maintains a staff intranet site to keep staff regularly informed of updates on HR related and other policies as well as information on any on-going reviews within the organisation. The Chief Executive and senior staff have facilitated information sessions with staff about the various reviews currently underway. The sessions provided an opportunity for staff to ask questions and share views. Staff were also encouraged to provide feedback through their internal Directorate channels and also through email and an online form on the staff intranet.
Management within HSCB also meet regularly with trade union colleagues to ensure there is continuous engagement and a vehicle for consultation with staff as appropriate.

Sickness Absence

The percentage figure for sickness absence during the financial year was 2.81% (3.36% 2014).

Complaints

The Board has responsibility for the monitoring and performance management of Health and Social Care complaints. Through agreed mechanisms, the Board has oversight of all Health and Social Care complaints raised at Trust and Family Practitioner Service level. The analysed information is

shared with relevant professionals and is considered by the Regional Complaints Subgroup of the Quality, Safety and Experience Group, which meets on a monthly basis. The Board has produced its fifth Annual Report on Complaints which is available on its website:
http://www.hscboard.hscni.net/publications/Complaints/index.html#P-1_0

During 2014/15, as part of the continued implementation of recommendations from the Evaluation of 'Complaints in Health and Social Care', and in response to feedback from service users, the Health and Social Care Board led a Complaints Awareness Campaign during June 2014. Called the 'Complaints Awareness Month', a variety of activities were conducted to promote the existence of the Complaints Procedure and enhancing its accessibility.

A new Complaints 'Signposting' leaflet was developed and distributed at Complaints Awareness Posts which were facilitated across Northern Ireland in non-healthcare facilities. This leaflet was shared with service users and amended following feedback.

A public focus group was conducted with service users in the Western Health and Social Care Trust area, so they could offer their views and opinions on the complaints procedure. Initial feedback demonstrated that staff attitude and communication remain the main areas of concern. The outcomes from the workshops will help inform the Board in determining how the public perceive their experience of Health and Social Care services, how to improve the complaints process, and how to attempt to address the reluctance on the part of some service users to make a complaint. There was an agreement at this event that the Board would aim to facilitate workshops of this nature on a bi-annual basis.

An important element of the Awareness Month was the HSC Complaints Learning Event held in Mossley Mill, Newtownabbey with representation from the Health and Social Care Board, Department of Health, Social Services and Public Safety, Public Health Agency, Patient and Client Council, Health and Social Care Trusts, community and voluntary groups, complainants and service users. The aim of the event was to share experiences of how the Complaints Procedure has developed and evolved since it was launched in April 2009. The audience also heard and reflected on some very powerful messages from a number of service users present, who detailed their experiences of the Complaints Procedure. Following the success of the event, it was agreed that this would be conducted on an annual basis.

Emergency Planning and Business Continuity

The Board adheres to the DHSSPS Emergency Planning Controls Assurance Standards which state "All Health and Social Care organisations should have detailed emergency preparedness plans in place, which are reviewed annually and which are part of an annual programme for testing and validating plans."

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. This year saw Health and Social Care organisations prepare for the Giro D'Italia event during May 2014. Effective planning enabled this event to pass off successfully and without any major impact upon health and social care services, and involved multi-agency working and collaboration.

In addition, the Board and PHA have worked collaboratively with the Health and Social Care organisations in planning and preparing for a potential presentation of an Ebola case in Northern Ireland. This has involved having oversight of the development of Trust-specific Ebola Preparedness Plans and ensuring mutual co-operation arrangements are in place with the Health Service Executive, Republic of Ireland. In addition, the Board and PHA were involved in the multi-agency response to the impact of the Northern Ireland Water industrial action.

The Board's Business Continuity Plan was revised and updated to reflect the requirements of the International Standard, ISO 22301, and was tested and validated through a joint Board/PHA desktop exercise. Work is on-going to develop Directorate specific Business Continuity Plans which will prioritise other less critical but nonetheless, key areas of work which will require to be delivered if the interruption to normal business becomes more projected.

Communications

The Board's Communications function aims to inform and engage stakeholders and the wider public about the role and work of the Health and Social Care Board. To deliver this, during 2014/15 the Communications Department reviewed and revised its overall communications strategy to ensure that communications continued to be effective.

Throughout the year, communications staff worked closely with Board colleagues to provide media liaison and the full range of communications support on a range of high profile issues. These included emergency department waiting times, budget, the future development of inpatient based addiction treatment services and statutory residential care homes. This support included, putting in place communication plans, internal communications, responding to media enquiries, arranging media interviews, providing briefings, issuing statements and press releases, supporting public meetings, updating the Board's website and engaging on social media.

Staff also provided communications advice and support for:

- the work of the Board's five Local Commissioning Groups and the developing role of Integrated Care Partnerships;
- the implementation of health and social care reforms;
- Board developments and initiatives, for example:
    - the development of an eHealth and Care Strategy for NI aimed at improving health through the use of information and communication technology,
    - Transforming cancer follow up care for patients, and
    - the launch of the first NI Medicines Formulary website.

<u>Choose Well Public Awareness Campaign</u>

In 2013/14 the Choose Well campaign aimed at raising awareness of the range of healthcare services and encouraging people to choose the service most appropriate to their needs was launched. Building on the level of public awareness raised in the first year, the Choose Well Year Two campaign was further developed in 2014/15 and extended to include the importance of good mental health in partnership with the Mental Health Rights Campaign and Participation and Practice of Rights.

Developed by the Board, the campaign is supported by the Health Minister, British Medical Association, Community Pharmacy NI, Patient Client Council and Health and Social Care organisations across Northern Ireland. This year's campaign included a targeted campaign with TV, radio, posters, press, online and outdoor advertising.

Partnerships and Planning

During the year, the Board's Communications team worked in partnership with a wide range of stakeholders from across the voluntary and community sector, practitioners and professional organisations as well as service users and carers to promote awareness of a broad range of health and care issues, including:

- World Social Work Day
- European Antibiotics Day
- Rare Disease Day
- Mouth Cancer Action Week
- Self-Care Week
- Dementia Awareness Week
- Ask the Pharmacist Week, and
- A recognition event to highlight the important role played by carers.

Communications staff also took part in major incident/public health planning events such as Ebola.

The Board's Communications Department has continued to develop its digital communications channels to engage with stakeholders and the wider public through greater use of social media, e-zines, vox pops and animation. A new website and intranet site for staff will be launched next year.

REPORT OF THE DIRECTOR OF TRANSFORMING YOUR CARE

Pamela McCreedy is the Director of Transforming Your Care. Following the publication of the Review of Health and Social Care in Northern Ireland – *Transforming Your Care (TYC)* in December 2011, the Health and Social Care Board has been moving forward with investment in, and implementation of, new models of care in line with the vision set out in Transforming Your Care.

The Board undertook a wide ranging public consultation on how we proposed to implement the Transforming Your Care recommendations, and this was completed in March 2013, with over 2000 responses and a positive endorsement of the proposed way forward.

Since the public consultation was completed, we have achieved significant progress with the implementation of a number of projects, across a number of programmes of care. Most notably, we are focussing on the development of initiatives which provide early intervention, support independent living and promote care closer to home, thereby providing an alternative to hospital or institutional care.

Whilst there has been continued widespread support for the model set out in Transforming Your Care, with many agreeing that the case for change is still relevant, it is recognised that the reform process needs to be implemented at greater pace and scale with further investment to support the reform process.

Building on the work of last year, some of the achievements of the 2014/15 year are:

Developing and implementing new models of care

Since 2012, there has been a total of £25.5m invested in the model of care set out in Transforming Your Care, including over £13m in service change initiatives and supporting local Trust reforms, and £6.2m in developing Integrated Care Partnerships and their projects.

In 2014/15, the Board secured £8m from the Northern Ireland Executive to invest in Transforming Your Care. Much of this investment allowed projects from 2013/14 to continue with additional investment in new projects through the Integrated Care Partnerships.

One of the central tenets within Transforming Your Care was the shift of resources from hospital settings into care in primary or community settings. By the end of 2014/15, we have achieved over £44m of the projected £83m of shift in resources described in the Transforming Your Care report, and anticipate this to rise further in 2015/16.

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

Integrated Care Partnerships

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

Since 2012, almost £6m has been invested in ICPs from Transforming Your Care transitional funding as well as investment from core funding and demography funding. Further information about their progress is set out in the Director of Integrated Care's Report in this Annual Report.

Self Directed Support

Self Directed Support is about giving individuals and their families more choice and control over the care they receive – one of the core tenets of Transforming Your Care. It encourages them to work in partnership with their key support worker in deciding the best care services for them, whether this is a direct payment, having a managed budget (where the Trust holds the budget, but the person is in control of how it is spent), letting the Trust arrange a service or a mixture of all three.

The Board is undertaking an Equality Impact Assessment, (including public consultation) on the Self Directed Support, and there are resources, communications and training in place to support its rollout across Trusts early in 2015/16.

Statutory Residential Homes

A thorough and robust consultation was led by the Board on the criteria to be used when making decisions about the future of our statutory residential homes. A post consultation report on the agreed criteria was approved at a public Board meeting in June 2014.

All five Health and Social Care Trusts completed their evaluation on the future role and function of their statutory residential care homes for older people against the new criteria. The Trusts' proposals for each home have been considered by the Local Commissioning Groups (LCGs) in the context of local needs assessments for older people's services, prior to submission to the Board for approval.

The Department of Health Social Services and Public Safety has requested the Board to pause in considering the Trusts' proposals on the future of each home at this stage, whilst it considers the outcome of a judicial review and the potential impact this may have on any future consultations.

Reablement

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

The aim of Reablement is to help people perform their necessary daily living skills such as personal care, walking, and preparing meals, so that they can remain independent within their own home. The Board is working with the Community and Voluntary Sector in this area and the sector have representation on the regional reablement steering group.

All five Trusts have achieved great progress over the last 12 months in Reablement. An audit of each Trust's implementation of the service model has been completed. This has led to increased consistency and focus on communications and training, as well as a regionally agreed model and pathway, and further rollout of the reablement service.

Domiciliary Care Review

The Board embarked on a review of domiciliary care models this year. The Board will develop a report which will include analysis of current models of delivery and options for service redesign that will inform future regional commissioning and procurement activities.

The review is considering issues such as the specification and models of the current Trust domiciliary care services, user specific issues (service accessibility and flexibility), workforce issues, provider/market issues and funding. The review has included engagement with Trust colleagues, service users and their representatives, Trade Unions and the independent sector to obtain views on how the service is functioning and what changes may be required. It is expected that the report will be available by Autumn 2015.

Community Information Project

In the past year, Transforming Your Care have been providing project management and administration support to a regional project on community information. The project will lead to more standardised information and comparability across the region for Community Nursing, Social Work, Residential and Nursing Homes, Domiciliary Care and Day Care.

Communication and Engagement

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

As well as engaging with stakeholders at a range of small and large events and meetings, the Transforming Your Care e-Zine has been issued 7 times to March 2015, highlighting projects from across the Board, the Public Health Agency, the 6 Trusts, primary care, and our third sector partners.

The e-Zines have included a wide range of stories of reform including Integrated Care Partnerships, Reablement, eHealth and the NI Electronic Care Record, new Cath Lab and Radiotherapy facilities in Altnagelvin, developments in our Primary Care infrastructure, Community Children's Nursing, changes in Mental Health and Learning Disability services and supported living, Community Pharmacy, Family Support Hubs and Carers.

The Transforming Your Care website has also been updated to reflect new projects, provide new information, and service user and carer's stories.

We have continued to support and progress the HSC Knowledge Exchange which provides access to resources, good practice, leading thinking and up to date news and events across local, national and international systems to everyone in the Health and Social Care system – both statutory and independent sectors. This initiative is now one year old and the website is growing all the time with over 10,000 visits in the last year.

Key Challenges

Funding

The provision of Transforming Your Care Transitional Funding has been slower than expected but in late March 2015, we have invested £24.4m since 2012 in the model of care set out in Transforming Your Care, in addition to core funding and demography funding. The reform and transformation agenda remains a high priority for the Board and the Health Minister, and we continue to work closely with the DHSSPS to seek additional funding to support its implementation.

Engagement

As recognised by the recent Donaldson Report, gaining public and political support for major reform is challenging, although there is strong agreement on the need for change and the model set out in Transforming Your Care. Continued engagement with the public, interested groups and politicians will be prioritised in the coming year to enable views to be discussed and concerns to be alleviated.

Clinical and Staff Leadership

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

Looking forward

We need ambitious reform at a system wide level if we are to have a sustainable health and social care system. Extensive engagement has been completed in order to map the way forward for reform across the health and social care service.

The current projects which have been getting underway over the past 2 years will continue to be implemented across Northern Ireland, with many more at Trust level. In 2015/16, we will also focus on system wide initiatives such as care pathways and outpatient reform.

REPORT OF THE DIRECTOR OF eHEALTH AND EXTERNAL COLLABORATION

Sean Donaghy is the Director of eHealth and External Collaboration.

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

Northern Ireland has the advantage of integrated health and social care, and the descriptor has therefore been extended to health ***and*** social care. This definition includes all aspects of technology and information management, including remote telecommunications to support patients and clients. During 2014/15, an eHealth & Care strategy was developed jointly by the Board and PHA, supported by other Health and Social Care organisations. A public consultation was managed by the Board, and the final strategy was launched on 12 March 2015. The strategy communicates how technology can support better health & wellbeing, and provides the basis for monitoring and supporting progress on the implementation plan designed to deliver the goals it sets out.

In progressing external collaboration, the objective of engaging with Europe and further afield is to secure support for the adoption of best practice and the development of innovative solutions to meet current service challenges. In addition to these benefits, health and social care seeks to attract additional funding from European competitive funding streams. The Board and Public Health Agency supported the development of partnerships across Europe, and promoted an integrated response from the health and social care service in Northern Ireland to maximise the opportunity for success in bidding, and the impact of those successes by promoting alignment with the agenda set out in Transforming Your Care, Quality 2020 and Making Life Better.

The Board's eHealth team oversees the strategic development of Information and Communication Technologies (ICT) services across the region. During the past year, the Board continued to invest in eHealth and Care systems and services to support transformational change. Achievements in 2014/5 include:

- The Northern Ireland Electronic Care Record (NIECR), launched in June 2013 is now used by 21,000 care professionals, with numbers of staff, and the scope of information available, growing. During 2014, the NIECR won 2 national awards from the internationally recognised eHealth insider (eHi) and Health Service Journal (HSJ) organisations for best use of technology to integrate care.

- The development of a 'roadmap' for the further development of the NIECR that will see more functions delivered by the NIECR, consolidating NI's position as a leader in the use of this technology to integrate care and to support better, safer, faster care decisions.

- Clinical eLearning tools - working with a local company to launch an innovative new tool to support clinicians to safely improve their clinical image interpretation skills.

- Over the past year, investment has been made to further develop electronic referral, assessment and discharge processes:

  - a project designed to improve uptake of the Clinical Communications Gateway (CCG) was undertaken. The CCG provides an electronic means for referring patients. By December 2015, over 75% of GPs referred patients electronically to hospital consultants.

  - electronic 'triage' of new outpatient referrals was tested by the Surgical team at Causeway Hospital, prior to roll out more widely in Northern Ireland.

  - a project was established to support instant document transfer from Trusts to General Practice, reducing delay and cost associated with processing paper.

  Taken together, these 3 projects have the potential to significantly accelerate assessment of referrals, care decision making, and care communication processes. They will significantly reduce the burden of paper referrals and manual booking processes that usually delay decision making and add cost in health and care systems.

- Pathway to Paperless

A task group has been established to look at the future of digital records across Northern Ireland. This group has reviewed what has already been achieved and will deliver an interim report on the future of digital records by 18 June 2015.

- Appointment of Chief Clinical Information Officers (CCIO)

In the eHealth and Care strategy, one of the most important aims of the leadership process is to harness the energy, enthusiasm and knowledge of the care professional community. Recruitment of CCIOs to help deliver on this aim is underway across Northern Ireland.

- Maintenance of existing services

The maintenance of existing services is critical part of the work of eHealth, working with Trusts, the Business Service Organisation and suppliers to ensure that services remain resilient. During 2014/15, investment included the upgrade of over 2000 computers, tablets and other devices, the upgrade of data and phone networks, improved data centres and the replacement of major software agreements.

REPORT OF THE DIRECTOR OF FINANCE

Overview

The Health and Social Care Board (HSCB) received funding from the Department of Health Social Services and Public Safety (DHSSPS) in 2014/15 of £4,252m (Revenue). In addition to this the HSCB also receives income from other sources, in 2014/15 this amounted to £53.6m.

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

The HSCB has an operational responsibility to ensure the overall financial stability of the Health and Social Care (HSC) system within Northern Ireland including the Trusts, HSCB and the Public Health Agency (PHA). In 2014/15 the significant financial constraints required rigorous planning, monitoring, management and decision making with respect to the budget by the HSCB. Throughout the year the HSCB worked closely and pro-actively with all HSC Trusts and the DHSSPS in order to address the severe financial challenges faced by the system. This ultimately necessitated the development of a revised financial plan during the year in order to maintain the quality of services required to manage the increased demand and corresponding financial pressures being experienced by Trusts.

The financial statements presented in this Annual Report and Accounts highlight a surplus of £7m for the HSCB which remains within the HSCB's breakeven target. It was necessary for the HSCB to retain this funding in order to offset the impact of the Western Health and Social Care Trust (WHSCT) incurring a deficit for the year of £6.7m. If this deficit had not occurred the HSCB could have invested this funding into additional patient and client care during 2014/15. However, without this intervention by the HSCB whole system financial balance would not have been delivered in 2014/15. All other Trusts were required to implement an agreed contingency plan in order to achieve break-even.

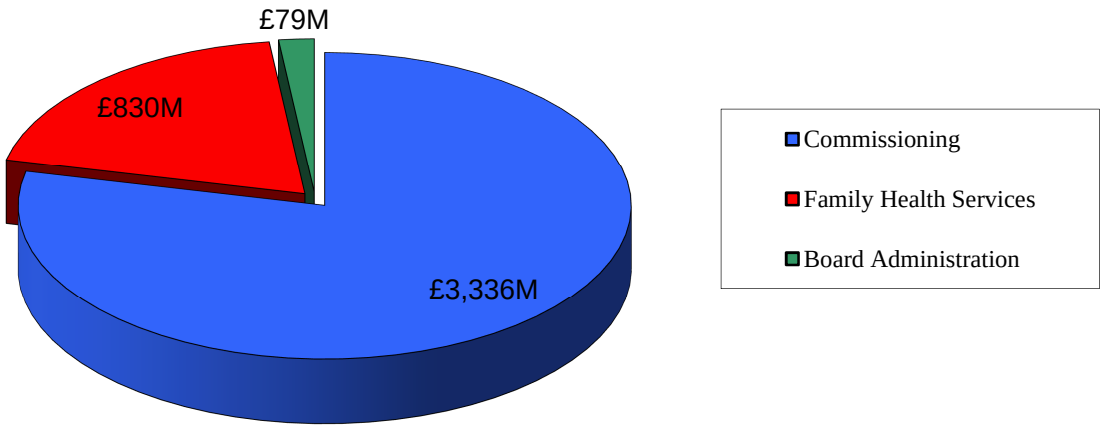
Outlook

The outlook for 2015/16 continues to be stark with the financial pressure experienced in 2014/15 continuing to grow in 2015/16 and outstrip additional available funding. This will impact on the HSCB's desire to commission new beneficial Health and Social Care (HSC) services and will require HSC organisations to deliver further substantial and challenging efficiency and productivity savings, in order for the available resources to be utilised as effectively as possible.

Health and Social Care Board Expenditure 2014/15

The Board's expenditure (gross) falls into three main areas as seen below:

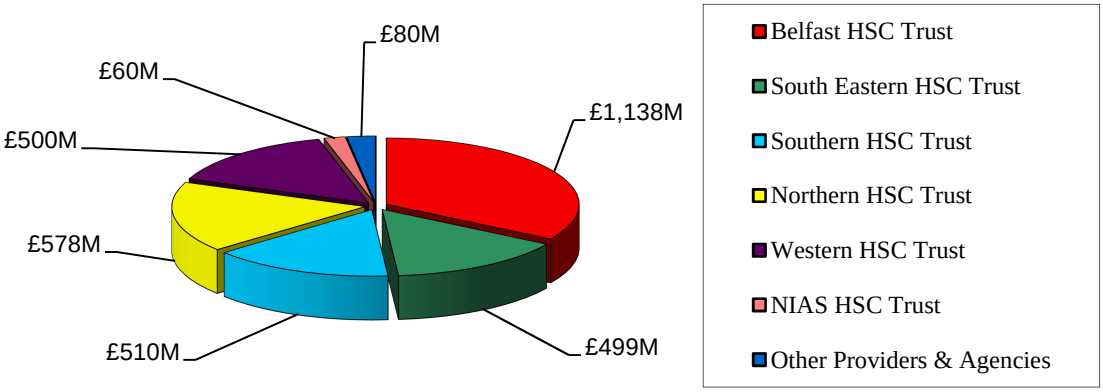
HSCB Gross Expenditure 2014/15



Commissioning

The Board commissions most of its services from local Trusts with a small amount being delivered by other providers. The gross commissioning expenditure of the HSCB is analysed below:

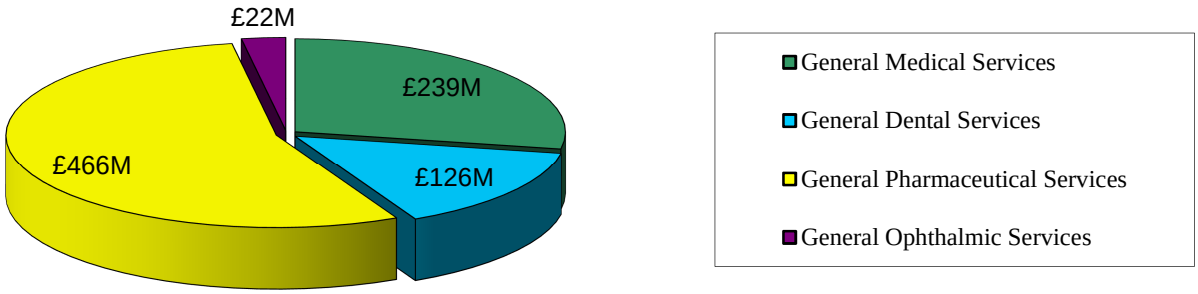
Commissioning Gross Expenditure 2014/15



Family Health Services

The Health and Social Care Board spent £853m (gross) on Family Health Services in 2014/15 to meet the health and social care needs of local populations. The breakdown by service area is shown below.

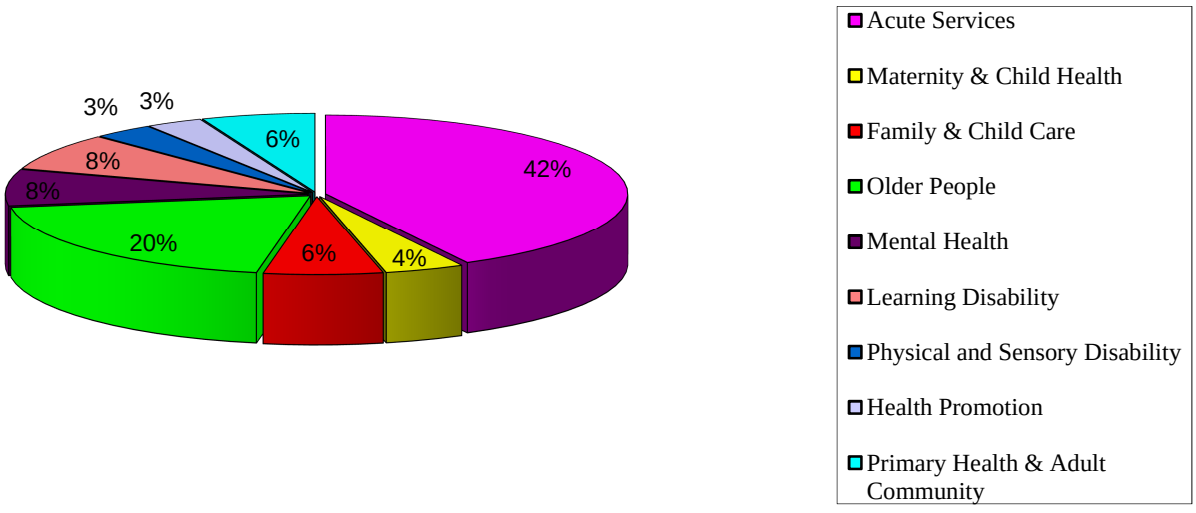
FHS Gross Expenditure 2014/15



Programmes of Care

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

Programmes of Care 2014/15

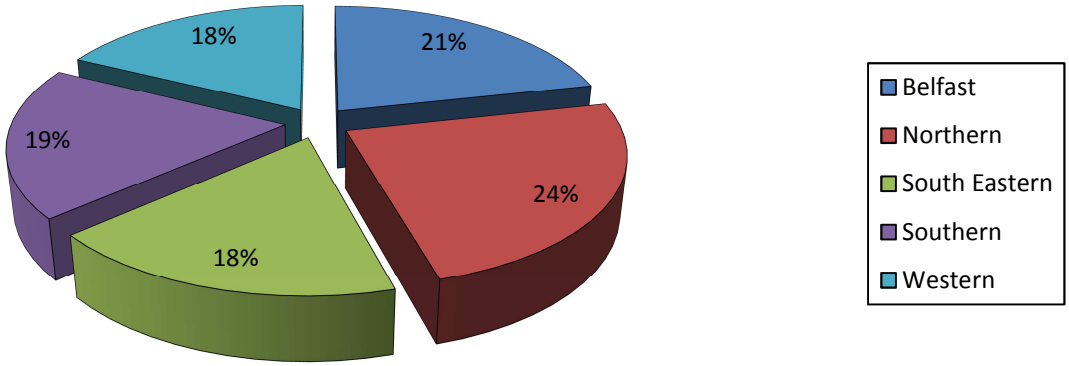


Source of data Strategic Resource Framework 2014/15

Local Commissioning Group Expenditure

Health and Social Care is commissioned across five locality areas. Each area has its own Local Commissioning Group and the analysis of the budget is set out in the chart below:

Local Commissioning Group Expenditure 2014/15



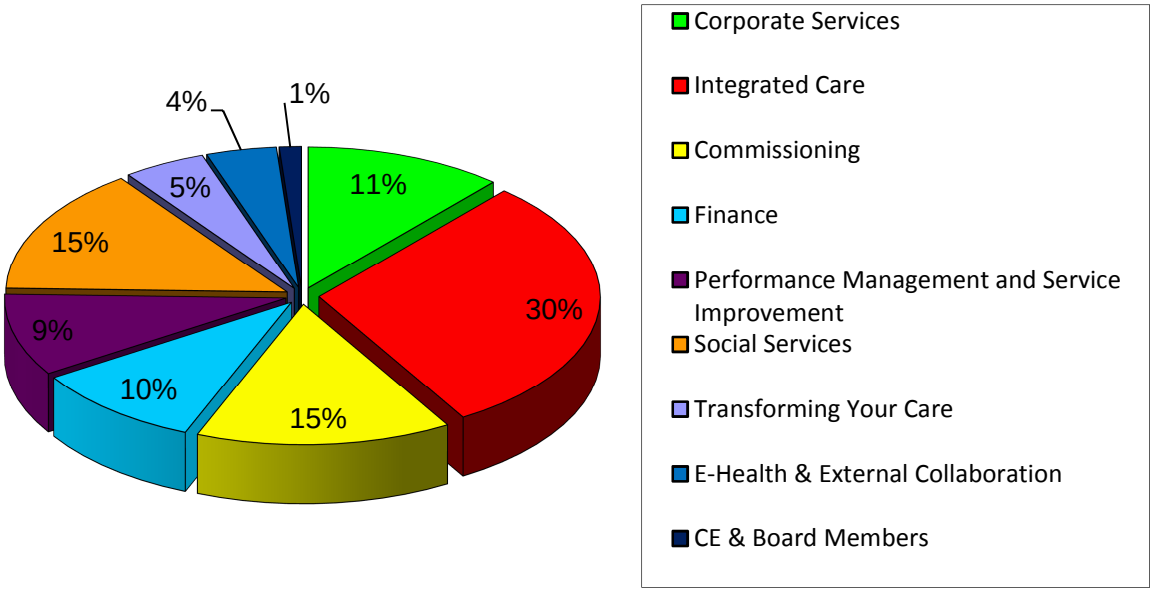
Source of data Strategic Resource Framework 2014/15

Health and Social Care Board Management Costs

At the centre of the Health and Social Care Board are the staff who manage the delivery of these high quality services. During 2014/15 the HSCB created efficiencies of £0.9m which was retracted by the DHSSPS towards closing the gap on the HSC financial plan. Going forward into 2015/16 the HSCB faces the difficult challenge of releasing £5.4m of its management and administrative budget.

The percentage breakdown by Directorate of the Health and Social Care Board's staff costs and goods and services for 2014/15 is shown below:

HSCB Management costs 2014/15



Reports from the Board's Committees

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

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

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

Report of the Board's Reference Committee

Within the 2014/15 year, the Reference Committee met on four occasions. Since its establishment in 2009, the Committee has considered 27 cases and concluded 16.

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

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

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

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

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

Mr Brendan McKeever
Chair of the Board Reference Committee

Membership of the Reference Committee:
Mr Brendan McKeever, Chair
Dr Melissa McCullough, Non-Executive Director
Mrs Fionnuala McAndrew OBE, Executive Director/Director of Social Care and Children's Services

In attendance:
Dr Sloan Harper, Director of Integrated Care - professional advice

Report of the Board's Governance Committee

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

In addition, the Board's Senior Management Team is in attendance at all meetings of the Governance Committee. During the 2014/15 financial year, the Governance Committee met on four occasions: 3 April 2014; 5 June 2014; 25 September 2014 and 29 January 2015. In addition to these scheduled Committee meetings, a joint meeting of the Audit and Governance Committees was held on 9 October 2014 to consider the Mid-Year Assurance Statement.

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

- Management of corporate risk
- Quality, safety and standards in health and social care
- Social Care Delegated Statutory Functions Controls assurance and internal control
- Serious adverse incident management
- Complaints management
- Litigation management
- Maintenance of the reputation, image and integrity of the Health and Social Care Board
- Professional regulation
- Information governance

During 2014/15, the Committee considered a range of important issues, including the Board's Corporate Risk Register, the year-end Governance Statement, the mid-year Assurance Statement, Learning Reports from Serious Adverse Incidents (SAIs), the Business Continuity Plan, relevant Regulation and Quality Improvement Authority (RQIA) reports, General Dental Services Governance Reports, Safety and Quality Alerts and reviewed the implementation of NICE guidance.

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

Dr Robert Thompson (Chair)
Governance Committee

Report of the Board's Audit Committee

Within the 2014/15 financial year, six 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 annually assesses itself against the 5 good practice principles published in the Audit and Risk Assurance Committee Handbook (NI), published by Department of Finance and Personnel in March 2014, and can demonstrate adherence to these principles covering:

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

During 2014/15 the Audit Committee advised the Board and Accounting Officer on the following:

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

Current membership of the Audit Committee:

Mrs Stephanie Lowry (Chair)
Dr Robert Thompson
Mr Robert Gilmore
Mr John Mone

In addition, the Board's Director of Finance attends all meetings along with the Internal and External Auditors. Once approved by the Committee, minutes of the Audit Committee meetings are brought to the attention of the full Board at the subsequent public Board meeting.

Mrs Stephanie Lowry
Chair of the Audit Committee

Report of the Pharmacy Practices Committee

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

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

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

The audio-visual trial was extended into 2014/15 following limited uptake in 2013/14 and there has been only one applicant availing of this facility in the current year. It is intended to carry out an evaluation around year end to determine if this facility will be provided on an on-going basis to persons attending PPC.

The Board decides upon minor and temporary relocations.

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

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

During the year 2014/15, the Pharmacy Practices Committee dealt with the following applications:

Full applications: 5 (5 refused)
Oxygen applications: 0
Change of hours: 2 (2 approved)

Mr John Mone
Chair of the Pharmacy Practices Committee

Remuneration Report

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

While the salary structure and the terms and conditions of service for Senior Executives is determined by the Department of Health Social Services and Public Safety (DHSSPS), the Remuneration and Terms of Service Committee has a key role in assessing the performance of Senior Executives and, where permitted by DHSSPS, agreeing the discretionary level of performance related pay. A circular on the 2014/15 Senior Executive pay award has not been received from the DHSSPS, therefore related payments have not been made to Executive Directors.

The salary, pension entitlement and the value of any taxable benefits in kind paid to both Executive and Non-Executive Directors is set out overleaf. None of the Executive or Non-Executive Directors of the HSCB received any bonus or performance related pay in 2014/15. 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.

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 2014/15 there were no such 'off-payroll' engagements.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to Senior Executives during 2014/15.

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

Senior Management Remuneration (Table Audited)

The salary, pension entitlements, and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows:

	2014/15				2013/14			
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**
Non-Executive Members								
I Clements	30-35	400	-	30-35	30-35	400	-	30-35
S J Leach	5-10	200	-	5-10	5-10	200	-	5-10
M McCullough	5-10	0	-	5-10	5-10	0	-	5-10
R Gilmore	5-10	200	-	5-10	5-10	300	-	5-10
B McKeever	5-10	500	-	5-10	5-10	300	-	5-10
J Mone	5-10	300	-	5-10	5-10	600	-	5-10
W R Thompson	5-10	0	-	5-10	5-10	0	-	5-10
Stephanie Lowry (Started 15/04/13)	5-10	100	-	5-10	5-10	0	-	5-10
Executive Members								
V Watts (Appointed 01/07/14) (1)	115-120	200	-	115-120	-	-	-	-
F McAndrew (Acting Chief Executive 01/04/14 -30/06/14)	90-95	500	49,000	140-145	80-85	400	6,000	90-95
P Cummings (Seconded to NHSCT 22/05/13 – 31/05/14) (2)	90-95	400	27,000	115-120	15-20	300	-	15-20
Owen Harkin (Acting Director of Finance from 22/05/13 until 31/05/14) (3)	10-15	300	-	10-15	75-80	1,600	-	75-80
S Harper	115-120	500	29,000	145-150	115-120	500	(1,000)	115-120
D Sullivan	105-110	600	38,000	145-150	100-105	500	6,000	110-115
M Bloomfield (Head of Corporate Services & Acting Director of PMSI since 19/11/12)	90-95	300	10,000	100-105	85-90	300	63,000	150-155
P McCreedy	75-80	0	18,000	90-95	70-75	0	22,000	95-100
Sean Donaghy (Commenced 13/05/13)	125-130	400	30,000	155-160	110-115	500	5,000	115-120
J Compton (Left 31/03/14)	-	-	-	-	145-150	100	0	145-150

For notes (1-4) relating to Senior Management Remuneration please see notes below Pensions of Senior Management below.

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 2013/14.

	2015	2014
Highest Earner's Total Remuneration (band in £'000) (a)	150-155	145-150
Median Salary (£)	34,530	31,768
Median Total Remuneration Ratio	**4.4**	**4.6**

(a) This value is the annualised total remuneration of the highest paid director.

Pensions of Senior Management (Table Audited)

	2014/15				
Name	**Real increase in pension and related lump sum at age 60 £000s**	**Total accrued pension at age 60 and related lump sum £000s**	**CETV at 31/03/14 £000s**	**CETV at 31/03/15 £000s**	**Real increase in CETV £000s**
Executive Members					
V Watts appointed 01/07/14	-	-	-	-	-
F McAndrew (Acting Chief Executive 01/04/14 - 30/06/14)	2.5-5 pension 5-10 lump sum	20-25 pension 65-70 lump sum	430	508	62
P Cummings (Seconded to NHSCT 22/05/13 – 31/05/14)	0-2.5 pension 5-10 lump sum	40-45 pension 125-130 lump sum	753	816	38
O Harkin (Acting Director of Finance until 31/05/14) (3)	-	-	-	-	-
S Harper (4a)	0-2.5 pension 5-10 lump sum	45-50 pension 140-145 lump sum	904	975	41
D Sullivan	2.5-5 pension	45-50 pension	494	539	31
M Bloomfield (Head of Corporate Services & Acting Director of PMSI since 19/11/12)	0-2.5 pension 2.5-5 lump sum	30-35 pension 90-95 lump sum	484	516	16
P McCreedy	0-2.5 pension	5-10 pension	59	74	14
Sean Donaghy (Commenced 13/05/13) (4b)	0-2.5 pension 5-10 lump sum	40-45 pension 125-130 lump sum	790	859	43

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.

(1) Pension benefits relate to a calculation based on the real increase in pension over a year. Therefore this is not available as the postholder does not have a full year's service in 2014/15.

(2) No pension benefit shown in prior year as these are annual calculations, postholder was employed by NHSCT at 31/03/14.

(3) This was a temporary acting up post, therefore the annual calculation of pension benefit would not be applicable and as postholder was not in post at 31/03/15 no calculations are available for Real Increase of CETV for 2014/15.

(4) CETV at 31/03/14 has been adjusted by Pensions branch from:
   (a) 884 to 904
   (b) 793 to 790.

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

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

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

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

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

Valerie Watts

Mrs Valerie Watts
Chief Executive

11/6/2015

Date

Public Sector Payment Policy – Measure of Compliance

The Department requires that the Health and Social Care Board pay their Non Health and Social Care trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The HSCB's payment policy is consistent with the Better Payments Practice Code and Government Accounting Rules, its measure of compliance can be found within note 15 of the Annual Accounts within this combined document.

Related Party Transactions

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

Mr Sheelin McKeagney (Chairman of the Southern LCG) is a Board Member of Community Development & Health Network, which may be likely to do business with the HSC in future.

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

Register of Interests

The Health and Social Care Board Register of Interests records formal declarations of interests, including details of all Directorships by Executive and Non-Executive Directors and Local Commissioning Group Chairs. A Register of Interests is in place for each of the five Local Commissioning Groups. These Registers are posted on the Board's website and a copy available at each public Board or Local Commissioning Group meeting. A Register of Interests has also been established and maintained in respect of the Pharmacy Practices Committee which includes persons who are not members of the Health and Social Care Board. The Registers are updated throughout the year with an annual review undertaken to ensure that any changes to interests declared during the preceding twelve months are incorporated. A copy is available on the Board's website www.hscb.hscni.net

Charitable Donations

The Health and Social Care Board did not make any charitable donations during the financial year.

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 cost of the audit for the year ended 31 March 2015 was £53,173. An additional amount of £1,173 was paid to the Audit Office in respect of work carried out on the National Fraud Initiative.

Audit Disclosure

The Accounting Officer and directors are not aware of any relevant audit information of which the auditor has not been made aware. The Accounting Officer has taken all necessary steps to ensure that all relevant audit information of which she is aware has been passed to the external auditors.

Staff Numbers

The Annual Accounts for the year ended 31st March 2015 are contained within this combined document. Please refer to note 3 for details of staff numbers which shows an increase in the average Whole Time Equivalent (WTE) of 35. This average increase relates to the full year impact of Transforming Your Care recruitment in 2013/14. The real WTE increase is 15, of which the majority related to new Social Care Initiatives funded by the DHSSPS during 2014/15.

Pension Liabilities

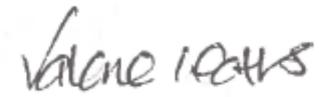
Information may be found within notes to the accounts within this combined document.

Governance Statement

The Governance Statement can be found in full within this combined document.

Preparation of Accounts

The Health and Social Care Board has prepared a set of accounts for the year ended 31 March 2015 and these can be found within this combined document.



Ms Valerie Watts
Chief Executive

Date

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

Chairman, Dr Ian Clements
Dr Clements lives in Newtownards, where he had practised as a GP for 27 years. Throughout his GP career, Dr Clements has continually sought to improve health and care services for patients through his involvement in the commissioning process. He also contributed his expertise as a doctor over many years, to a wide array of leading health and care organisations.

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

Mr Robert Gilmore OBE, Non-Executive Director
Mr Gilmore lives in County Down and is a Public Sector Advisor and former Local Authority Chief Executive. He is Non-Executive Director of a Local Enterprise Agency and an Associate with SOLACE Enterprises.

Mr Stephen Leach CB, Non-Executive Director
Mr Leach lives in North Down. He is a retired senior civil servant and was Chair of the Northern Ireland Criminal Justice Board from 2000 – 2009. He was appointed as a Parole Commissioner in November 2009 and is a lay member of the National Security Certificate Appeals Tribunal for Northern Ireland.

Mrs Stephanie Lowry, Non-Executive Director
Mrs Lowry has 20 years' experience working in both the private and public sector throughout her career. She has held several public appointments in a variety of areas, including Independent Board Member with the Department of Culture, Arts and Leisure, deputy Chair of the Health and Safety Executive and is currently a member of the Office of the First Minister and Deputy First Minister (OFMFDM) Audit Committee and an Independent Assessor for Public Appointments.

Dr Melissa McCullough, Non-Executive Director
Dr McCullough lives in Belfast and is a Lecturer in the School of Medicine, Centre for Medical Education in Medical Ethics and Law at Queen's University, Belfast. She is a Lay Member of the Clinical Ethics Committee, Belfast Trust and a Member of Research Ethics Committee, Queen's School of Medicine, Dentistry and Biomedical Science and works with local voluntary bodies.

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

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

Dr Robert Thompson, Non-Executive Director
Dr Thompson lives near Craigavon. 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.

Director of Finance, Paul Cummings
Paul Cummings is Director of Finance, HSCB. 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. From May 2013 to May 2014 Paul was seconded to the position of Accountable Office in the Northern Health and Social Care Trust. He is also a board member of Sport Northern Ireland.

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

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

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

Glossary of Terms

Bamford Report – a major study commissioned by the Department of Health, Social Services and Public Safety in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

BSO – Business Services Organisation

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

DEXA scan - a DEXA scan is a special type of X-ray that measures bone density and is most commonly used to diagnose osteoporosis.

DHSSPS – Department of Health, Social Services and Public Safety

ECG - electrocardiogram

ED – Emergency Department

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

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

GP – General Practitioner

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

HRPTS – Human Resources, Payroll, Travel and Subsistence

HSC – Health and Social Care

IMROC - Implementing Recovery through Organisational Change

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

ICATS – Integrated Clinical Assessment and Treatment Services

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

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

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

MRI – Magnetic Resonance Imaging

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

NIAS – Northern Ireland Ambulance Service

NIASP - Northern Ireland Adult Safeguarding Partnership

NISAT - Northern Ireland Single Assessment Tool

OFMDFM - Office of the First Minister and Deputy First Minister

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

PHA – Public Health Agency

PPI – Patient and public involvement

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

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

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

RQIA - Regulation and Quality Improvement Authority

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

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

TYC – Transforming Your Care

PCI – Percutaneous Coronary Intervention

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2015

HEALTH AND SOCIAL CARE BOARD

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

FOREWORD

These accounts for the year ended 31 March 2015 have been prepared in a form determined by the Department of Health, Social Services and Public Safety (DHSSPS) based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health, Social Services and Public Safety has directed the Health & 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 & Social Care Board, of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.

- make judgements and estimates on a reasonable basis.

- state whether applicable accounting standards as set out in FReM have been followed, and disclose and explain any material departures in the financial statements.

- prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Health & 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 & Social Care Board.

- pursue and demonstrate value for money in the services the Health & Social Care Board provides and in its use of public assets and the resources it controls.

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

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 113 to 152) 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 & Social Care Board and with the accounting standards and policies for HSC bodies approved by the DHSSPS.

Paul Cummings

Paul Cummings
Director of Finance

Date 11th June 2015

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 113 to 152) as prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Ian Clements
Chairman

11th June 2015

Date

Valerie Watts
Chief Executive

11/6/2015

Date

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 2015 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 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 the 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 2015 and of the net expenditure, cash flows and changes in taxpayers' equity 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, Social Services and Public Safety directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Department of Health, Social Services and Public Safety directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and
- the information given in the Annual 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 part of the Remuneration 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 and Personnel's guidance.

Report

I have no observations to make on these financial statements.

KJ Donnelly

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

2 June 2015

HEALTH AND SOCIAL CARE BOARD
ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015
GOVERNANCE STATEMENT

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015
GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

Processes in place by which the HSCB works with partner organisations

- Public Health Agency (PHA)

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

- Business Services Organisation (BSO)

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

- Health and Social Care (HSC) Trusts

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

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

Inter-relationship with DHSSPS and HSCB

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

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

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

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

2. Compliance with Corporate Governance Best Practice

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

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

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

During the year there were six conflicts of interests declared at Board meetings: three on 13 November 2014 and three on 11 December 2014. On review of the minutes, appropriate action was taken in accordance with the Code of Conduct. 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 a Register of Interests for the following groups:

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

- Committee Members: There is a Register of Interests for each of the five LCGs which are also subject to annual review and if relevant throughout the year. These are noted at public LCG meetings and also published on HSCB website.

- There is a Register of Interests for those involved in Board Committees who are not HSCB Officers and relates solely to those who participate in the Pharmacy Practices Committee. This Register is also reviewed annually.

- Staff: A Register of Interests for all HSCB staff was established in March 2015. This will be reviewed annually.

Gifts and Hospitality Policy
The HSCB Gifts and Hospitality Policy was published in April 2012 and is compliant with HSS (F) 49/2009, HSS (F) 35/2009 and FD (DFP) 19/09. A nominated Officer in each HSCB Directorate maintains a log with a periodic report reviewed by the Governance Committee. During the reporting year, the Committee received one report at its meeting on 25th September 2014.

Performance Appraisal System
During 2014/15, Performance Appraisals were completed and Performance Development Plans agreed for 88.4% of staff. In addition, the DHSSPS carried out its annual appraisal with the HSCB Chair who, in turn, carried out an annual assessment of each Non-Executive Director.

A formal annual assessment of LCG Chairs was not undertaken during 2014/15 because of the on-going process to recruit four LCG Chair posts. Interim Chairs have been in place since 1 April 2015 and will remain so until substantive chairs have been appointed.

Training
As the "Essential Skills" refresher training which was undertaken in 2013 is valid for three years, no further training was provided during the period under review.

Self Assessment
- The Audit Committee completes a National Audit Office self-assessment checklist each year which is submitted to DHSSPS (February 2014).

- A Board Governance Self-Assessment Tool was approved by the Board at its meeting on 10 April 2014 and subsequently submitted to the DHSSPS on 15 April 2014.

  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 2013/14 self-assessment evaluation included one mandatory case study to demonstrate the impact the Board is having on its organisation, clients, other organisations, patients, carers and the public.

  The HSC Board is currently completing a Governance Self-Assessment Tool in respect of the 2014/15 financial year.

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through its Governance Framework, which includes:

- A schedule of matters reserved for Board decisions, some of which may have been delegated to Committees.

- A scheme of delegation, which devolved decision making authority within set parameters to the Chief Executive and other officers.

- Standing Orders and Standing Financial Instructions, which set out the HSCB's governance regulations (referred to above).

- The operation of a Governance Committee and an Audit Committee (comprised of Non-Executive Directors) to assure adherence to those regulations (as above).

- The adoption of a Governance Framework which consists of a suite of documents that provides the Board with the necessary assurances that the organisation is discharging its functions in a way which ensures that risks are managed as effectively and efficiently as possible to acceptable standards of quality.

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

The current Framework was revised and approved by the Governance Committee at its meeting on 29 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 paragraphs describe in more detail the role of the Board, its Committee structure and attendance during the reporting year.

The Board

The Board of Directors is comprised of a Non-Executive Chair, seven Non-Executive Directors, the Chief Executive and four Executive Directors.

The Chief Executive and the Executive Directors, Director of Finance, Director of Commissioning, Director of Social Care and Children's and Director of Performance Management and Service Improvement are employees of the HSCB. A number of Directors from the Board's Senior Management Team also attend Board meetings including the Director of Integrated Care, the Regional Director of eHealth and External Collaboration, the Director of Transforming Your Care, the Director of Corporate Services, the Executive Medical Director/Director of Public Health (PHA), and the Director of Nursing and Allied Health Professionals (PHA).

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

The HSCB has three main functions:

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

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In the 2014/15 year, the Board met on 11 occasions and, in accordance with the Board's Standing Orders, was quorate for each meeting. During this period there was 100% attendance at one meeting; 93% attendance at six meetings; 86% at one meeting and; 80% at two meetings during the period under review. There were no Special Board meetings held during this period.

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

- The appointment of the Chief Executive on 1 July 2014.
- The Director of Finance returned from secondment to the Northern Trust on 1 June 2014.
- The continued secondment of the Director of Performance Management and Service Improvement, an Executive Director, as Programme Director for the development of a Clinical Leadership programme within Health and Social Care Northern Ireland.
- The Head of Corporate Services continued as Acting Executive Director of Performance Management and Service Improvement during this year.

Role of the Audit Committee

The DHSSPS has the right to be represented at any meeting of the Audit Committee. The Department's policy is to be represented at one meeting per year, and a DHSSPS observer attended the Committee meeting on 5 June 2014. The Audit Committee comprises four Non-Executive Directors. The Director of Finance has a standing invitation to attend, with the exception of the annual meeting with the External and Internal Auditors, and the Committee is also attended by other relevant Finance and Internal Audit staff. The External Auditor is invited to attend any meeting of the Committee.

The Terms of Reference of the Audit Committee are in accordance with the Good Practice Principles contained within the Audit and Risk Assurance Committee Handbook NI (March 2014) and are kept under review in light of any emerging or changing accountability arrangements for the HSCB. The Code of Conduct and Code of Accountability for Board Members of HSC Bodies (July 2012) which 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 2014/15 financial year, six meetings of the Audit Committee were held and attendance by members was 100%. A joint meeting with the Governance Committee took place to consider the mid-year Assurance Statement. A Non-Executive Member replaced the incumbent Chair and the appointment was formally reported to the Board at its meeting on 12 June 2014.

The Chair stood down from the Committee at the Board meeting on 12 June 2014 and a new Chair was appointed from the existing membership to ensure continuity. In addition, a new Non-Executive Director was appointed to membership on 12 June 2014.

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

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

The Audit Committee assessed itself against the five good practice principles published in the Audit and Risk Assurance Committee Handbook (NI), published by Department of Finance and Personnel in March 2014, and can demonstrate adherence to these principles covering:

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

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. This includes reviewing Board officers' responses and actions in relation to regional procedures in respect of the management and follow up of serious adverse incidents and complaints where the HSCB has a regional responsibility.
- Seeking assurances and advising the Board on protocols in respect of the HSCB's social care statutory responsibilities.

In the 2014/15 year the Governance Committee met on four occasions: 100% attendance at three meetings and 75% attendance at one meeting. A Non-Executive Member replaced the incumbent Chair and the appointment was formally reported to the Board at its meeting on 12 June 2014.

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During the year the Governance Committee considered the following:

- Management of corporate risk.
- Quality, safety and standards in health and social care.
- Progress on implementation of Safety and Quality Alerts and RQIA recommendations.
- Social Care Delegated Statutory Functions.
- Controls assurance and internal control.
- Serious Adverse Incident management.
- Complaints management.
- Identification of Regional Learning from (Serious Adverse Incidents) SAIs and Complaints.
- Litigation management.
- Maintenance of the reputation, image and integrity of the HSCB.
- Professional regulation.
- Information governance.
- Other matters, excluding finance that pertains to good corporate governance.

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

- The operation of an ***Assessment Panel,*** to consider and determine, where the Board has rejected a closure notice, whether a General Medical Services contractor should be permitted to close his list of patients, and if so, the terms on which he should be permitted to do so and to consider where the Board wishes to assign new patients to contractors which have closed their lists of patients. The Assessment Panel has not been required to meet during the 2014/15 year.

- The ***Disciplinary Committee*** was not required to meet during the period under review. In November 2014, the Health and Social Care (Disciplinary Procedures) Regulations (Northern Ireland) 2014 were issued. Whilst there is no requirement to do so, the Board at its meeting on 12th February 2015, agreed to establish a Disciplinary Committee and a targeted consultation on the constitution of the proposed Committee is underway.

- The operation of a ***Governance Officers Group***. This is a multi-disciplinary team who are accountable to the HSCB Senior Management Team for the operational implementation of governance activities across the HSCB. One of the functions of this group is to consider and agree any issues that require to be brought to the attention of the Governance Committee.

- The operation of five ***Local Commissioning Groups*** to exercise the Board's functions under Section 9 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. In accordance with HSCB Standing Orders, LCGs have met at least nine times during 2014/15 and all meetings were quorate.

- The operation of a ***Pharmacy Practices Committee*** to exercise the functions of the Board under Regulation 6 (9) the Pharmaceutical Regulations (NI) 1997 on behalf of the Board and in accordance with Schedule 4 of the same Regulations. The Pharmacy Practices Committee held five meetings during 2014/15 and has been quorate on each occasion.

- The operation of a ***Reference Committee*** to exercise the HSCB's function under the Disciplinary Procedures Regulations (NI) 1996 with respect to the referral of disciplinary matters relating to Family Practitioner Services. During the year April 2014 to November 2014, the Reference Committee held three meetings and was quorate on each occasion.

  The Health and Personal Social Services (Disciplinary Procedures) Regulations (Northern Ireland) 1996 were revoked by the Health and Personal Social Services (Disciplinary Procedures) Regulations (Northern Ireland) 2014 which were issued in November 2014. These provide for the investigation and determination of questions about whether a chemist, dentist, ophthalmic medical practitioner and opticians have failed to comply with their terms of service but do not apply to General Medical Practitioners. The Board, at its meeting on 12 February 2015, approved an extension to the Terms of Reference of the Reference Committee in order to comply with the Regulations, and in conjunction with a newly established Disciplinary Committee. A further meeting of the Reference Committee took place on 31 March 2015 which was quorate.

- The operation of a ***Remuneration and Terms of Service Committee*** (also comprised of Non-Executive Directors) to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives and Consultants within Departmental policy. In accordance with HSCB Standing Orders, the Remuneration and Terms of Service Committee met on one occasion and was quorate.

- The operation of a ***Review Panel*** to conduct oral hearings in relation to removal from the Primary Medical Performers List other than in circumstances where the HSCB is obliged to remove a performer's name or in relation to suspension of a performance or in review proceedings. The Review Panel has met on one occasion during the period under review and was quorate.

- A meeting of the ***Joint Audit and Governance Committee*** is convened to consider and approve the Board's Mid-Year Assurance Statement enabling the Chief Executive, as Accountable Officer for the HSCB, to attest to the continuing robustness of the organisation's system of internal control. The Audit & Governance Committees have met on one occasion during the reporting year.

The Board Governance Self-Assessment, which was also independently verified during the reporting period, reflected that the Board and it's Committees conduct business in accordance with best practice. The Terms of Reference of each Committee is kept under review throughout the year.

4. Framework for Business Planning and Risk Management

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

Business Planning

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

Commissioning Plan

In line with the above statute, the Board is required to prepare and publish an Annual Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery. The preparation of the Commissioning Plan is done in partnership with the PHA and is implemented through a series of integrated service teams. It takes full account of the financial parameters set by the Executive and the DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Plan Direction. It encompasses the system of reform and modernisation, to ensure that the Board, as the Commissioner of health and social care services is able to meet the increased demand, make the best use of the resources available, and adapts to changing expectations and ways of delivering care.

Corporate Plan

Many of the Board's objectives and responsibilities for the year to 2015/16 are reflected in the Commissioning Plan. The Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery.

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

The key objectives for the focal year 2014/15 have been subject to bi-annual review. The first of these reviews was carried out as at 30 September 2014 and was approved by the Governance Committee at its meeting on 29 January 2015. The second of these reviews was carried out as at 31 March 2015 and will be approved by SMT prior to being approved by the Governance Committee at its meeting on 4 June 2015.

The business requirements specified by the DHSSPS to be delivered by the HSCB during 2014/15 were included as an Annex to the 2014/15 Corporate Plan. Progress on these has been monitored in line with the above bi-annual reviews.

In planning for 2015/16, the HSCB held a corporate planning workshop on 14 November 2014, which was attended by approximately 100 staff representing all levels of the organisation, directorates and locations from the HSCB. The event was also supported with relevant staff from the PHA. The purpose of the workshop was to provide:

- Recognition of what has been achieved over the last 12 months across all directorates;
- An overview of the corporate planning process and commissioning context, in order to help develop key priorities/objectives for 2015/16 and to highlight any refinements to the five corporate themes.

In taking forward key objectives during 2015/16, the HSCB will:

- Continue to work closely with our colleagues in the PHA; so learning from incidents, complaints and patient experience, as well as regional and national reports, is disseminated

and acted upon to continually strive to improve the quality and safety of the services so valued by the local population.

- Continue to ensure effective user engagement by implementing its Personal and Public Involvement (PPI) strategy.
- Continue to promote equality and diversity in all its functions, and will reflect the duties placed on it to implement Human Rights legislation and the relevant conventions, and to make more explicit how commissioning decisions support these duties.
- In conjunction with PHA colleagues, fully contribute to the implementation of regional policies and initiatives including Quality 2020 and the new 'Making Life Better' strategy.

Business Continuity Plan

The Board Corporate Business Continuity Management System (Policy and Plan) has been reviewed and revised to align to the requirements of the International Standards Organisation (ISO) 22301. The Plan identifies the HSCB functions deemed as 'critical', which must continue to be delivered during an interruption to normal business. Each directorate undertook a risk analysis and developed strategies and tactics to detail how the critical functions would be delivered during an interruption. The Plan is available on the HSCB intranet site, along with guidance for staff. Directorate specific Business Continuity Plans will be developed during 2015/16 which will identify and prioritise other key areas of work which require to be delivered should an interruption to normal business become more projected. The Plan has been validated through a desktop test in March 2015.

It was acknowledged that SMT were aware of arrangements to decant staff and of the Corporate decant facility at NIAS Headquarters. It was also apparent that staff were aware of their own business/contingency arrangements. However, a number of areas for improvement were identified, for example, an agreed and consistent approach in terms of staff evacuating and relocating, as well as regular updating and testing of the 'cascade' communication arrangements within directorates.

Risk Management

The HSCB recognise risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible. Therefore, the HSCB has in place incident reporting and information systems that play a vital role in identifying and managing risk.

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

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

An e-learning risk management awareness programme has been developed within the HSCB and is mandatory for all HSCB staff. Training in this programme is also incorporated in the overarching corporate induction programme which has been rolled out during 2014/15.

Risk Appetite

- Categorisation of Risk

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

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

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

- Acceptable Risk

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

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

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

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

- Risk Activity

As part of the Board led system of risk management, the Corporate Risk Register is presented to the Governance Committee for discussion and approval at each of its meetings and annually to the Board. The Board is also informed of significant risks by way of the annual Governance and Mid-Year Assurance statements.

Quarterly reviews for 2014/15 have now been completed for both directorate and corporate registers. Each review reflects 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.

Directorate risk workshops have taken place during quarters three and four of 2014/15 and provided an opportunity to discuss the revised Governance Framework and HSC Risk Matrix, action the recommendations from the Risk Management Audit 2013/14 and provide guidance on completing Risk Register reviews. The workshops provided Directorate governance leads and senior staff an opportunity to complete a more in depth review of their Directorate and the Corporate Risk Registers within their scope of responsibility.

<u>Stakeholder Risk</u>

- Serious Adverse Incidents (SAIs)

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

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

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

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

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

- Learning from SAIs

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

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

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

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

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

SAI LEARNING MECHANISMS

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

- Local organisation actions, these are implemented and monitored by individual organisations;

- Formal learning letter – five issued during the 2014/15 year;

- Formal Learning Reminders – four learning reminders have been issued during the 2014/15 year;

- Thematic Reviews – Commissioned by the Regional SAI Sub Review Group and the QSE Group, to review trends, patterns and provide an in-depth analysis. Seven thematic reviews have been carried out during 2014 with key learning points being disseminated across the HSC;

- Learning Matters Newsletter – HSCB and PHA has developed a regular newsletter to ensure that local incidents are shared regionally to drive improvements for patients and services across the HSC. The 3rd edition of the newsletter was issued in December 2014;

- The SAI Bi-annual Learning Report provides an overview on all learning letters / thematic reviews carried out and/or reported on during the year of reporting. The latest edition covered the period 1 June to 30 September 2014 and was issued to the wider HSC in December 2014.

- Service User/Family Involvement in SAIs

The SAI Procedure (October 2013) makes clear the need for and importance of, appropriate communication and involvement of service users, relatives and carers. However, in order to ensure a consistent approach is afforded to the level of service user/family engagement across the region the HSCB introduced the following for immediate effect in April 2014:

- revised SAI Notification Form; and

- developed a SAI Investigation Report Checklist which should accompany all SAI Investigation Reports regardless of the investigation level. The checklist also contains a section in relation to those SAIs that have been notified to the Coroner (*where there is a requirement to do so*).

In addition, and in line with DHSSPS communication, the HSCB and PHA have worked with the Patient Client Council, RQIA, and Trust Governance Leads to develop guidance for HSC organisations when involving service users/families throughout the relevant stages of the SAI process.

The purpose of the guidance (issued in February 2015) is to ensure that communication with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner; thereby promoting a culture that effectively leads to improved service user and

staff acceptance of the event. The guidance should be read in conjunction with the revised SAI Procedure in order ensure the engagement process is closely aligned to the required timescales, documentation, investigation levels etc.

The current SAI procedure will be reviewed in light of the recommendations made within the Donaldson Report, *'The Right Time, The Right Place'*, after the consultation process on the report has been completed.

- Complaints

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

In June 2014, the Board, working collaboratively with the HSC Trusts and the Patient Client Council led on a Complaints Awareness Campaign to promote the visibility and accessibility of the HSC complaints arrangements. During this month a 'signposting' leaflet, which the Board led on the development of with HSC organisations and services users, was launched and distributed at various 'awareness posts' in public places across Northern Ireland. In addition a HSC Complaints Learning Event also took place in June 2014, which had representation from the Board, the PHA, the HSC Trusts, GP Practices, the Patient Client Council, DHSSPS, community and voluntary groups and service users. The aim of the event was to learn how the process has evolved and embedded since 2009, and to review how organisations learn from complaints and establish change. Service users provided direct input in this very successful learning event which will now be held on an annual basis.

During complaints awareness month (June 2014) a further service user focus group was facilitated by the Board in the Western area.

- Medical Negligence Cases

The Board is responsible for the management of outstanding medical negligence cases which pre-date Trust status (pre-1996). A Preliminary Advisory Group meets regularly to review activity on cases and in particular those listed for hearing during the financial year, which require specific authorities. This Group is attended by the Assistant Director of Legal Services (BSO), Public Health Consultants from the Public Health Agency (PHA), the Complaints/Litigation Manager and a representative from the Finance Directorate. The number of pre-Trust cases being managed have reduced from over 300 in 2009 to just over 80 cases.

- Emergency Preparedness

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

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

The Board, PHA and BSO work collaboratively to continually review and enhance emergency preparedness arrangements. The Emergency Planning Programme Board, chaired jointly by the Director of Public Health, PHA and the Director of Performance and Corporate Services, HSCB oversees the wider Health and Social Care emergency preparedness and the coordination of planning for major events and preparation for adverse events. This year saw Health and Social Care organisations prepare for the Giro D'Italia event during May 2014. Effective planning enabled this event to pass off successfully and without any major impact upon health and social care services, which involved multi-agency working and collaboration.

In addition, the HSCB and PHA have worked collaboratively with the Health and Social Care organisations in planning and preparing for a potential presentation of an Ebola case in Northern Ireland. This has involved having oversight of the development of Trust specific Ebola Preparedness Plans and ensuring mutual co-operation arrangements are in place with the Health Service Executive, Republic of Ireland. In addition, the HSCB and PHA were involved in the multi-agency response to the impact of the Northern Ireland Water industrial action.

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, SMT and the Board's Governance Committee.

An Information Asset Register is maintained and regularly updated. Data flow analysis and risk assessments are completed and reviewed as necessary for all Assets. Treatment plans are produced to highlight and address any identified risks. Identified actions are agreed with Information Asset Owners who in turn provide regular assurance to the Senior Information Risk Owner on progress.

The Accounting Officer and Board receive assurances on information risk via formal reporting mechanisms. The Information Governance Steering Group, chaired by the Senior Information Risk Owner, meets quarterly and receives updates as necessary at each meeting. Quarterly reports to SMT and six monthly reports to the HSCB Governance Committee are provided from the Senior

Information Risk Owner who attends both groups. Further assurances are sought via self-assessment of the Information Management Controls Assurance Standard and by inclusion of Information Governance as part of the rolling Audit Programme.

6. Public Stakeholder Involvement

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

- Recruitment of service users and carers onto Integrated Care Partnerships.
- Involvement of 40 young people in the design and content of new web site for Children and Young Peoples' Strategic Partnership.
- Promoting the needs of looked after children through the active participation of young people and carers of looked after young people in the development of a personal health journal called 'About Me'.
- NI Formulary Pharmacy and Medicines Management public workshops which have shaped the production of a number of patient leaflets aimed at improving medicines safety and compliance, and reducing waste.
- Personalisation – service user and carer input into how services are delivered. Self-directed Support and Direct Payments are the main vehicles to enable this to happen.
- A Service User Recognition Day, attended by service users and carers, which celebrated the valuable contribution made by service users and carers.
- Engagement of service users, patients and staff in relation to TYC reforms.

The HSCB continues to work with the PHA in the delivery of the PPI Joint Strategy, and progressing with the Action Plan of key deliverables for 2014/2015. A Personal and Public Involvement Core Group, chaired by the Director of Social Care and Children and which has representative leads from each Directorate, meets on a monthly basis to ensure these key actions are driven within each directorate.

7. Assurance

Assurance Framework

As part of the overarching Governance Framework, the HSCB has in place an Assurance Framework (the Framework). The Framework, which operates to maintain and help provide reasonable assurance of the effectiveness of controls, has been in place since 2011/12, with bi-annual progress reports to the Board's Senior Management Team in the 2nd and 4th quarters of the financial year. Minutes of Governance Committee meetings are available to further attest to this.

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

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

As part of the bi-annual review as at 31 March 2015 there were a total of 88 assurance functions contained within the HSCB Assurance Framework relating to the following domains:

DOMAIN 1 Corporate Control (CC) the arrangements by which the HSCB directs and controls functions and relates to stakeholders.

DOMAIN 2 Safety and Quality (SQ) the arrangements for ensuring that health and social care services are safe and effective and meet patients' needs.

DOMAIN 3 Finance (FIN) the arrangements for ensuring the financial stability of the HSC, for ensuring value for money and for ensuring that resources allocated by the Minister/Department are deployed fully in achievement of agreed outcomes.

DOMAIN 4 Operational Performance and Service Improvement (OPSI) the arrangements for ensuring the delivery of Government and Ministerial targets and required service improvements.

The review indicated the following, in relation to the 88 assurances:

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

The review was approved by the Senior Management Team on 12 June 2014 for onward referral to the Governance Committee for approval at its meeting on 4 June 2015.

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 in September 2014 and submitted to DHSSPS. HSC Trusts have developed action plans where remedial action was required. The quality of supporting data has continued to improve and together with regular monitoring meetings, ensure that this area is kept under constant review.

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Controls Assurance Standards

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

The HSCB achieved the following levels of compliance for 2014/15.

Standard	DHSS&PS 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)	95%	-
Environmental Cleanliness	75% - 99% (Substantive)	Not Applicable	-
Environment Management	75% - 99% (Substantive)	82%	
Financial Management ***(Core Standard)***	75% - 99% (Substantive)	87%	✓
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)	91%	✓
Health & Safety	75% - 99% (Substantive)	90%	-
Human Resources	75% - 99% (Substantive)	89%	-
Infection Control	75% - 99% (Substantive)	Not Applicable	-
Information Communication Technology	75% - 99% (Substantive)	87%	-
Management of Purchasing	75% - 99% (Substantive)	83%	-
Medical Devices and Equipment Management	75% - 99% (Substantive)	Not Applicable	-
Medicines Management	75% - 99% (Substantive)	Not Applicable	-
Information Management	75% - 99% (Substantive)	82%	-
Research Governance	75% - 99% (Substantive)	Not Applicable	-
Risk Management ***(Core Standard)***	75% - 99% (Substantive)	92%	✓
Security Management	75% - 99% (Substantive)	88%	-
Waste Management	75% - 99% (Substantive)	86%	-

8. Sources of Independent Assurance

The HSCB obtains Independent Assurance from the following sources:

- Internal Audit
- Northern Ireland Audit Office
- External Audit
- Regulation, Quality Improvement Authority
- NCEPOD Reports

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 2014/15 Internal Audit reviewed the following systems:

- Financial Review
- Budgetary Control
- Management of Contracts
- Voluntary Organisations Expenditure and Management of Voluntary Contracts with Community Sector, including Visits to Organisations
- Transforming Your Care
- Statutory Responsibilities
- Extra Contractual Referrals
- Performance Management – Elective Care (Trusts)
- Family Practitioner Services – Management of Pharmacy dispensing incidents and complaints
- Allocations to Trusts
- Risk Management
- Serious Adverse Incidents
- Information Governance
- 2013/14 Out Of Hours Audit Report – review of recommendations*
  (* denotes report not subject to categorisation)

The Allocations to Trusts audit received a substantial level of assurance, the remainder received a satisfactory level of assurance*, with the exception of one element of the FPS audit relating to the management of Community Pharmacy complaints and Transforming Your Care which received a limited level of assurance. The recommendations relating to these reports are highlighted in detail below.

In her annual report the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the HSCB's objectives**.** However, 7 weaknesses in control (priority 1) were identified in the following reports:

- Voluntary Organisations Expenditure and Management of Voluntary Contracts with Community Sector, including Visits to Organisations
- Management of Contracts
- Extra Contractual Referrals

- Family Practitioner Services (FPS) – Management of Pharmacy dispensing incidents and complaints
- Transforming Your Care

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

Voluntary Organisations Expenditure and Management of Voluntary Contracts with Community Sector, including Visits to Organisations

There were 2 priority 1 recommendations made relating to the prompt signing of Service Level Agreements and the recording of activity by partners in a new database. Management accepted these recommendations and are working towards implementation in 2015/16. In addition, one organisation visited received a limited level of assurance and management have followed this up with the organisation concerned.

Management of Contracts

One priority 1 recommendation was made relating to the maintenance of a central contracts database, which management have agreed to progress for the 2015/16 financial year.

Extra Contractual Referrals

A priority 1 recommendation was made in relation to introducing reasonable and cost effective controls to validate the accuracy of charges included from other NHS suppliers. While there are cost, legal and data security issues surrounding the implementation, management have agreed to explore options to improving access to patient treatment information in 2015/16.

Family Practitioner Services (FPS) – Management of Pharmacy dispensing incidents and complaints

Changes to the legislation in regard to enhancing clarity and control over Practitioner complaints, coupled with a review of the current processes, governance and the assurance framework was assessed as a priority 1 recommendation. Management have agreed to work with Community Pharmacy NI and the DHSSPS during 2015/16 to ensure that the overall process is effective.

Transforming Your Care (TYC)

The Internal Auditor made 2 priority 1 recommendations relating to TYC implementation, including the risk of full and timely implementation due to the delay in transitional funding, with recommendations focussing on integration and mainstreaming of TYC within mainstream funding allocations. In addition it was recommended that ICT governance arrangements should be updated to ensure full integration of TYC and performance reports should be consolidated with performance against targets incorporated in monthly highlight reports for all projects.

Management have agreed to continue to ensure reform is embedded in the 2015/16 Commissioning plans and continue to champion the provision of mainstream funds for reforms should they become available. However, this is in the context of the DHSSPS 2015/16 budget. The new e-Health Strategy has been approved which includes the integration of TYC and performance reports were in

development to take into account the recommendations made and these will be available early in 2015/16.

External Audit

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2014, the Comptroller and Auditor General to the NI Assembly gave an unqualified audit opinion on the financial statements and the regularity opinion of the HSCB's accounts, with four priority 1 issues being raised.

In summary the four priority 1 recommendations related to:

- Reliance on third party organisations (BSO)
- Payroll Information provided by BSO
- Shared Service Centre (BSO)
- Supplier amendments to Standing Data (BSO)

In summary, all of these recommendations referred to Shared Services provided to the HSCB under the Service Level Agreement (SLA) held with the Business Services Organisation (BSO). External Audit noted that 'These errors have resulted in additional work for Board staff and for the auditors. While these errors were rectified prior to the draft accounts being prepared, it increases staff workload rather than improving the efficiency of the process.'

The HSCB had been pressing the BSO to set up an appropriate Customer engagement framework to ensure that progress on all issues highlighted in the RTTCWG is made, and a Customer Forum was established with effect from 21st November 2014. This Forum, while in its infancy, has proved beneficial in resolving issues highlighted by both the Internal and External Auditors. In addition, significant progress has been made on the development of the detailed Service Level Agreement for Shared Services and the resultant performance monitoring framework.

While there remain areas for improvement, management consider that progress has been made on all recommendations, which are monitored by the Director of Finance and reported to each meeting of the Audit Committee during 2014/15.

Regulation Quality Improvement Authority

The HSCB/PHA introduced a system via the Safety and Quality Alerts Team (SQAT) during 2013/14 to provide the appropriate assurance mechanism that all HSCB/PHA actions contained within RQIA reports are implemented. All RQIA 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 SQA Team, other existing structures, or bespoke Task and Finish Groups.

This system of assurance takes the form of a six monthly overview report which details the progress on implementation of RQIA recommendations.

The six monthly report for the period ending 31 March 2015 was approved by SMT on 26 May 2014 for onward referral to the Governance Committee for approval on 4 June 2015.

RQIA published the following 14 reports during the period 1 April 2014 – 31 March 2015:

RQIA Report	Date Published	Open/Closed to 6 Monthly overview Report
Final Report on the Inspection of USC in the BHSCT	April 2014	Open
Review of Theatre Practice in Acute Hospitals	June 2014	Open
RQIA Review of the Implementation of NICE CG42 Dementia	June 2014	Open
RQIA Oversight of Patients Finances in Residential Settings Report	June 2014	Open
RQIA Independent Review of Cherry Tree House, Carrickfergus	July 2014	Open
RQIA Report on arrangements for management and co-ordination of unscheduled care in the Belfast Trust and related regional considerations	July 2014	Open
An Independent Review of actions taken in response to HSCB report on Respite Support (Dec 2010) and of the development of future respite care/short break provision in NI	August 2014	Open
Child Sexual Exploitation in Northern Ireland Independent Inquiry	November 2014	Open
Review of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings	December 2014	Open
Review of Discharge Arrangements from Acute	December 2014	Open
Unannounced Inspection of Care Environment – Ulster Hospital	December 2014	Open
Review of the Implementation of the Dental Hospital Inquiry Action Plan (July 2013) Overview Report -	December 2014	Open
Review of Stroke Services in Northern Ireland	December 2014	Open
RQIA Follow Up Inspection of USC in the BHSCT	December 2014	Open

National Confidential Enquiry into Patient Outcome and Death Reports

A similar system has being 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 SQA Team, other existing structures, or bespoke Task and Finish Groups.

The first report which gives the position as of 31 December 2014 was approved by the Governance Committee on 2 April 2015.

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

Interruption of ICT services

The ICT services provided by BSO Information Technology Service to the HSCB suffered from several serious data centre outages over the past five years. The data centres are physically located at the Royal Victoria and Belfast City Hospital complexes, and power issues affecting those sites meant that engineering responses were geared to clinical, rather than IT services.

These outages had an adverse impact on the ability of the HSCB to carry out its day to day business. BSO senior management and the HSCB (in its role as ICT commissioner) have systematically addressed the root causes of the data centre problems at a technical, process, and management level. Capital investment in the data centre infrastructure has greatly improved resilience. Team restructuring, more rigorous testing and change management processes, and more extensive out-of-hours support from BSO internal staff and external suppliers have all helped to improve the early detection of potential data centre problems and the speedy resolution of actual problems. The last serious data centre failure occurred in June 2014 and the failed services were recovered within 90 minutes.

Plans are now in place to move from the hospital based data centres to purpose built data centres. These new Data Centres will provide a much more reliable environment for the BSO ICT operations. The new Data Centres are planned to be operational within two years, subject to procurement and final business case approval.

During February 2015 BSO ITS was awarded ISO 20000 certification. This is an IT management standard based on the industry best practice guidelines for IT services delivery. The standard covers a broad set of areas including the management of incidents, service requests, service level agreements, security management, change, service transition etc.

Given the continuing improvement of the service provided by BSO ITS and its approach to improving both the resilience of the data centre infrastructure and the professionalism of its staff, this issue is no longer considered to be a control issue.

Breast Cancer Services

Regionally during 2014/15, 81% of urgent breast cancer referrals were seen within 14 days and, it should be noted that performance improved significantly in the second half of 2014/15.

In delivering this improved position, the Board met regularly with all Trusts in dedicated cancer performance and improvement meetings and also with individual Trusts as required. The focus of these meetings was to apply the models of best practice that exist within Northern Ireland across all Trusts to ensure a consistent approach to delivery of the 14-day standard. This included ensuring that existing triple assessment capacity is maximised through using the most appropriate pathways for routine and review patients and in the implementation of effective triage practice in line with good practice. Additional clinics were also undertaken and recurrent investment has been put in place in South Eastern and Northern Trusts as there was a recognised capacity gap in the services in these areas.

Royal Victoria Hospital Emergency Department Major Incident

The Minister commissioned the RQIA to undertake a review of a major incident declared at the RVH ED on 8 January 2014. The HSCB participated fully in that Review and provided a wide range of information and analysis to the RQIA to inform the review. The HSCB also fully participated in the Unscheduled Care Task Group subsequently established by the Minister to take forward the recommendations of the RQIA Report, including to lead a number of the work streams set up under the Task Group.

At the request of the Department, the HSCB, working with PHA has undertaken a review of all ED-related Serious Adverse Incidents (SAI) since 2011, and has identified those cases where delay may have been a possible contributory factor in a patient's death. This review identified that families had not been appropriately involved in all cases as required by the SAI procedure, and the HSCB has taken steps to address this and to require more details of family involvement to be recorded in SAI Investigation Reports.

The HSCB, working with the PHA, has also developed guidance for Trusts on the effective engagement with service users and families in the SAI process.

Northern HSC Trust performance

In May 2013 the Minister announced new management arrangements in the Northern Trust to take forward the next stage of the turnaround process in the Trust, and to secure improvements in key performance issues. This resulted in the secondment of the HSCB Director of Finance to the Trust until 31 May 2015.

The HSCB has participated in joint meetings between DHSSPS and the Trust as part of the process for taking forward the recommendations of the Turnaround Team, who were accountable to DHSSPS.

The involvement of the external Turnaround Team has now concluded and any remaining issues are being taken forward under normal business arrangements.

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

Quality, Quantity and Financial Controls 2014/15

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

Health and Social Care (HSC) in Northern Ireland began in 2014/15 to face very significant financial challenges, taking into account pressures faced by Trusts, as well as planning to meet further service development pressures to fully address demographic growth, and planned service enhancements to meet the commissioning and performance agendas within the HSC sector. These financial constraints continued to be rigorously monitored and managed by the HSCB throughout the financial year. The HSCB worked closely and pro-actively with all HSC Trusts and the DHSSPS in order to address the significant difficulties faced. However, in order to maintain the quality of services required and to absorb the increased demand presenting, it was necessary to develop a revised 2014/15 financial plan and financially balanced Commissioning Plan in order to achieve an HSC breakeven position.

Through the revised financial plan and Commissioning Plan the Department and the HSCB sought to manage the pressures using a range of measures, including:

- Implementation by Trusts of contingency and curtailment measures which were considered to have the least impact on patient care;
- Obtaining additional resources through the in-year monitoring rounds;
- Allocation of additional HSCB Funding to Trusts; and
- Establishment of a revised financial plan and financially balanced Commissioning Plan.

Implementation of the above measures enabled all HSC Trusts to achieve financial breakeven in 2014/15 with the exception of the Western HSC Trust (WHSCT) which incurred a deficit for the year of £6.7m.

In order to offset the impact of the WHSCT deficit, and to ensure the HSC system as a whole achieved breakeven, it was necessary for the HSCB to report a surplus of £7m for 2014/15. If the WHSCT deficit had not occurred the HSCB could have invested this funding into additional patient and client care during 2014/15. However, without this intervention by the HSCB, whole system financial balance would not have been delivered in 2014/15.

Looking forward to 2015/16, it is anticipated that, despite the additional funding for Health and Social Care set out in the 2015/16 budget, the difficulties faced within the HSC sector will accelerate further. The HSCB will continue to proactively work with HSC Trusts and the DHSSPS

in order to review and develop financially effective solutions which will seek to maintain the integrity of services to the public and secure financial balance. These solutions will be required to meet unavoidable pressures, such as price inflation and demography, thus impacting on HSCB's ability to take forward key HSC strategic developments and associated key performance indicators.

In addition the HSCB's budget for 2015/16 has been reduced by £5.4m recurrently, representing 15% of the administration budget. While plans have been drafted to address this issue there will be a significant impact on the capacity which the HSCB has to deliver its functions.

Actions taken during 2014/15 with respect to financial planning and associated efficiency plans for 2015/16, will contribute towards mitigating the qualitative risks associated with managing services within a constrained budget.

Business Services Transformation Project/Shared Services

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

Post implementation, significant system difficulties had been encountered over a range of areas including the prompt payment of invoices (target 95% within 30 days – 2014/15 out-turn was 86% by number and 87% in value, please refer to Page 144). This resulted in the Internal Auditor providing limited assurance and the External Auditor providing priority 1 recommendations in relation to the associated financial processes. The associated action plans have now been sufficiently progressed to a 'business as usual' status within the HSCB. Therefore due to the continued improvements observed during 2014/15, the BSTP risk had been removed from the HSCB corporate Risk Register.

However, the Internal Auditor has provided limited assurances to BSO for one element of Accounts Payable Shared Services, relating to duplicate payments and Payroll Shared Services in 2014/15. While the duplicate payment issue has subsequently been resolved for the HSCB, BSO have advised that the payroll implementation is likely to be implemented during the early part of 2015/16. The HSCB is therefore concerned that the control issues highlighted in Payroll Shared Services could have an adverse impact on the HSCB, and therefore will continue to monitor progress and developments in this area.

Elective Care

The Commissioning Plan Direction for 2014 requires Trusts to ensure that from April 2014:

- at least 80% of patients wait no longer than 9 weeks for their first outpatient appointment and no patient waits longer than 15 weeks;
- no patient waits longer than nine weeks for a diagnostic test;
- at least 80% of inpatients and day cases are treated within 13 weeks and no patient waits longer than 26 weeks.

Regionally performance falls well below the elective access standards/targets and has deteriorated significantly compared to March 2014. At the end of March 2015:

- 44% of patients were waiting less than 9 weeks for a first outpatient appointment, compared to 69% at the end of March 2014;

- 107,957 patients were waiting longer than 9 weeks for a first outpatient appointment compared with 39,768 at the end of March 2014 and, 82,486 were waiting longer than 15 weeks compared to 19,173 at end of March 2014;

- the number of patients waiting longer than nine weeks for a diagnostic test has increased from 7,837 at the end of March 2014 to 17,807;

- 52% of patients were waiting less than 13 weeks for inpatient of day case treatment, compared to 67% at the end of March 2014; and

- 27,778 patients were waiting longer than 13 weeks for inpatient or day case treatment compared to 16,356 at the end of March 2014 and, the number waiting longer than 26 weeks has increased from 4,312 to 13,621.

A significant proportion of the increase in 9/13 weeks in the first half of the year can be attributed to the under delivery of core capacity in all Trusts across a range of specialties and as a result the Board withdrew an element of funding from the relevant Trusts. In view of the extent of the under delivery of core activity and concerns about the chronological management of routine patients, the Board has also undertaken an audit of Trusts' waiting list management processes. The Board will work with Trusts to analyse the outcomes from the audits and progress relevant actions.

In order to maintain the end of March 2014 waiting time position, the Board funded Trusts non-recurrently to undertake additional activity (40,000 new outpatient assessments and 12,500 inpatient/day case procedures) during quarters one and two of 2014/15 in elective care specialties where there was an agreed recurrent capacity gap. However, given the wider HSC financial position, it was not possible to fund Trusts to undertake additional activity in the second half of the year therefore, given the gap between demand and funded capacity, an increase in the number of patients waiting longer than the Ministerial maximum waiting time standards across a range of specialties in all Trusts was inevitable. Regrettably, the financial position means this will continue in 2015/16.

Given this position and the need to minimise the impact on waiting times, the Board continues to stress the need for the Trusts to ensure the full delivery of the commissioned volumes of core elective activity in all specialties along with strict chronological management of waiting lists.

The Board will continue to monitor Trusts' progress against the Ministerial waiting time standards and to ensure that the agreed volumes of core activity are delivered, while at the same time work with Trusts to expand capacity in specialties with a recurrent capacity gap.

In relation to diagnostics, following the outcome of the October 2014 monitoring round, the Board confirmed non-recurrent funding to Trusts (at end of November 2014) to undertake additional radiology activity to deliver improved waiting times by March 2015.

Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the Board has prioritised the allocation of the limited funding

currently available for elective care in 2015/16 for diagnostics. As a result, waiting times are expected to improve further during 2015/16.

In relation to cardiology, IPTs are being developed to increase capacity in 2015/16 which is expected to rapidly improve the waiting time position.

Emergency Department (ED) (4 and 12 hour performance standards)

There was a material reduction in the number of patients waiting longer than 12 hours in Emergency Departments during the first three quarters of 2014/15 – from April to December 2014, 1,536 patients waited longer than 12 hours compared to 2,278 during the same period in 2013/14, a reduction of 742 (33%).

In relation to the deterioration in performance during the final quarter of 2014/15, it should be noted that regionally there was a 3.8% increase in attendances at the larger Type 1 and Type 2 emergency departments and a 2% increase in admissions compared with the same period last year. Furthermore, during quarter four, Trusts experienced an 11% increase in the number of attendances by patients aged 80 or over and an 3% increase in the number of patients who were triaged as category 2 (very urgent) or 3 (urgent). All of these factors combined will have contributed to the increased pressures experienced by Trusts in the latter part of 2014/15.

The majority of the breaches of the 12-hour standard in 2014/15 were in the Belfast Trust, 1,756 out of a total of 3,171 – this compared with 517 in Belfast Trust during 2013/14. It should be noted however, that there has been a sizeable reduction in the number of patients who have waited longer than 12 hours in the remaining four Trusts during 2014/15 compared to 2013/14.

In relation to the 4-hour standard, regionally during 2014/15, 78% of patients attending an Emergency Department were treated and discharged, or admitted within four hours of arrival – this is unchanged from 2013/14.

During 2014/15, the Board undertook a series of re-audits of Trusts' implementation of a number of the 18 key actions to improve the unscheduled care pathway. The re-audit process is currently in its final phase and a summary paper of the findings is expected to be available by end of June 2015. The findings from the audits and agreed actions will be monitored at the regular performance meetings with Trusts to ensure improvements are secured in 2015/16.
Improving performance against the 4 and 12 hours standard remains a priority for the Board and it is continuing to work with Trusts to expand 7 day services to improve patient flow, taking forward recommendation from the Unscheduled Care Task Group.

Cancer Services

Trusts were required to ensure that from April 2014, that at least 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.
Performance has continued to be below the 95% standard in all Trusts during 2014/15. Regionally during 2014/15, 73% of patients began their first definitive treatment within 62 days. However, it should be noted that performance in the Western Trust has remained strong with 92% of patients commencing their first definitive treatment within 62 days during 2014/15. There has been a significant improvement in the Southern Trust's performance, from 83% in September 2014 to 96% in March 2015.

Given the limited progress towards achievement of the 62-day standard, the Board has enhanced monitoring arrangements in place with Trusts specifically around improving cancer performance. This approach includes a strong focus on treating the longest waiting patients and, as performance against the 62-day cancer access standard is based on completed waits in month. The pace of progress towards achievement of the 95% standard is as expected as it reflects that a higher proportion of patients treated in month were the longest waiters.

Regionally, the 62-day performance is weakest within urology and almost half of the patients waiting beyond 62 days at the end of March 2015 were waiting within the urology specialty. Urology services across Northern Ireland remain very challenged, primarily as a result of on-going manpower difficulties, and the Board is leading a service improvement initiative across all Trusts to improve the position. The Board is also working closely with the Trusts to identify and implement best practice models across other cancer pathways.

Allied Health Professionals (AHP) (9 weeks)

Given the variation in the AHP information that was being reported by Trusts and the inconsistencies in how the definitions were being applied, formal reporting of AHP performance was suspended during quarter one of 2014/15 to allow Trusts to apply the revised AHP waiting time definitions and to put in place arrangements to consistently report performance in line with these definitions.

This was completed in the first instance for physiotherapy, occupational therapy and dietetics and waiting time information for these services has been reported from 30 June 2014. A similar exercise was completed for the remaining AHP services (speech and language therapy, orthoptics and podiatry) and from October 2014, waiting time information has been available for all AHP services. This indicates that regionally at the end of March 2015, 15,364 patients were waiting longer than 9 weeks across all AHP areas, however issues remain with the accuracy of the information submitted by Trusts. The Board and PHA are meeting with Trusts to discuss the findings from the demand and capacity exercise and to agree the steps to be taken to ensure more robust information is available to inform actions to reduce waiting times in 2015/16.

Healthcare Acquired Infection (HCAI) – MRSA

Regionally, the 2014/15 target to have no more than 50 cases of MRSA has not been achieved. During 2014/15, with regard to individual Trusts, the number of cases of MRSA in Northern and South Eastern Trusts was within their respective target levels for 2014/15 however, the remaining Trusts exceeded their target levels.

PHA has co-ordinated a recent study of MRSA across all Trusts. Areas for improvement identified through this work include implementation and assurance of MRSA screening policy and practices, decolonisation processes and assurance, implementing learning arising from root cause analyses. The final report of this MRSA study will be available from February 2015.

Healthcare Acquired Infection (HCAI) – C. difficile

Regionally, the 2014/15 target to have no more than 288 cases of C. difficile has not been achieved. During 2014/15, there were 379 cases of C. difficile. All Trusts exceeded their maximum target level for 2014/15.

The Public Health Agency (PHA) circulated an alert/learning note on the C. difficile position to Trusts in September 2014 (signalling that regional CDI position had moved above trajectory). This alert included a recommendation for the Lead HCAI Director, Lead Infection Prevention and Control doctor and nurse in each Trust to review their current CDI position to reinforce key improvement messages and actions.

The PHA HCAI Team is currently considering hosting a series of HSC-wide meetings to share learning and inform key improvement actions required in 2015/16. Building operational links between quality improvement expertise and infection prevention/control expertise is likely to be an area of concerted focus going forward.

Children's Services (Unallocated Cases)

Unallocated cases across Children's Services continue to fluctuate. The overall referral rate has not increased to any significant extent but Trusts report that pressures further into the system are impacting upon their capacity to reduce the numbers. This specifically refers to an increased number of children entering the looked after system which is also resource intensive.

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

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

The HSCB will be working with the Trusts to apply Service Improvement processes to this area of Children's Services to determine if progress can be made. This will run parallel to on-going developments of Family Support Hubs to offer support services to families at an earlier stage with a view to preventing deterioration and escalation.

Paediatric Congenital Cardiac Services (PCCS)

Following the work of the PCCS working Group in 2012, a Preferred Option document, recommending that services be commissioned primarily from Dublin, was submitted for Ministerial approval in April 2013.

A further expert assessment undertaken by an International Working Group (IWG) was jointly commissioned by the Ministers for Health in Northern Ireland and the Republic of Ireland in December 2013. The IWG report published in September 2014 included 14 recommendations associated with the establishment of an 'all island' model of service provision for congenital cardiac services. Following a period of consultation on the IWG Report, the Minister for Health in Northern Ireland announced the proposed implementation of all-island child heart services. In future, children will have their surgery in Dublin. In the interim, while implementation of the long-term model is progressed, arrangements are in place through formal Service Level Agreements (SLAs) for children from Northern Ireland with congenital heart disease to receive treatments at the

most appropriate specialist centre to meet their needs. These SLAs are subject to on-going monitoring and review.

Resettlement

2014/15 is the final year of the Mental Health and Learning Disability Resettlement Programme and Trusts were required to resettle the remaining 49 long stay learning disability patients and 43 long stay mental health patients to appropriate homes in the community. Regionally, at the end of March 2015, 13 learning disability and 20 mental health patients have been resettled.

At 31 March 2015, 35 long stay patients remained in learning disability hospitals. The majority (32) of these were as a result of some schemes being delayed due to procurement, planning permission issues and being new builds. Plans are in place to commence resettlement during 2015/16 for 28 of these long stay patients with the remaining four to be resettled in 2016/17. Of the remaining three long stay patients who were not resettled at 31 March 2015, two continue to require inpatient treatment and a legal challenge to being resettled is on-going in respect of the final patient.

In relation to mental health, at 31 March 2015, 23 long stay patients remained in psychiatric hospitals. The majority (16) of these were as a result of some schemes being delayed due to procurement, planning permission issues and being new builds. Plans are in place to commence resettlement during 2015/16 for 11 of these long stay patients with the remaining five to be resettled in 2016/17. Of the remaining seven long stay patients who were not resettled at 31 March 2015, two continue to require inpatient treatment and the final five are either detained under the Mental Health Order or a legal challenge to being resettled is on-going.

Mental Health Access-child/adolescent and adult (9 and 13 weeks)

Trusts are required to ensure that from April 2014 no patient waits longer than 9 weeks to access child and adolescent (CAMHS) or adult mental health services and that no patient waits longer than 13 weeks for psychological therapies.

- CAMHS

Regionally at the end of March 2015, the number of patients waiting longer than nine weeks to access child and adolescent mental health services has reduced compared to the position at the end of March 2014. At the end of March 2015, 73 patients were waiting longer than nine weeks – compared to 113 at the end of March 2014. Almost all of the patients waiting longer than nine weeks at end of March 2015 were in the Northern Trust (72). The Trust continues to action to action a recovery plan which will resolve breaching by early summer. In line with this plan the Trust has recruited additional staff which will increase capacity.

- Adult Mental Health and Dementia Services

Regionally at the end March 2015, 180 patients were waiting longer than nine weeks (137 Adult Mental Health and 43 Dementia Services). The majority of the breaches in Adult services were in the Community Mental Health Service in Belfast and Western Trusts. Belfast Trust has plans in place to recover the nine week waiting times by 31 March 2015. The Western Trust has started to breach significantly in the last quarter (rising to 27 in December 2014). This is due to a loss in capacity as a result of vacant posts. The Trust is in the process of recruiting to these positions and once filled will assist the Trust in resolving and reducing the number of breaches. In respect of

Dementia services, the majority are in the SHSCT (79) and whilst the Trust is working on a services reform it has indicate that the standard will not be achieved by March 2015. However, the weekly report indicates a continuing downward trend in the numbers breaching.

- Psychological Therapies

In relation to psychological therapies, at the end of March 2015, 912 patients were waiting longer than 13 weeks. This represents an increase of 486 from the position at the end of March 2014. More than half (53%) of the breaches were in the South Eastern Trust, which has increased from 200 to 487 over the year. The HSCB has been working with the Trust to explore ways of resolving this trend. Additional investment has been identified to fund capacity gaps and service improvement initiatives are being put in place which will more effectively manage demand and reduce breaches. It is expected that this process will take a year to complete. The Board has acknowledged that there is a recurrent capacity gap in these services across all Trusts and as a result psychological therapies has been registered as an on-going cost pressure. Consequently, the position regarding accessibility to psychological therapies remains vulnerable. It is important to note however, that people referred for psychological therapies are triaged and those requiring acute care are prioritised.

Securing TYC Transitional Funding

The corporate risk rating relating to a delay in the provision of transitional funding that could negatively affect the timescales for implementing TYC recommendations has remained at High throughout the course of 2014/15. A bid of £21.3m was sought through the June 2014 monitoring round. This bid was unsuccessful. As it was recognised that Trusts and other providers were making financial commitments on the basis of previously approved investment proposals, the HSCB committed to provide funding of up to £13.1m, as part of the management of the overall financial plan for 2014/15, should transitional funding from the NI Executive not become available. Receipt of £8m from the October 2014 monitoring round reduced the level of HSCB funding required.

We will continue to engage with the DHSSPS regarding future transitional funding for implementation of the essential reform required to achieve the long-term transformation of the HSC.

Monitoring of Shift Left validated that £44m of the £83m target has been delivered by end of 2014/15. The DHSSPS and HSCB have agreed the shift left measurement methodology.

Implementation of TYC

The corporate risk that exists in relation to a lack of consensus on the implementation of TYC impeding delivery of the reforms had its risk rating reduced in the course of 2014/15 from Medium in June 2014 to Low at December 2014 and remained low for the period to March 2015. This risk has been mitigated through a range of awareness, engagement and involvement activities continuing throughout the implementation phase, with an increasing focus on the achievement of outcomes for individuals. Such activities to demonstrate progress include:

- Short films with patients, users, carers and staff showing their experience of changes to services in line with TYC.

- A TYC eZine was issued to over 1000 stakeholders, including media, councillors and MLAs, plus all HSC staff 7 times in 2014/15.
- A dedicated website and social media channel for TYC containing information about implementation and stories about real changes.

Additionally monthly reporting takes place to the HSCB Board and Transformation Programme Board and an updated Communications and Engagement Strategy for 2014/15 was developed.

HSC Senior Leaders, including clinicians, attended an HSC wide workshop on Reform in September 2014 to gain consensus on the key areas of reform to be taken forward.

As at 31st March 2015 there were 84 separate projects or enablers that were funded through the TYC Programme. Twenty new investments, which mainly relate to ICPs, were approved in the period November 2014 to March 2015.

Statutory Residential Homes

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

Health and Social Care Trusts have assessed their residential care homes against the criteria in accordance with the process agreed with the Board. This has included a review of their positions on new admissions following proposals about the future for each individual home. Current permanent residents will benefit from the Ministerial commitment that no one will be asked to leave their home whilst their needs can continue to be met there. There are 190.

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

The Report was due to be considered at a public meeting of the Board on 15th January 2015 but this has been deferred, on Departmental instructions, pending consideration of the implications of the Judicial Review process initiated in relation to the proposed closure of Dalriada Hospital.

The Report was considered by HSCB at their meeting on 19th May 2015 at which they approved the proposals to proceed to consultation.

Health Visiting

The DHSSPS Health 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 is 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, Allied Health Professionals and Social Services.

The PHA continues to work closely with HSCB and HSC Trusts to increase health visiting capacity. The Director of Commissioning has written to Trust Chief Executives in August 2014 regarding

recruitment expectations. All Health Visitors from the student Health Visitor group graduating October 2014 (n=38) have been recruited onto permanent contracts. Permanent funded vacancies were filled in all HSC Trusts with the exception of Western Trust that has been unable to recruit into three permanently funded vacant positions. Since October 2014 to March 2015 the number of vacancies has increased to 11 whole time equivalents. This is expected to rise between April 2015 and October 2015 as a result of Health Visitors being recruited into other posts. 54 Health Visitors are predicted to move out of core universal health visiting services or retire over the next three years.

61 student Health Visitors have commenced the 2014 course at University of Ulster and are expected to be available for recruitment in October 2015.

Compliance with the Child Health Programme per Trust and regionally will continue to be measured on a three monthly basis using regionally agreed Indicator of Performance tolerances. The PHA is leading work on normative staffing levels relating to health visiting and regular Health Visitor workforce updates from HSC Trusts will continue to be analysed.

GP Out of Hours (OOH) Services

The call volumes to GP OOH services continue to remain high with 578,149 calls received from 1st April 2014 to 31st March 2015. There is continued difficulty at present in recruiting sufficient GPs to work during unsocial hours and busy years in the OOH services. While additional funding has helped at key times it is not sufficient to retain the voluntary GP workforce. From 1st April 2014 to end of March 2015 on average providers indicate that they achieved 91% triage of urgent calls within 20 minutes which is within target but on average 77% of routine calls were triaged within 1 hour which is outside the target of 90%. Individually however providers have varying levels of compliance with targets.

In recognition of the additional pressures across the five GP Out of Hours services during the winter months, the HSCB has made available £600,000 to enable them to increase clinical capacity, both GPs and Nurses, and to retain sufficient GPs, specifically during the winter year. This funding has been made available from 1st December 2014 through to end of March 2015. In addition the HSCB made available to providers funding for an additional 10% of GP time to meet service demands specifically during January 2015. Analysis of the demand for GP Out of Hours services has shown that that the service experiences particular pressure at weekends and public holidays. On this basis, HSCB provided additional funding of £1.16 million for increased clinical capacity at weekends and during public holidays throughout 2014/15.

To enhance recruitment of GPs into the Out of Hours service the HSCB provided £130,000 additional funding for a pilot Local Enhanced Service, commissioned from local GP practices which provides an additional weekday evening rota service in the Craigavon and Altnagelvin GP OOH sites. This service is designed to secure additional GP input from local practices and also to develop collaborative working between general practices and OHH providers in order to provide cover and enhance service capacity. The overall aim of the pilot is to encourage GPs to come back to working in OHH.

HSCB has provided additional funding to improve skill mix in GP Out of Hours services, so reducing reliance on scarce GP resource, as follows:

- Funding for Dalriada Urgent Care to replace their nurse triage computer system and train triage nurses. The 3 GP Out of Hours services providing nurse triage now use the same computer system which is in line with the strategic direction for the service. Through natural wastage the pool of nurses in Dalriada had reduced from 50 to 34. The 29 additional nurses recruited increased the pool of triage nurses in order to cover all shifts.

- Funding for Southern Health and Social Care Trust to pilot pharmacist prescribers and to implement nurse triage and nurse practitioners. Due to the time required for recruitment processes, for example Access NI checks etc and training the pharmacist prescriber pilot began on1st March 2015. Lead nurses are now in post and are in the process of training 30 new nurses who are gradually commencing work in the service.

- Funding for Belfast Health and Social Care Trust for a supervisor during the Out of Hours period.

- Funding to Western Urgent Care for nurse triage software and a medical manager.

HSCB is also in discussion with the South Eastern Health and Social Care Trust regarding plans for nurse triage.

The consolidated GP Out of Hours computer system implemented in the regional data centres has enabled electronic communication of calls between GP Out of Hours services as well as an enhanced technology platform and it has been further improved with small enhancements this year as well as the implementation of configuration to enable pharmacist prescribers to work in the Southern Health and Social Care Trust and nurse triage in Southern HSC Trust and Dalriada Urgent Care. There are automated daily and weekly reporting of statistics and key performance indicators from all GP Out of Hours services.

Each GP Out of Hours provider has been provided with a training budget of up to £30,000 per provider in order to enhance and develop the skills of staff and address any issues arising out of complaints or incidents. The complaint rate continues to be very low remaining at 0.02% of the calls received by GP Out of Hours services.

The Regional Workforce Planning Group has produced a report in relation to GP workforce planning. The report makes a clear recommendation for an increase in GP training places in NI to 111 annually, phased in over four years with an initial target to increase the number by 15, for commencement by August 2015, but implemented no later than August 2016. It is estimated that this will cost approximately an additional £90k per training place, or £1.35m in total. The decision on this recommendation rests with the DHSSPS and DFP.

Service and Budget Agreements

Trusts identified a range of issues which could potentially affect agreement of the 2014/15 Service and Budget Agreements (SBAs). These issues fell into two broad categories:

- Disagreement with the Board's position on the level of activity that should be delivered for the resources available.
- Lack of consensus on the contract currencies and/or indicators that should be used in non-acute programmes to define and monitor SBA delivery.

LCGs worked to identify and address a number of issues at local level. Issues which had not been resolved at local level were escalated to the Director of Commissioning with the aim of reaching an agreed position at Trust Director level meetings.

The current focus is on trying to resolve outstanding issues so that we have an agreeable SBA position during 2015/16. The HSCB is seeking to fund relevant elements of Trust deficits recurrently from 2015/16. It is anticipated that this should resolve many of the outstanding issues. Work will also be on-going in relation to the Community Information Project which is reviewing, in operation with Trusts, currencies and currency definitions used in the SBA.

Child Sexual Exploitation (CSE)

The HSCB continues to respond to concerns surrounding CSE under Protocol for Joint Investigation procedures. Operation Owl has now been stood down although a number of investigations are on-going. The HSCB made additional investments to retain and increase the capacity of Trusts to address issues around CSE within each Trust. Local Trust and Police Service of Northern Ireland meetings also continue to address CSE issues and social work staff complete risk assessments on any young person who may be at risk of CSE. The risk assessment tool which was updated in October 2014 is applied across all Trusts. Recurrent funding has still to be secured.

The HSCB continues to part fund Safe Choices which is a project managed by Barnardos to facilitate direct work with young people suspected of being subject to CSE and provides training and consultation to a range of staff across a number of agencies. Significant training of HSC staff has also been facilitated. The HSCB has also reviewed the missing–children guidance and is reviewing how statistical data is collated at the HSCB. The revision of the guidance has been completed jointly with PSNI and joint training will follow. Trusts and Voice of Young People in Care are engaging with young people directly to ensure their views are available and taken into account.

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

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

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

Ambulance Response Times

Regionally during 2014/15, 58% of Category A calls were responded to within eight minutes (target: 72.5% by March 2015, 67.5% in each LCG area). This performance compares with 68% during 2013/14.

NIAS has indicated that the number of calls responded to in 2014/15 was 11% higher than in 2013/14, and this has had an adverse impact on the 8-minute response time. This needs to be viewed in the context of overall activity, particularly in relation to categorisation of Health Care Professionals (HCP) calls (previously categorised as GP urgent calls) and the introduction of the Card 35 scheme. Changes proposed to the application of the Card 35 scheme are due to be implemented early in 2015/16.

Other issues impacting on response times in 2014/15, and which are being addressed by NIAS, include a significant recruitment and training process for operational staff, and a continued focus on the management of absence. In addition, the Board will be working with NIAS to take forward a detailed demand and capacity exercise during 2015/16.

Domiciliary Care

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

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

Historical Institutional Abuse Inquiry

The HSCB is a core participant to the Inquiry and represent all current and previous statutory bodies. The Inquiry is covering the year 1922-1995. The demands of the Inquiry remain challenging and additional staff have had to be allocated to this work. There has been criticism of the HSCB (in its role as core participant) from The Inquiry Team and this is likely to continue throughout the lifetime of the Inquiry. The criticism largely focuses on the lack of records provided. While the Trusts and Board have provided what is available, in some cases no files are still in existence or cannot be found. Explanations have been given to the Inquiry about destruction of records arrangements to try to explain some of this. Other potential criticism focuses on whether action was adequate and robust. These actions need to be set in the context of legislation, policy and practice at that time, but differing views are emerging.

Western Trust Financial Support

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

Following discussions with the DHSSPS the Board has been asked to provide additional monitoring and support to the Western Trust. This support will last for an initial six month period.

The Board will conduct an initial review to include the following:

- A review of financial control systems;
- A review of the proposed 2015/16 efficiency saving;
- A review of budgetary control reports; and
- A review of 14/15 expenditure trends and financial performance.

Following this review and approval of the HSC system wide plan, the Board will assist the Trust in achieving financial breakeven by implementing the agreed Western Trust efficiency plan and in-year control of expenditure via effective financial management.

The increased monitoring will be conducted by Directors of the HSCB as required and chaired by the Director of Finance. They will review with the Trust, on a monthly basis, Trust performance against the agreed plan and the financial performance in-year against the agreed Trust budgets.

Phase I

The review stage commenced on 19 February and will be supported by Phil Taylor, past HFMA president and will be supported by the HSCB Finance Directorate, with additional support from LCG officers as required. This stage has focussed on:

- Expenditure trends in 14/15;
- Financial reporting in 14/15;
- 14/15 Contingency Plans;
- Proposed 15/16 Efficiency Plans;
- 15/16 Income and Expenditure Reports;
- Budgetary Control system and Reports; and
- Review or Approval of Trust 15/16 Budgets.

Phase II

This phase will commence in June 2015 and will involve increased monitoring and support to the Trust which will assist with the achievement of the plan. This will require the establishment of a monthly Project Board which will review the progress on service efficiency and financial performance review within the Trust. This Project Board will include HSCB Directors, supported by Mr Taylor and various Trust Directors

Membership of the team is to be agreed with the Chief Executive. Additional support from HSCB may be provided on an on-going basis dependent on the identified issues from phase 1 and the on-going monitoring meetings.

<u>Dental Prior Approval Issue</u>

The BSO processes payment claims from dentists made under the Northern Ireland General Dental Services (GDS) contract. However, before dentists can commence higher value courses of

treatment (those above £280) the treatment plan must first be checked for clinical appropriateness by dental advisers in BSO. This process is referred to as prior approval.

In December 2014, a new computerised payment system, in part designed to allow the prior approval function to be discharged in a more efficient way, was introduced by BSO. It was anticipated that a number of settling in issues would come to light but it eventually became clear that the early problems were persisting and significantly slowing the prior approval process. These issues were escalated to relevant senior staff within BSO and at that time it was felt that the problems could be resolved in a relatively short period of time. However, despite numerous meetings between HSCB and FPS staff in BSO, there are still marked performance problems with the prior approval process and many treatment requests have been waiting well beyond the normal 8 week processing time for approval, risking a deterioration in patients' oral health.

The Board has agreed with BSO the short term actions that need to be taken and these are to be reviewed, along with BSO's analysis of the scale and core causes of the problem at a meeting of the FPS New Payment System Project Board on 12 June 2015.

Conclusion

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

Further to considering the accountability framework within the Body and in conjunction with assurances given to me by the Head of Internal audit, I am content that the HSCB has operated a sound system of internal governance during the year 2014/15.

Valerie Watts.

Mrs Valerie Watts
Chief Executive

11/6/2015

Date

HEALTH AND SOCIAL CARE BOARD
ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

HEALTH AND SOCIAL CARE BOARD

STATEMENT of COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2015

	NOTE	2015 £000s	2014 £000s
Expenditure			
Staff costs	3.1	(29,653)	(25,721)
Depreciation	4.3	(2,601)	(2,498)
Other Expenditures	4.0	(979,888)	(913,702)
		(1,012,142)	(941,921)
Income			
Income from activities	5.1	52,167	51,651
Other Income	5.2	1,412	1,368
Deferred income	5.3	0	0
		53,579	53,019
Net Expenditure		**(958,563)**	**(888,902)**
Revenue Resource Limit (RRL) issued (to)			
Belfast HSC Trust		(1,137,664)	(1,117,045)
South Eastern HSC Trust		(499,429)	(494,270)
Southern HSC Trust		(510,383)	(502,657)
Northern HSC Trust		(577,546)	(558,892)
Western HSC Trust		(500,022)	(489,703)
NIAS HSC Trust		(59,943)	(60,155)
NIMDTA		(1,290)	(1,179)
NISCC		(6)	(44)
Total RRL issued		(3,286,283)	(3,223,945)
Total Commissioner resources utilised		(4,244,846)	(4,112,847)
RRL received from DHSSPS	25.1	4,251,874	4,113,044
Surplus against RRL		**7,028**	**197**

OTHER COMPREHENSIVE EXPENDITURE

	NOTE	2015 £000s	2014 £000s
Items that will not be reclassified to net operating costs:			
Net gain/(loss) on revaluation of property, plant and equipment	6.1/10/6.2/10	1,109	38
TOTAL COMPREHENSIVE EXPENDITURE for year ended 31 March 2015		**(957,454)**	**(888,864)**

The notes on pages 117 to 152 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

STATEMENT of FINANCIAL POSITION as at 31 March 2015

		2015		2014	
	NOTE	**£000s**	**£000s**	**£000s**	**£000s**
Non Current Assets					
Property, plant and equipment	6/1.2/6.2	15,889		15,334	
Intangible assets	7.1/7.2	905		1,072	
Financial assets	8	0		0	
Trade and other receivables	12	0		0	
Other current assets	12	0		0	
Total Non Current Assets			16,794		16,406
Current Assets					
Assets classified as held for sale	9	0		0	
Inventories	11	0		0	
Trade and other receivables	12	6,611		7,562	
Other current assets	12	128		27	
Intangible current assets	12	0		0	
Financial assets	8	0		0	
Cash and cash equivalents	13	2,315		3,402	
Total Current Assets			9,054		10,991
Total Assets			**25,848**		**27,397**
Current Liabilities					
Trade and other payables	14	(150,937)		(145,491)	
Other liabilities	14	0		0	
Intangible current liabilities	14	0		0	
Provisions	16	(7,307)		(6,534)	
Total Current Liabilities			(158,244)		(152,025)
Non Current Assets plus/less Net Current Assets / Liabilities			**(132,396)**		**(124,628)**
Non Current Liabilities					
Provisions	16	(36,299)		(37,722)	
Other payables > 1 yr	14	0		0	
Financial liabilities	8	0		0	
Total Non Current Liabilities			(36,299)		(37,722)
Assets less Liabilities			**(168,695)**		**(162,350)**
Taxpayers' Equity					
Revaluation reserve		8,004		6,895	
SoCNE Reserve		(176,699)		(169,245)	
			(168,695)		**(162,350)**

The notes on pages 117 to 152 form part of these accounts.

Signed Ian Clements (Chairman) Date

11-6-'15.

Signed Valerie Watts (Chief Executive) Date

HEALTH AND SOCIAL CARE BOARD

STATEMENT of CASH FLOWS for the year ended 31 March 2015

	NOTE	2015 £000s	2014 £000s
Cash flows from operating activities			
Net expenditure after interest		(958,563)	(888,902)
Adjustments for non cash costs	4	12,709	6,481
(Increase)/decrease in trade and other receivables	12	850	2,879
(Increase)/decrease in inventories	11	0	1
Increase/(decrease) in trade payables	14	5,446	(44,394)
Less movements in payables relating to items not passing through the NEA			
Movements in payables relating to the purchase of property, plant and equipment	14	398	42
Movements in payables relating to the purchase of intangibles	14	71	(192)
Use of provisions	16	(10,241)	(14,058)
Net cash outflow from operating activities		(949,330)	(938,143)
Cash flows from investing activities			
(Purchase of property, plant & equipment)	6	(2,504)	(2,287)
(Purchase of intangible assets)	7	(310)	(250)
Net cash outflow from investing activities		(2,814)	(2,537)
Cash flows from financing activities			
Grant in aid		951,057	940,223
Net financing		951,057	940,223
Net decrease in cash & cash equivalents in the period		(1,087)	(457)
Cash & cash equivalents at the beginning of the period	13	3,402	3,859
Cash & cash equivalents at the end of the period	13	**2,315**	**3,402**

The notes on pages 117 to 152 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

STATEMENT of CHANGES in TAXPAYERS' EQUITY for the year ended 31 March 2015

	NOTE	SoCNE Reserve £000s	Revaluation Reserve £000s	Total £000s
Balance at 31 March 2013		(220,632)	6,857	(213,775)
Changes in Taxpayers Equity 2013/14				
Grant from DHSSPS		940,223	0	940,223
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(888,902)	38	(888,864)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	4	66	0	66
Balance at 31 March 2014		**(169,245)**	**6,895**	**(162,350)**
Changes in Taxpayers Equity 2014/15				
Grant from DHSSPS		951,057	0	951,057
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(958,563)	1,109	(957,454)
Transfer of asset ownership		0	0	0
Non cash charges - auditors remuneration	4	52	0	52
Balance at 31 March 2015		**(176,699)**	**8,004**	**(168,695)**

The notes on pages 117 to 152 form part of these accounts.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

STATEMENT OF ACCOUNTING POLICIES

1.0 Authority

These accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting Manual (FReM) and in accordance with the requirements of 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.

1.1 Accounting convention

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

1.2 Currency and Rounding

These accounts are presented in UK Pounds sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, 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 and individually have a cost of more than £1,000, 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 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 (RICS) Valuation - Professional 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 part of the Department of Finance and Personnel. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard. Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS**.**

Land and buildings used for the Arm's Length Body (ALB) services or for administrative purposes 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;

- Properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets

Modern Equivalent Asset

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

Assets Under Construction

The HSCB had no Assets Under Construction in either 2014/15 or 2013/14

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 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 ALB 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. 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 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 year 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 must be capitalised if their individual value is at least £1,000 each and 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 exits 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 2014/15 or 2013/14.

1.9 Inventories

The HSCB had no inventories as at 31 March 2015 and 31 March 2014.

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 Department is accounted for as grant in aid and reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The HSCB did not have any investments in either 2014/15 or 2013/14.

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 does not hold any finance leases.

<u>The HSCB as lessee</u>

The HSCB held no finance leases during 2014/15 or 2013/14.

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

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

The HSCB as lessor

The HSCB did not have any lessor agreements in either 2014/15 or 2013/14.

1.15 Private Finance Initiative (PFI) transactions

The HSCB had no PFI transactions in either 2014/15 or 2013/14.

1.16 Financial instruments

Financial assets

Financial assets are recognised on the Statement of Financial Position 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.

Financial assets are initially recognised at fair value.

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the HSCB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired. Financial liabilities are initially recognised at fair value.

Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the relationship with the DHSSPS, and the manner in which they are funded, financial instruments play a more limited role within HSC bodies in creating risk than would apply to a non-public sector body of a similar size, therefore the HSCB is not exposed to the degree of financial risk faced by business entities. The HSCB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the HSCB in undertaking activities. Therefore the HSCB is exposed to limited 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 Department of Health Social Services and Public Safety, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.17 Provisions

In accordance with IAS 37, Provisions are recognised when the HSCB has a present legal or constructive obligation as a result of a past event, it is probable that the HSCB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting year, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using Department of Finance and Personnel's discount rates of -1.5% (1-5 years), -1.05% (>5-10 years), 2.2% (>10 years) or 1.3% in the case of pensions provisions, 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 has developed 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 entity.

1.18 Contingencies

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 has been calculated based on the balance remaining in the computerised leave system for all staff as at 31 March 2015. It is not anticipated that the level of untaken leave will vary significantly from year to year. Untaken flexi leave is estimated to be immaterial to the HSCB and has not been included.

Retirement benefit costs

The HSCB participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Board and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Board 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 Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the HSCB and charged to the Statement of Comprehensive Net Expenditure at the time the HSCB commits itself to the retirement.

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 the 2014/15 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.

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 Property Plant and Equipment.

1.22 Third Party Assets

The HSCB had no third party assets in 2014/15 or 2013/14.

1.23 Government Grants

The HSCB had no Government grants in either 2014/15 or 2013/14.

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 their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

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. The suggested wording is as follows;

The IASB have issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards have an effective date of 1st January 2013, and EU adoption is due from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on Office of National Statistics (ONS) control criteria, as designated by Treasury. A review of the NI financial process is currently under discussion with the Executive, which will bring NI departments under the same adaptation. Should this go ahead, the impact on DHSSPS and its Arm's length bodies is expected to focus around the disclosure requirements under IFRS 12 'Disclosure of Interests in other entities'.

The impact on the consolidation boundary of Non Departmental Public Bodies (NDPB's) and trading funds will be subject to review, in particular, where control could be determined to exist due to exposure to variable returns (IFRS 10), and where joint arrangements need reassessing

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 Policy/Prior Year Restatement

There were no changes in Accounting Policy during the year ending 31st March 2015.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

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	2015	2014
Net Expenditure		**£'000s**	**£'000s**
Commissioning	2.1	3,335,760	3,260,426
FHS	2.2	829,952	782,684
Board Administration	2.3	79,134	69,737
Total Commissioner Resources utilised		**4,244,846**	**4,112,847**

2.1 Commissioning

Expenditure			
Belfast HSC Trust	SoCNE	1,137,664	1,117,045
South Eastern HSC Trust	SoCNE	499,429	494,270
Southern HSC Trust	SoCNE	510,383	502,657
Northern HSC Trust	SoCNE	577,546	558,892
Western HSC Trust	SoCNE	500,022	489,703
NIAS HSC Trust	SoCNE	59,943	60,155
NIMDTA	SoCNE	1,290	1,179
NISCC	SoCNE	6	44
Other providers	4.1	78,510	65,857
		3,364,793	**3,289,802**
Income			
Income from activities	5.1	29,033	29,376
		29,033	**29,376**
Commissioning Net Expenditure		**3,335,760**	**3,260,426**

2.2 FHS

Expenditure			
General Medical Services	4.1	238,597	234,109
General Dental Services	4.1	125,559	124,055
General Pharmaceutical Services	4.1	466,506	424,696
General Ophthalmic Services	4.1	22,424	22,099
		853,086	804,959
Income			
FHS Receipts & Recovery of Charges	5.1	23,134	22,275
FHS Net Expenditure		**829,952**	**782,684**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 2. ANALYSIS of NET EXPENDITURE by SEGMENT (cont'd)

2.3 Board administration

	Note	2015 £'000s	2014 £'000s
Expenditure			
Salaries and Wages	3.1	29,653	25,721
Operating Expenditure	4.2	38,184	38,903
Non Cash Costs	4.3	9,701	3,552
Depreciation	4.3	3,008	2,929
		80,546	71,105
Income			
Staff Secondment Recoveries	3.1	559	503
Operating Income	5.2	853	865
		1,412	1,368
Board Administration Net Expenditure		**79,134**	**69,737**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.1 Staff Costs

Staff costs comprise:	2015			2014
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	23,273	1,246	24,519	21,217
Social security costs	2,013	109	2,122	1,871
Other pension costs	2,859	153	3,012	2,633
Sub-Total	28,145	1,508	29,653	25,721
Capitalised staff costs	0	0	0	0
Total staff costs reported in Statement of Comprehensive Expenditure	28,145	1,508	29,653	25,721
Less recoveries in respect of outward secondments			559	503
Total net costs			**29,094**	**25,218**

Staff Costs exclude £Nil charged to capital projects during the year (2014 £Nil).

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

3.2 Average number of persons employed

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

	2015			2014
	Permanently employed staff	Others	Total	Total
	No.	No.	No.	No.
Commissioning of Health and Social Care	554	40	594	557
Less average staff number in respect of outward secondments	10	0	10	8
Total net average number of persons employed	**544**	**40**	**584**	**549**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.3 Senior Employees' Remuneration

The salary, pension entitlements and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows:

	2014/15				2013/14				2014/15				
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	Real increase in pension and related lump sum at age 60 £000s	Total accrued pension at age 60 and related lump sum £000s	CETV at 31/03/13 £000s	CETV at 31/03/14 £000s	Real increase in CETV £000s
Non-Executive Members													
I Clements	30-35	400	-	30-35	30-35	400	-	30-35	-	-	-	-	-
S J Leach	5-10	200	-	5-10	5-10	200	-	5-10	-	-	-	-	-
M McCullough	5-10	0	-	5-10	5-10	0	-	5-10	-	-	-	-	-
R Gilmore	5-10	200	-	5-10	5-10	300	-	5-10	-	-	-	-	-
B McKeever	5-10	500	-	5-10	5-10	300	-	5-10	-	-	-	-	-
J Mone	5-10	300	-	5-10	5-10	600	-	5-10	-	-	-	-	-
W R Thompson	5-10	0	-	5-10	5-10	0	-	5-10	-	-	-	-	-
Stephanie Lowry (Started 15/04/13)	5-10	100	-	5-10	5-10	0	-	5-10	-	-	-	-	-
Executive Members													
V Watts (appointed 01/07/14) (1)	115-120	200	-	115-120	-	-	-	-	-	-	-	-	-
F E McAndrew (acting Chief Executive 01/04/14-30/6/14)	90-95	500	49,000	140-145	80-85	400	6,000	90-95	2.5-5 pension 5-10 lump sum	20-25 pension 65-70 lump sum	430	508	62
P Cummings (Seconded to NHSCT 22/05/13 -31/05/14) (2)	90-95	400	27,000	115-120	15-20	300	-	15-20	0-2.5 pension 5-10 lump sum	40-45 pension 125-130 lump sum	753	816	38
O Harkin (Acting Director of Finance from 22/05/13-31/05/14) (3)	10-15	300	-	10-15	75-80	1,600	-	75-80	-	-	-	-	-
S Harper (4a)	115-120	500	29,000	145-150	115-120	500	(1,000)	115-120	0-2.5 pension 5-10 lump sum	45-50 pension 140-145 lump sum	904	975	41
D Sullivan	105-110	600	38,000	145-150	100-105	500	6,000	110-115	2.5-5 pension	45-50 pension	494	539	31
M Bloomfield (Head of Corporate Services & Acting Director of PMSI since 19/11/12)	90-95	300	10,000	100-105	85-90	300	63,000	150-155	0-2.5 pension 2.5-5 lump sum	30-35 pension 90-95 lump sum	484	516	16
P McCreedy	75-80	0	18,000	90-95	70-75	0	22,000	95-100	0-2.5 pension	5-10 pension	59	74	14
S Donaghy (Commenced 13 May 2013) (4b)	125-130	400	30,000	155-160	110-115	500	5,000	115-120	0-2.5 pension 5-10 lump sum	40-45 pension 125-130 lump sum	790	859	43
J Compton (Left 31/03/14)	-	-	-	-	145-150	100	0	145-150	-	-	-	-	-

No Bonus/Performance Related Payments were made to any Executive or Non-Executive Director in 2014/15 or 2013/14. A circular on the 2014/15 Senior Executive pay award has not been received from the DHSSPS therefore related payments have not been made to Executive Directors.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, plus the real increase in any lump sum, less the contributions made by the individual.

The real increases exclude increases due to inflation or any increase or decrease due to transfer of pension rights.

(1) Pension benefits relate to a calculation based on the real increase in pension over a year. Therefore this is not available for the postholder as they do not have a full year's service in 2014/15.

(2) No pension benefit shown in prior year as these are annual calculations, postholder was employed by NHSCT at 31/03/14.

(3) This was a temporary acting up post, therefore the annual calculation of pension benefit would not be applicable and as postholder was not in post at 31/03/15 no calculations are available for Real Increase of CETV for 2014/15.

(4) CETV at 31/03/14 has been adjusted by Pensions branch from :

(a) 884-904

(b) 793-790

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.3 Senior Employees' Remuneration (continued)

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 the member's accrued benefits and 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 the member leaves a scheme and chooses to transfer the 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 the 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 HPSS pension scheme. They also include any additional pension benefit 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 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 in accrued pension due to inflation, contributions paid by the employee (Including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

3.4 Reporting of early retirement and other compensation scheme - exit packages

The HSCB had no early retirements or other compensation exit packages agreed in 2014/15 or 2013/14.

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.5 Staff Benefits

The HSCB had no staff benefits in 2014/15 or 2013/14.

3.6 HSCB Management Costs	2015 £000s	2014 £000s
HSCB Management Costs	35,065	32,383
Income:		
RRL	4,251,874	4,113,044
Less non cash RRL excluding element to cover clinical negligence provision	(12,709)	(6,481)
Income per Note 5	53,579	53,019
Total Income	4,292,744	4,159,582
% of total income	**0.82%**	**0.78%**

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.

3.7 Retirements due to ill-health

During 2014/15 there were no early retirements from the HSCB agreed on the grounds of ill-health.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 4. OPERATING EXPENSES

4.1 Commissioning	**2015**	**2014**
	£000	**£000**
General Medical Services	238,597	234,109
General Dental Services	125,559	124,055
General Pharmaceutical Services	466,506	424,696
General Ophthalmic Services	22,424	22,099
NHS Trusts	30,613	22,719
Other providers of healthcare and personal social services	47,897	43,138
Total Commissioning	**931,596**	**870,816**

4.2 Operating Expenses are as follows:		
Supplies and services - General	719	603
Establishment	35,041	36,021
Transport	18	6
Premises	2,406	2,273
Total Operating Expenses	**38,184**	**38,903**

4.3 Non cash items		
Depreciation	2,601	2,498
Amortisation	407	431
Loss on disposal of property, plant & equipment (including land)	58	23
Provisions provided for in year	9,490	3,229
Cost of borrowing of provisions (unwinding of discount on provisions)	101	234
Auditors remuneration	52	66
Total non cash items	**12,709**	**6,481**
Total	**982,489**	**916,200**

During the year the HSCB paid its share of regional audit services (£1,173) from its external auditor (NIAO) for the National Fraud Initiative (NFI) and is included in operating costs above.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 5. INCOME

5.1 Income from Activities

	2015 £000s	2014 £000s
Income from Department of Education	26,509	25,116
CAWT	2,075	3,378
Family Health Services Receipts	23,134	22,275
Other Income	449	882
Total	**52,167**	**51,651**

5.2 Other Operating Income

	2015 £000s	2014 £000s
Accommodation	638	658
Canteen	215	207
Seconded staff	559	503
Total	**1,412**	**1,368**

5.3 Deferred income

	2015 £000s	2014 £000s
Total	**0**	**0**

TOTAL INCOME	**53,579**	**53,019**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 6. PROPERTY, PLANT AND EQUIPMENT

NOTE 6.1 Property, plant & equipment - year ended 31 March 2015

	Land £000s	Buildings (excluding dwellings) £000s	Plant and Machinery (Equipment) £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation						
At 1 April 2014	2,722	7,208	6	18,511	164	28,611
Indexation	0	0	0	0	0	0
Additions	0	52	0	2,055	0	2,107
Reclassifications	0	0	0	(2)	0	(2)
Transfers	0	0	0		0	0
Revaluation	428	(478)	0	0	0	(50)
(Disposals)	0	0	0	(2,987)	0	(2,987)
At 31 March 2015	**3,150**	**6,782**	**6**	**17,577**	**164**	**27,679**
Depreciation						
At 1 April 2014	0	934	6	12,173	164	13,277
Indexation	0	0	0	0	0	0
Revaluation	0	(1,159)	0	0	0	(1,159)
(Disposals)	0	0	0	(2,929)	0	(2,929)
Provided during the year	0	274	0	2,327	0	2,601
At 31 March 2015	**0**	**49**	**6**	**11,571**	**164**	**11,790**
Carrying Amount						
At 31 March 2015	**3,150**	**6,733**	**0**	**6,006**	**0**	**15,889**
At 31 March 2014	**2,722**	**6,274**	**0**	**6,338**	**0**	**15,334**
Asset financing						
Owned	3,150	6,733	0	6,006	0	15,889
Carrying Amount						
At 31 March 2015	**3,150**	**6,733**	**0**	**6,006**	**0**	**15,889**

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 (2014 £Nil).

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil (2014 £Nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 6.2 Property, plant & equipment - year ended 31 March 2014

	Land £000s	Buildings (excluding dwellings) £000s	Plant and Machinery (Equipment) £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation						
At 1 April 2013	2,722	6,981	6	16,850	164	26,723
Indexation	0	52	0	0	0	52
Additions	0	175	0	2,069	0	2,244
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	(157)	0	(157)
Revaluation	0	0	0	0	0	0
(Disposals)	0	0	0	(251)	0	(251)
At 31 March 2014	**2,722**	**7,208**	**6**	**18,511**	**164**	**28,611**
Depreciation						
At 1 April 2013	0	688	6	10,138	161	10,993
Indexation	0	14	0	0	0	14
Revaluation	0	0	0	0	0	0
(Disposals)	0	0	0	(228)	0	(228)
Provided during the year	0	232	0	2,263	3	2,498
At 31 March 2014	**0**	**934**	**6**	**12,173**	**164**	**13,277**
Carrying Amount						
At 31st March 2014	**2,722**	**6,274**	**0**	**6,338**	**0**	**15,334**
At 1st April 2013	**2,722**	**6,293**	**0**	**6,712**	**3**	**15,730**
Asset financing						
Owned	2,722	6,274	0	6,338	0	15,334
Carrying Amount						
At 31 March 2014	**2,722**	**6,274**	**0**	**6,338**	**0**	**15,334**
Asset financing						
Owned	2,722	6,274	0	6,338	0	15,334
Carrying Amount						
At 1st April 2013	**2,722**	**6,293**	**0**	**6,712**	**3**	**15,730**

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 7. INTANGIBLE ASSETS

NOTE 7.1 Intangible assets - year ended 31 March 2015

Cost or Valuation	Software Licenses £000s	Information Technology £000s	Total £000s
At 1 April 2014	1,343	3,734	5,077
Indexation	0	0	0
Additions	74	165	239
Reclassifications	0	1	1
Transfers	0	0	0
At 31 March 2015	**1,417**	**3,900**	**5,317**
Amortisation			
At 1 April 2014	853	3,152	4,005
Indexation	0	0	0
Provided during the year	185	222	407
At 31 March 2015	**1,038**	**3,374**	**4,412**
Carrying Amount			
At 31 March 2015	**379**	**526**	**905**
At 31 March 2014	**490**	**582**	**1,072**
Asset financing			
Owned	379	526	905
Carrying Amount			
At 31 March 2015	**379**	**526**	**905**

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 was £Nil (2014 £Nil).

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 7.2 Intangible assets - year ended 31 March 2014

	Software Licenses	Information Technology	Total
Cost or Valuation	**£000s**	**£000s**	**£000s**
At 1 April 2013	1,208	3,270	4,478
Indexation	0	0	0
Additions	117	326	443
Reclassifications	0	0	0
Transfers	18	138	156
At 31 March 2014	**1,343**	**3,734**	**5,077**
Amortisation			
At 1 April 2013	688	2,887	3,575
Indexation	0	0	0
Provided during the year	165	265	430
At 31 March 2014	**853**	**3,152**	**4,005**
Carrying Amount			
At 31 March 2014	**490**	**582**	**1,072**
At 1st April 2013	**520**	**383**	**903**
Asset financing			
Owned	490	582	1,072
Carrying Amount			
At 31 March 2014	**490**	**582**	**1,072**
Asset financing			
Owned	520	383	903
Carrying Amount			
At 1st April 2013	**520**	**383**	**903**

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 8. FINANCIAL INSTRUMENTS

Due to the relationships with HSC Commissioners, and the manner in which they are 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.

NOTE 9. ASSETS CLASSIFIED AS HELD FOR SALE

Non current assets held for sale comprise of non current assets which 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 2014/15 or 2013/14.

NOTE 10. IMPAIRMENTS

The HSCB had no impairments in either 2014/15 or 2013/14.

NOTE 11. INVENTORIES

The HSCB did not hold any inventories as at 31st March 2015 and as at 31 March 2014.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 12. TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.1 Trade receivables and other current assets	2015 £000s	2014 £000s
Amounts falling due within one year		
Trade receivables	5,589	6,940
VAT receivable	780	526
Other receivables - not relating to fixed assets	242	96
Trade and other receivables	6,611	7,562
Prepayments and accrued income	128	27
Other current assets	128	27
TOTAL TRADE AND OTHER RECEIVABLES	6,611	7,562
TOTAL OTHER CURRENT ASSETS	128	27
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**6,739**	**7,589**

The balances are net of a provision for bad debts of £Nil (2014 £Nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 12. TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.2 Trade receivables and other current assets: Intra-Government balances

	Amounts falling due within 1 year 2014/15 £000s	Amounts falling due within 1 year 2013/14 £000s
Balances with other central government bodies	1,494	2,179
Balances with local authorities	8	1,732
Balances with NHS /HSC Trusts	1,764	479
Intra-government balances	**3,266**	**4,390**
Balances with bodies external to government	3,473	3,199
Total receivables and other current assets at 31 March	**6,739**	**7,589**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 13. CASH AND CASH EQUIVALENTS

	2015 £000s	2014 £000s
Balance at 1st April	3,402	3,859
Net change in cash and cash equivalents	(1,087)	(457)
Balance at 31 March	**2,315**	**3,402**

The following balances at 31 March were held at	2015 £000s	2014 £000s
Commercial banks and cash in hand	2,315	3,402
Balance at 31 March	**2,315**	**3,402**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 14. TRADE PAYABLES AND OTHER CURRENT LIABILITIES

14.1 Trade payables and other current liabilites

	2015 £000s	2014 £000s
Amounts falling due within one year		
Other taxation and social security	335	577
Trade capital payables - property, plant and equipment	323	720
Trade capital payables - intangibles	121	192
Trade revenue payables	50,907	46,797
Payroll payables	1,696	1,390
Clinical negligence payables	1,018	0
BSO payables	5,481	9,440
Other payables	2,114	2,561
Accruals and deferred income	88,942	83,814
Trade and other payables	150,937	145,491
Total payables falling due within one year	150,937	145,491
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**150,937**	**145,491**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 14. TRADE PAYABLES AND OTHER CURRENT LIABILITIES

14.2 Trade payables and other current liabilities - Intra-government balances

	Amounts falling due within 1 year 2014/15 £000s	Amounts falling due within 1 year 2013/14 £000s
Balances with other central government bodies	262	3,502
Balances with local authorities	412	8
Balances with NHS /HSC Trusts	26,481	18,506
Balances with public corporations and trading funds	22	0
Intra-government balances	**27,177**	**22,016**
Balances with bodies external to government	123,760	123,475
Total payables and other liabilities at 31 March	**150,937**	**145,491**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 15. PROMPT PAYMENT POLICY

15.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that the 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:

	2015 Number	2015 Value £000s	2014 Number	2014 Value £000s
Total bills paid	20,599	55,753	18,875	44,753
Total bills paid within 30 day target or under agreed payment terms	17,647	48,532	15,930	36,091
% of bills paid within 30 days of receipt of an undisputed invoice	**85.7%**	**87.0%**	**84.4%**	**80.6%**
Total bills paid within 10 day target	11,992	38,555	11,181	24,663
% of bills paid within 10 day target	**58.22%**	**69.15%**	**59.24%**	**55.11%**

15.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of Compensation paid for payment(s) being late	0
Amount of Interest paid for payment(s) being late	292
	292

This is also reflected as a fruitless payment in note 26.

*New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16th March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 16. PROVISIONS FOR LIABILITIES AND CHARGES - 2015

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2015 £000s
Balance at 1 April 2014	16,721	18,657	8,878	44,256
Provided in year	1,274	8,697	1,880	11,851
(Provisions not required written back)	(1,957)	(343)	(61)	(2,361)
(Provisions utilised in the year)	(629)	(9,111)	(501)	(10,241)
Cost of borrowing (unwinding of discount)	301	(354)	154	101
At 31 March 2015	**15,710**	**17,546**	**10,350**	**43,606**

Comprehensive Net Expenditure Account charges	2015 £000s	2014 £'000
Arising during the year	11,851	7,701
Reversed unused	(2,361)	(4,472)
Cost of borrowing (unwinding of discount)	101	234
Total charge within Operating expenses	**9,591**	**3,463**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2015 £000s
Not later than one year	629	5,742	936	7,307
Later than one year and not later than five years	2,600	4,257	1,742	8,599
Later than five years	12,481	7,547	7,672	27,700
At 31 March 2015	**15,710**	**17,546**	**10,350**	**43,606**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 16. PROVISIONS FOR LIABILITIES AND CHARGES - 2014

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2014 £000s
Balance at 1 April 2013	17,584	28,491	8,776	54,851
Provided in year	341	6,904	456	7,701
(Provisions not required written back)	(468)	(3,982)	(22)	(4,472)
(Provisions utilised in the year)	(1,170)	(12,353)	(535)	(14,058)
Cost of borrowing (unwinding of discount)	434	(403)	203	234
At 31 March 2014	**16,721**	**18,657**	**8,878**	**44,256**

Provisions have been made for 4 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement and Injury Benefit. The provision for Early Retirement and Injury Benefit relates to the future liabilities for the HSCB based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the HSCB has estimated an appropriate level of provision based on professional legal advice.

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2014 £000s
Not later than one year	1,192	4,787	555	6,534
Later than one year and not later than five years	4,985	5,386	1,739	12,110
Later than five years	10,544	8,484	6,584	25,612
At 31 March 2014	**16,721**	**18,657**	**8,878**	**44,256**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 17. CAPITAL COMMITMENTS

The HSCB did not have any capital commitments at 31 March 2015 or 31 March 2014.

NOTE 18. COMMITMENTS UNDER LEASES

18.1 Operating Leases

The HSCB had no operating leases in 2014/15 or 2013/14.

18.2 Finance Leases

The HSCB had no finance leases in 2014/15 or 2013/14.

18.3 Operating Leases

The HSCB had no lessor obligations in either 2014/15 or 2013/14.

NOTE 19. COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

The HSCB had no commitments under PFI or other service concession arrangement contracts in 2014/15 or 2013/14.

NOTE 20. OTHER FINANCIAL COMMITMENTS

The HSCB did not have any other financial commitments at either 31 March 2015 or 31 March 2014.

NOTE 21. 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.

The HSCB did not have any financial instruments at either 31 March 2015 or 31 March 2014.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 22. CONTINGENT LIABILITIES

Clinical negligence

The HSCB has contingent liabilities of £213k.

	2015 £000s	2014 £000s
Total estimate of contingent clinical negligence liabilities	213	762
Amount recoverable through non cash RRL	(213)	(762)
Net Contingent Liability	**0**	**0**

In addition to the above contingent liability, provision for clinical negligence is given in Note 16. 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:

	2015 £000s	2014 £000s
Employers' liability	0	3
Amount recoverable through non cash RRL	0	(3)
Total	**0**	**0**

NOTE 23. RELATED PARTY TRANSACTIONS

The HSCB is an arms length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party with which the HSCB has had various material transactions during the year. In addition, the HSCB has had various material transactions with the Business Services Organisation for which the Department 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 HSC in the future.

Mr Sheelin McKeagney (Chairman of the Southern LCG) is a Board Member of Community Development & Health Network, which may be likely to do business with the HSC in future.

NOTE 24. THIRD PARTY ASSETS

The HSCB had no third party assets in 2014/15 and 2013/14.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 25. FINANCIAL PERFORMANCE TARGETS

25.1 Revenue Resource Limit

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

	2015 Total £000s	2014 Total £000s
DHSSPS (excludes non cash)	4,239,060	4,106,563
Non cash RRL (from DHSSPS)	12,709	6,481
Ajustment for CRL grants received for Brightstart	105	0
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**4,251,874**	**4,113,044**

25.2 Capital Resource Limit

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

	2015 Total £000s	2014 Total £000s
Gross capital expenditure	2,346	2,687
Net capital expenditure	2,346	2,687
Capital Resource Limit	2,354	2,689
Underspend against CRL	**(8)**	**(2)**

NOTE 25.3 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.

	2014-15 £000s	2013-14 £000s
Net Expenditure	(4,244,846)	(4,112,847)
RRL	4,251,874	4,113,044
Surplus against RRL	7,028	197
Break Even cumulative position (opening)	760	563
Break Even cumulative position (closing)	**7,788**	**760**

Materiality Test:	2014-15 %	2013-14 %
Break Even in year position as % of RRL	0.17%	0.00%
Break Even cumulative position as % of RRL	0.18%	0.02%

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

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2015

NOTE 26. LOSSES & SPECIAL PAYMENTS

26 Losses and Special Payments

Type of loss and special payment		2014/15		2013/14
		Number of Cases	£	£
Cash losses	Cash Losses - Exchange rate fluctuations	1	510	55
		1	**510**	**55**
Claims abandoned	Waived or abandoned claims	0	0	8,860
		0	**0**	**8,860**
Fruitless payments	Late Payment of Commercial Debt	2	292	0
		2	**292**	**0**
Stores losses	Losses of accountable stores through any deliberate act	0	0	265
		0	**0**	**265**
Special Payments	Compensation payments			
	- Employers Liability	3	25,167	0
	- Clinical Negligence	17	6,320,188	10,492,268
		20	**6,345,355**	**10,492,268**
	TOTAL	**23**	**6,346,157**	**10,501,448**

26.1 Special Payments

There were no other special payments or gifts made during the year.

26.2 Other Payments and Estimates

There were no other payments made during the year.

Estimate of patient exemption fraud.

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 HSCB, 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 Total loss for the NI region 2014/15 has been estimated as £3.69m (£2.96m Dental, £0.73m Ophthalmic). Comparative figures for 2013/14 when uplifted to 2014/15 activity levels, are: Dental £2.67m and Ophthalmic £0.71m.

26.3 Losses and Special Payments over £250,000

Losses and Special Payments over £250,000	Number of Cases	2014/15 £	2013/14 £
Special Payments			
Clinical Negligence £0.77m- Misdiagnosis	1	770,000	
Clinical Negligence £1.2m - Birth Complications	1	1,213,598	
Clinical Negligence £3.3m - Birth Complications	1	3,300,000	
Clinical Negligence £0.5m - Birth Complications	1	500,000	
Prior year total for comparison (7 cases)			10,492,268
TOTAL	**4**	**5,783,598**	**10,492,268**

NOTE 27. POST BALANCE SHEET EVENTS

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

NOTE 28. DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 01 July 2015.