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CONTENTS

Introduction by Chairman and Chief Executive................................. 2
Membership of the Board...................................................................... 4
Role of the Board................................................................................ 5
Commissioning Directorate................................................................ 7
The five Local Commissioning Groups............................................. 10
Corporate Services............................................................................. 22
Directorate of Social Care and Children.......................................... 29
Directorate of Performance Management and Service Improvement.................................................. 31
Directorate of Integrated Care......................................................... 36
Finance Directorate............................................................................ 40
Reference Committee......................................................................... 43
Pharmacy Practices Committee......................................................... 45
Remuneration Report.......................................................................... 47
Statement on Internal Control............................................................ 52
Summary Financial Statement............................................................. 54
Introduction to the first Annual Report by Mr John Compton, Chief Executive, and Dr Ian Clements, Chair.

We are very pleased to introduce this first Annual Report on behalf of the Health and Social Care Board, which plans or ‘commissions’ a comprehensive range of health and social care services for everyone in Northern Ireland.

The Board was one of a number of new organisations established by the Minister for Health, Social Services and Public Safety, Michael McGimpsey MLA, on 1st April 2009, under the Review of Public Administration. Throughout its first full year of operation the Board has worked ardently to ensure that health and social care services are provided at optimal quality, and demonstrate value for public money. This is a very challenging task and will remain so in the light of increasing demand for care services of all kinds – and the prospect of constrained public spending during the next few years. Increasingly, the Board will be expected to make far-reaching decisions about the future scale of, location and cost of health and social care.

But in reaching decisions on the big issues of the day, the Board must actively engage with those affected by its decisions – because we want to work with and alongside everyone who maintains a community or ‘stakeholder’ interest in our role. We must therefore act as a partner and broker with a wide range of interest groups or ‘stakeholder’ bodies. These include, for example, the general public and their representatives, health and social care Trusts, the Public Health Agency, the Northern Ireland Assembly, local government, the Patient and Client Council, the trades unions, voluntary, community and independent sectors and many others. Collectively, these partners serve as the voice or influence of the community and service users on whom the work of the Board is most clearly focussed. So what they say, what they aspire to and what they can offer us in terms of guidance and joint working is vital and will remain so.

Building influence among community interests can also build confidence in the system of care. To help achieve this, the Board made a significant and successful effort in this first year to establish its five regional ‘arms’ or Local Commissioning Groups (LCGs). Each of the LCGs are geographically coterminous with the five health and social care Trusts, and their work is crucial in allowing the Board to fulfil its commissioning role at a more local and sensitive level. This sensitivity is enhanced by the direct roles being played within all five LCGs by local GPs, by other practitioners such as pharmacists and social workers, and by community and elected representatives. So we have a robust commissioning system based upon giving people a real say and genuine influence at grass roots.

We believe this report will show that the Board has made a solid start to its work and that innovations have been put in place during the last twelve months that offer scope for further success. These embrace all the key services that people receive from their local...
Health and Social Care Trust, their GP, their social worker and all the other practitioners, independent, voluntary and community bodies, who contribute to the provision of care.

But none of this is possible without the commitment of the Board's staff and those of its partners in this collective effort. That commitment has been freely and unstintingly given at a time when staff are facing unprecedented changes to the future roles of the organisations in which they work. In an era in which health and social care is facing ever growing demand and the prospect of constrained finance, staff have shown a remarkable resilience and flexibility. This has enabled the Board to successfully achieve challenging efficiencies required under the Review of Public Administration to release resources for front line care services of all kinds. So we fully acknowledge – and value - that contribution and effort.

In retrospect, the first year of the Board has been characterised by changes and challenges, many of which continue at the time of publication of this report. But within this context, the Board has been able to consolidate its role and put in place working arrangements that will optimise its functions and effectiveness in the future. Much valuable work continues, for instance, in areas such as corporate governance, equality and risk management to ensure that what is a comparatively new organisation delivers public accountability to the highest required levels. Similarly, work continues apace on other fronts to maximise the performance monitoring of Trusts, to maintain quality of care in both hospital and community settings and to address quickly complaints from service users.

The role of the Board is of course a highly complex one. It spends around £3.7 billion of public funds - in the region of £10 million every day - to provide the community with the accessible health and social care that people have rightly come to expect. An operation of this scale requires a Board that can balance an interplay of influence and pressures – the expectations of people, the finite nature of resources, the impact of new health care technologies, changing demographics and the capacity of its staff.

In this context, we believe the Board has made significant progress in this it’s inaugural year, and has laid the foundation for the work to come. The fact that we have been able to get off to a good start reflects well on all our staff and our many partners. So our thanks go to everyone who has assisted in ways big or small.

Next year will bring further challenges. On the basis of what has been achieved so far, as set out in this report, we believe the Board is well placed to meet them.

Dr Ian Clements
Chair

Mr John Compton
Chief Executive
Membership of the Health and Social Care Board

The Health and Social Care Board is comprised of both ‘executive’ and ‘non-executive’ directors. ‘Executive’ directors are senior members of its full time staff who have been appointed to lead each of its major professional and corporate functions. ‘Non-executive’ directors are appointed by the Minister for Health, Social Services and Public Safety to reflect wider outside and community interests in the decision-making of the Board.

The Board comprised the following directors during its first year of operation, 1st April 2009 – 31st March 2010:

Non Executive Directors:

Dr Ian Clements  
Chairman

Dr Melissa McCullough

Mr Robert Gilmore

Mr Brendan McKeever

Mrs Elizabeth Kerr

Mr John Mone

Mr Stephen Leach

Dr Robert Thompson

Executive Directors:

Mr John Compton  
Chief Executive

Mrs Fionnuala McAndrew  
Director of Social Care and Children

Mr Paul Cummings  
Director of Finance

Mr Hugh Mullen  
Director of Performance Management and Service Improvement
The role of the Health and Social Care Board

The Health and Social Care Board was established by the Minister Michael McGimpsey MLA on 1st April 2009 and faces a diverse and challenging role as it seeks to develop health and social care services across Northern Ireland. The Board replaced the four former area-based health and social services Boards under the Review of Public Administration in Northern Ireland, an important process to streamline many public services, which continues at the present time.

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 1.7 million people who live in Northern Ireland.

2. To performance manage health and social care trusts that directly provide services to people to ensure that these achieve 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 £3.7 billion – to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

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

The Board is further advantaged because the commissioning of care services now rests with one single organisation, and specific arrangements have been put in place to connect it with community interests and to enable it to work effectively with a range of partner organisations. These important aspects are provided through:

- The devolution of the Board’s role through five regional arms or Local Commissioning Groups or LCGs. The groups are geographically coterminous with each of the five health and social care trusts that already directly provide services to the community. The LCGs incorporate a range of professional interests such as GPs, nurses, dentists, pharmacists and social workers, as well as voluntary and elected representatives, to ensure that the work of the Board has genuine sensitivity and influence at a local level.

- Engagement by the Board and the LCGs with a wide range of stakeholders - partner organisations, community interests and elected representatives, to give local people a voice on and influence over the range of services available to them.
This partnership role is keenly manifest in an effective and dynamic working relationship with another new organisation – the Public Health Agency (PHA). The Board works in close association with the Agency to help facilitate its role in protecting public health and in actively promoting health improvement.

The Public Health Agency

The Agency, like the Board, was established on 1st April 2009 and the two organisations share a common interest in health improvement and in the planning of health and social services for the people of Northern Ireland.

Broadly, the role of the Public Health Agency is to:

- Develop plans and strategies to improve the health and wellbeing of the people of Northern Ireland, and reduce inequalities.
- Protect the community from risks to health, for example, through prevention and control of infection, and preparation and response to major incidents.
- Oversee introduction and ongoing development of screening programmes, for example, breast, cervical and bowel cancer screening.
- Advise the HSC Board on commissioning, particularly in relation to medicine, nursing and allied health professions.
- Consider, and if appropriate, approve the commissioning plan.

The PHA is represented on the HSC Board by its Medical Director and Director of Nursing and AHPs. Commissioning teams are comprised of HSCB and PHA staff, including teams which relate primarily to the PHA’s role. This demonstrates the common agenda shared by both organisations and their ability to work in close association with one another. The PHA is also represented on each of the five Local Commissioning Groups or LCGs which provide for local influence for the work of the Board and, here again, this shows the capability of both organisations to bring a local focus to their roles and to work actively with community and elected representatives.

The remainder of this report will now describe in more detail how the Health and Social Care Board discharged its functions during its first full year of operation.
Commissioning Directorate

Regional Commissioning and Contracting

The services which the Board commissions for the Northern Ireland population can be broken down into three categories; services delivered through local providers and Trusts; services delivered by one or at most two providers for all of our population and highly specialist services often delivered from outside Northern Ireland. These last two categories are managed by a Regional Commissioning and Contracting Office. This office is also responsible for procuring additional specialist services and high cost drugs to meet exceptional health or social care needs and for the overall coordination of service agreements.

Regional Commissioning and Strategic Planning

Regional/specialist commissioning arrangements are in place in Northern Ireland for a discrete number of medical and social care services as:

- Highly specialist services tend to require expertise to be concentrated within single teams to ensure skills are maintained and good practice standards are met;
- Northern Ireland has a relatively small population of 1.7m. This means that there will tend to be a smaller number of people who require specialist care;
- The service may be very high cost and the pattern of demand unpredictable across the region. Provision via a single arrangement supports a financial risk sharing approach across the localities. This means that if a high cost case or a small cluster of high cost cases occur within a particular locality then an equitable approach is taken to supporting the resultant costs on a regional rather than a local basis;
- Where facilities and high cost equipment are required to deliver the service it again may be necessary to concentrate these on a specific site. For example linear accelerator machines for radiotherapy or intensive rehabilitation facilities for patients following significant trauma.

Managed Clinical Networks

More recently Northern Ireland has been developing a Managed Clinical Network (MCN) approach across the region. Services such as critical care, cancer, cardiology and pathology services have all been established as formal networks. These networks operate through teams of clinicians and other staff working together to review the current standards of practice, compare these with national and international standards and develop pathways towards making improvements wherever these services are provided in the region.
Regional Social Care Commissioning Arrangements

During 2009/10 the Board has begun to develop new systems to support regional social care commissioning arrangements. Previously these were commissioned via individual Health and Social Services Boards. Regional social care services will most likely need to be considered under the auspices of 3 specialist groupings covering mental health, physical disability and children’s services.

Regional Service Procurement

2009/10 was an important year for establishing systems to support these regional commissioning roles and to begin to prepare for additional responsibilities devolved to the Board from the DHSSPS e.g. Pharmaceutical Clinical Effectiveness and investment in services provided by a number of voluntary and community organisations.

In 2009/10 the Regional Office focused on engagement with the various stakeholders both within the HPSS family and outside agencies to identify priority projects and undertake some important groundwork for bedding in regional commissioning systems following reorganisation.

Prison Health

Lead responsibility for prison health transferred to HSC on the 1st April 2008. During 2009/10 the Regional Office worked with the Prison Health Partnership Board, whose membership includes representatives from the DHSSPS, the HSCB, the South Eastern Health and Social Care Trust and the Northern Ireland Prison Service to ensure that prisoners receive health services equivalent to those in the community.

Engagement with the Voluntary and Community sectors

Working with service users and carers, such as in this project on autism, is becoming increasingly important for the Board.
The third sector is an increasingly important provider of health and social care services and some of its services are directly commissioned by the Board and the Public Health Agency. During 2009/10 the Regional Office and PHA colleagues engaged with the Chief Officers of Voluntary and Community Organisations to seek their views on ways to improve our commissioning with the sector.

Following this consultation a range of standard documentation was completed for use in 2010/11. In addition the Regional Office took the lead in developing a regional database to record all the Board and PHA contracts agreed across the province. During the 2009/10 year over 600 contracts were agreed with the sector by the Board and PHA.

**Service and Budget Agreements**

The Regional Office has a role in co-ordinating arrangements for governance and accountability which are the common responsibility of the five Local Commissioning Groups. The Service and Budget Agreement document is an example, as it provides a signed record of agreement between each local Trust, the Board and the PHA.

During 2009/10 the Regional Office engaged with the Local Commissioning Group leads and colleagues in Performance Management and Service Improvement to agree a common structure and content for the standard 2010/11 Service and Budget Agreement document.

**Specialist Commissioning**

The Regional Office has the role of commissioning services to meet rare or exceptional health and social care needs which are identified by Trusts. During 2009/10 work was undertaken to analyse the trends in referrals to specialist providers outside the NI HPSS and to assess to what extent local service developments might offer more accessible value for money alternatives. The 2010/11 Commissioning Plan includes a target for reducing our reliance on specialist “Tier 4” Eating Disorder services outside Northern Ireland by developing our local provision. This is an example of invest to save which can be built upon throughout 2010/11 and beyond.
The Five Local Commissioning Groups or LCGs

The Board’s role as a commissioner of health and social care services is fulfilled locally by each of the five Local Commissioning Groups. The groups are each comprised of a membership that reflects the professional interests of the Board, the Public Health Agency and community and elected representatives. In terms of geography, they are each coterminous with the five Health and Social Care Trusts that directly provide commissioned services to the community – Belfast, South East, Northern, Southern and Western. Each of the LCGs commenced their work during the past year, and their activities and achievements are summarised here.

The Belfast Local Commissioning Group

Members of the Belfast LCG pictured at one of their public meetings held each month.

The Belfast Commissioning Group held its inaugural meeting in Belfast City Hall on 19th November 2009. This firmly established the link between the LCG and the City Council. The LCG held its January meeting in Castlereagh Borough Council offices to demonstrate its cooperative working with both Councils.

Engagement with Users and Local Communities

LCGs have a lead role in personal and public involvement within their areas and from the outset the Belfast Group has been determined to maximise its engagement with the most disadvantaged communities and groups in the city, and focus on their health and care needs. The Group has already held meetings in Bryson House, Farset Hostel on the Springfield Road, Shankill Spectrum Centre and Tullycarnet Community Resource Centre. People living in these neighbourhoods have some of the poorest health and well-being in Northern Ireland.

The community organisations and Area Partnerships working to improve health and well being in these areas have been invited to present their work and their recommendations for action to the LCG. Presentations have been given to the LCG by the West Belfast; Greater Shankill; East Belfast; North Belfast and South Belfast Partnerships; Tullycarnet Neighbourhood Partnership and Ballybeen Women’s Centre, as well as An Munia Tober; an
organisation that represents the interests of the travelling community in Northern Ireland.

The format of LCG meetings has been designed to put these groups to the fore in leading the debate by breaking down traditional committee-style barriers and promoting direct engagement. Community and voluntary groups have been actively encouraged to participate and some 30 groups have already been represented at LCG meetings and joined in the discussions.

The LCG has developed a close working relationship with the Patient and Client Council and identified a range of joint initiatives to be taken forward.

Topics for in-depth discussion at the LCG workshops and meetings have focused on the social determinants of health and the wider public health and well being agenda, including suicide prevention, the hidden impact on families of addiction and violence, the social exclusion experienced by carers and the support they need, the health needs and barriers to access experienced by Travellers and the need for integrated planning of services for children and young people.

Programme of Reform

The LCG is looking closely at how patients access services, the barriers to access, the signposts along the journey and alternative, more appropriate and speedier alternatives to traditional services. A wide range of conversations have been begun with clinicians from primary and secondary care and voluntary organisations who provide services along these pathways. The participation of users and carers in these discussions is critical.

Pathways being reviewed at present are:

- Diabetes
- Mental Health Services
- Community Care for Older People
- Eye Care
- Emergency and out of hours care

Integrated working has been a core theme for the LCG both within the health and social care sector, across disciplinary boundaries and between hospital and community, as well as between the statutory, voluntary and community sectors, and between statutory agencies.

The LCG has supported Belfast Healthy Cities and the new Belfast Health Development Unit and is working to promote Health and Health Equity in All Policies across all sectors of government. The LCG has also taken a leadership role in the Healthy Ageing Strategic Partnership.

The LCG has promoted integrated planning for Children and Young People in the context of the Children’s Strategy working closely with the Councils, Area Partnerships, Public Health Agency, Education and other partners.

Belfast LCG has been to the fore in promoting and facilitating debate and developing ideas on new forms of integrated working. In an era when there will be little growth in
funding but continuing increases in demand for services and rising standards of quality, the creation of added value from existing funding will be crucial. This requires integrated working to be comprehensive and well-organised at the frontline.

The LCG has proposed the establishment of 4 new Primary Care Partnerships to provide integrated primary and community care services across Belfast.

These new providers would focus on needs at community and individual level and make decisions about the deployment of resources as close to the point of service delivery as possible. They would include all independent GP and Community Pharmacy practices in a locality and involve service users at their heart and will work closely with Area Partnerships and other community, voluntary and statutory partners involved in providing services directly to patients and clients and their families.

The LCG will work with partners to facilitate and promote Locality Planning at neighbourhood level, giving service users and local communities full involvement in decision-making over resources being deployed in their areas. This will ensure that resources are effectively targeted to those most in need.

South Eastern Local Commissioning Group

The South Eastern LCG in session at a public meeting in Newcastle.

The South Eastern Local Commissioning Group, under the Chairmanship of Dr Nigel Campbell, has enjoyed an active year in its new role as the local Commissioner for the south east, with a responsibility for a population of some 341,000 which covers the geographic area covered by Down, Lisburn and North Down local government districts. In January 2010, Mr Paul Turley was appointed as the Commissioning Lead for the locality and the Group looks forward to further appointments being made into both the Management Board and the management structure which will support the functioning of the Group.

The LCG has also invited to the management board table local managers from the Patient Client Council and the Investing for Health Initiative, underscoring our commitment
to the voice of patients and carers and our emphasis on addressing health inequalities. The Group has also expressed its support for the overall equality agenda, and sought to ensure that its commissioning decisions align with the Board equality framework.

In 2009/10 the Group’s activities have provided a good foundation for members in regard to the substantial issues that will come their way in future commissioning cycles. The Group has already begun to develop processes around its key mandates of assessing need, planning and commissioning services, securing delivery of services in a co-ordinated cost-effective way and improving the quality of health and social care services delivered to our population.

The LCG has formed a clear understanding of the health and social care issues that confront the population locally. In terms of disease prevalence the clinical register within QOF displays that the population within the south east has the highest levels in the following disease areas – asthma, cancer, dementia, diabetes, and certain categories of heart failure and stroke. The theme of an ageing population is one the LCG has registered in particular; our assessment on the 75 plus population indicates a significant increase in the sub-localities of Lisburn and Ards, with projected increases between 2009-15 of 20.7% and 19.4% respectively.

The LCG recognises that the financial climate in 2009/10 has been particularly difficult and that the settlement for the health sector in 2010/11 will be even more challenging for both Commissioners and all service providers, not just the Health and Social Care Trusts. Therefore the allocated resources available to the LCG will mean that it may no longer be possible to replicate current pattern of care and support. This point has been emphasised this year in our discussions with partner organisations. As a result, the LCG has been involved with the Performance Management and Service Improvement Directorate in dialogue with the SE Trust to ensure value for money in the services already commissioned.

While significant investments have been made in the year to develop additional capacity in services, specifically in the acute hospital sector the LCG worked both regionally, as part of a demand management project team to understand the referral patterns from primary care into secondary care (given the significant year-on-year rise in referrals) and locally to implement some of the learning from the project team’s work. As a result, the LCG have taken forward a project on ophthalmology and commenced some early analysis within the dermatology speciality.

Other topics occupying the LCG agenda in 2009/10 included proposals to transfer the consultant led in-patient obstetric service from the Lagan Valley site and the ministerial decision to build a Midwifery Led Unit on the LVH site. Also, in Mental Health services, the work in relation to the resettlement and transfer of in-patient services from the Downshire site continues with the Trust pursuing the development of community home treatment teams and prioritisation of support for community based therapies, patient advocacy and support for carers.
In our discussions with the South Eastern Trust, the need for substantial capital investment in the locality to support new service models is clearly apparent and this issue is being progressed in partnership with the Department of Heath in respect of the capital investments options. The completion of the new Critical Care Complex this year – a first phase project in the planned redevelopment of the Ulster Hospital site afford our population the opportunity of the highest quality care in one of Europe’s most technologically engineered healthcare facilities. While this project represents state of the art critical care and other facilities it does present the Commissioner and the Trust with very significant additional revenue consequences in 2010/11.

The additional revenue for this and other development schemes, such as the Dunmurry Wellbeing and Treatment Centre, remain as issues for further discussion. The LCG also supported in-year the Trust’s request to prepare plans for a major redevelopment of the Lagan Valley Hospital site in Lisburn.

It is evident to the LCG in its first year that within the south eastern area there is a strong community development culture which is already being harnessed to address the health and social care agenda. The Group has spent time in conversation with the community networks across the locality and a feature of our public board meetings, which commenced in December 2009, was the opportunity to hear at first hand from this sector about issues relevant to the communities within which they are established.

The South Eastern LCG has given a commitment to community representatives that they will have a voice when it comes to shaping and planning future local services through our commissioning processes. The LCG has prioritised its relationship with the Public Health Agency and locally with the Investing for Health initiative to give continued momentum to the health improvement agenda in tackling inequalities and those factors in early life that can determine the health outcomes for individuals throughout their lives. While the Colin area, in the Lisburn City Council area, remains an important area for the LCG in terms of improving health outcomes, the Group has been keen to target all those areas of high deprivation within the locality for scrutiny with a view to improving health opportunities and outcomes.

The LCG also commenced a programme of direct engagement with the four District Councils in the locality (Ards, Down, Lisburn and North Down) in 2009/10. This engagement with our local Council colleagues will be on-going as the LCG is keen to exploit the potential added value that our Council partners can contribute to improving health opportunities in their future new community planning role. Likewise the LCG has commenced discussions with local independent contractors.

GPs locally have been invited to get involved in a recent demand management pilot with the LCG and the Group will also be keen to follow up with local pharmacists, dentists and optometrists in scoping and implementing similar initiatives.
Northern Local Commissioning Group

With the advent of the Health and Social Care Board and the Public Health Agency in April 2009, came a new era in local commissioning with the creation of five Local Commissioning Groups. As local expressions of the Health and Social Care Board, the LCGs are well placed to take commissioning decisions rooted in the knowledge of their local area, the services provided and the financial parameters within which they must operate.

In the Northern LCG, there has been some continuity of representation with all of the independent practitioners having served on previous LCGs. In addition, their expertise has been bolstered with the appointment of four elected representatives and two voluntary sector members, all of whom were selected through the Public Appointments process.

As before, the LCG is well supported by a number of professional staff from the Board and Agency with considerable expertise in commissioning.

Building the Knowledge and Skills

As with any new Group, there is a certain amount of capacity building needed to ensure the LCG can deliver on its potential. Early LCG meetings have focussed on building knowledge and skills across the range of health and social care issues. Contributions from Board, Agency and Trust staff have been instrumental in that early development. Members are increasingly aware of the financial backdrop against which they will be commissioning services over the next number of years and the challenges that this will present. Working with The Beeches Management Centre, the Northern LCG will develop an action plan for the year ahead prioritising its resources and energies. Input will also be forthcoming from The Beeches to ensure that the LCG works well as a Group. Support will be available for the Chair and Commissioning Lead and a programme of ongoing development for members is also being arranged.
Early Initiatives

- The LCG has worked in partnership with the Northern Health and Social Care Trust, the Ulster Farmers’ Union and a local Livestock Market to bring health promotion services to farmers in the workplace. For three consecutive days at a local livestock mart, farmers were able to have a range of health checks completed: blood sugar, cholesterol testing, blood pressure, BMI checks and dietary advice. Results were given to the individuals concerned and also passed to their GP to initiate follow up action, if required. Targeting farmers was seen as a local priority given the age profile of the community and the fact that they would not easily avail of services in traditional settings. Feedback from the local farming community and the health professionals involved was very positive. Dr Brian Hunter, Chair of the Northern LCG, was instrumental in bringing together the key players and harnessing the collective energies of those involved. He described this as an example of the LCG working in partnership with other agencies to improve health and well-being outcomes for the local population, in particular those who are hard to reach.

- Each LCG has been assigned a role in pathway redesign in secondary care and the Northern LCG has chosen to look at ENT services. This is a considerable challenge given the growth in secondary care referrals in recent years and the presenting financial climate. Engagement with Trust clinicians around the whole patient pathway and the role and remit of ICATS (Integrated Care, Assessment and Treatment Service) has been particularly insightful, and further stakeholder discussion will follow on how best to take all of this forward.

- GP representatives on the LCG have been actively involved in referral management projects and peer reviewing their referral patterns. This is in support of the wider regional project to understand demand for secondary care services and design pathways to deal with the presenting workload.

Engagement with Stakeholders

As a new entity, engaging with local communities and other bodies is an important building block in the development of a local Commissioning Plan. Both the Chair and the LCG Lead have met a wide range of stakeholders to canvas views on commissioning priorities for the years ahead and to share the challenges of what will be a fairly difficult financial outlook. From councils to community networks, the messages have been consistent and robust: more needs to be done at a local level to address health inequalities and to support families and communities make healthy and informed choices. Early engagement has highlighted the need for upstream commissioning and the need to do things differently. The LCG is keen to respond to these challenges and will focus on these key themes as part of its forthcoming action planning day.

Mindful of the financial climate for the next year and beyond, the LCG knows that difficult commissioning decisions lie ahead. There is an energy and enthusiasm within the LCG to take forward these challenging agendas with support from the Health and Social Care Board, the Public Health Agency, the local Trusts and other stakeholders.
Southern Local Commissioning Group

The Southern Local Commissioning Group (LCG) was formally established at its inaugural meeting on 7 January 2010.

During 2009, while appointments to the LCG were being made through the public appointment process, it existed in shadow form and met regularly to prepare for commissioning health and social care in the Southern area. At monthly meetings and workshops members took opportunities to learn more of the range of services, delivery mechanisms and challenges facing commissioning health and social care on behalf of the population living in the Southern area. They also participated in a development workshop to increase their understanding and capacity to be effective commissioners and are committed to an on-going capacity building programme to achieve this.

Early in 2009, the LCG took some time to consider the development of the 'Stepped Care Model' for Primary Care Mental Health Services and affirmed its intention to be involved in supporting its implementation across the Southern area. In December, the LCG formally visited the Bluestone Unit, a state of the art 74 bed unit on the Craigavon Area Hospital site for individuals with mental health needs, recognising the need to ensure in-patient mental health needs were also addressed.

In response to a 16.7% growth in general surgery out-patient referrals over the last three years in the Southern area, the LCG led a review process to consider if there were alternative pathways which could be employed to more efficiently and effectively manage this rising demand. Following discussion on the findings of this review, a number of approaches are being pursued within both primary and secondary care to provide guidance to clarify referral, diagnostic and treatment processes.

LCG members have been involved in the development of a pilot of an acute physician post within the Southern Health and Social Care Trust. This post will provide a fast access point for primary care professionals to discuss the assessment of acutely ill patients. GPs on the LCG have also been involved in the implementation of the Regional Stroke Strategy, specifically providing input in the areas of the organisation of services to assess and treat stroke patients who are suitable for thrombolysis, and in the work ongoing around the discharge and follow-on care of patients after stroke.
Public Engagement

Working with stakeholders has formed an important part of the Southern LCG’s first year.

Throughout the past year, the LCG engaged with a range of key stakeholders within the community, voluntary and public sectors to promote the existence and work of the Group. At its February 2010 meeting, LCG members agreed to pro-actively engage with members of the public, users, clients and Elected Representatives to seek their views on the health and social care services which the Group should commission on their behalf.

Pictured above at the LCG Public Engagement Meeting above in Newry were Sheelin McKeagney, Chair, Southern LCG (far left) and Lyn Donnelly, Commissioning Lead (far right) and participants.

During February and March three public engagement events were held across the Southern area and over 70 individuals attended and shared their health and social care priorities, needs and concerns with LCG members. Key issues raised at the events included; the need for open and transparent communication, the importance of commissioning prevention and early intervention programmes across all programmes and themes, and the need to work in true partnership with the community and voluntary sector.

Following the success of these events, the LCG is committed to developing a User, Communication and Engagement Policy in 2010, to ensure it continues to develop and utilise its understanding of the needs and experiences of individuals and communities as it responds to the challenges facing health and social care commissioning.

Future Direction

The LCG will place significance emphasis during the coming year on commissioning, prevention and early intervention initiatives and programmes, particularly those which target the most disadvantaged within our communities. It will work closely with the Public Health Agency and other partners and stakeholders to reduce the significant health inequalities experienced by the population living in the Southern area in line with the regional ‘Investing for Health Strategy’.

While recognising the current challenging financial climate, the LCG will pursue the commissioning of evidence based and patient centred services which incorporate
significant modernisation and reform. During 2010, it will continue to review demand for consultant led services and work with groupings of primary care professionals, especially GPs, to design and implement pathways and guidance and provide innovative and pioneering solutions to managing this demand.

**Western Local Commissioning Group**

At the Western Local Commissioning Group’s inaugural meeting on 9 December 2009 in Enniskillen, Dr Brendan O’Hare, LCG Chair, reflected on the local commissioning journey which had finally delivered local authority among the multi-disciplinary members to drive change in Health and Social Care. He accepted that it would take time for the LCG to be fully functioning and fully conversant with the range of challenges facing the West but expressed optimism going forward which was shared by LCG members.

It had taken some time to appoint the members of the new group. Some carried on their involvement from the previous LCGs. Others were recruited through an open process. Those nominated by the Health and Social Care Board and Public Health Agency brought considerable commissioning expertise and joined independent practitioners, voluntary and community sector members, and elected representatives, all of whom added their frontline experience and knowledge to the new commissioning body. All members were appointed on merit.

**Commissioning**

In the months leading up to the inaugural meeting, the LCG Chair and the Commissioning Lead worked closely together to gain insight into the current services and to understand the challenges facing Health and Social Care in the West. They took forward ongoing commissioning roles in relation to Trust performance management working closely in this process with colleagues in performance management, and with Trust officers to consider opportunities for service improvement and redesign.

The Chair has played a central role in a programme to manage demand on secondary care services, engaging with clinicians to undertake referral review exercises in dermatology and gynaecology and, in turn, offering proposals to the Trust on improving care pathways which would lead to more efficient use of resources. The Chair has also developed a pilot to improve referral practices in Primary Care which it is hoped will lead to fewer referrals to secondary care.

The Commissioning Lead has been closely involved in progressing a series of capital developments in the West which require additional revenue monies and has kept the LCG apprised of progress. The proposed Altnagelvin Radiotherapy Unit continues to be scrutinised to ensure the considerable capital and revenue finance required will meet the capacity shortfall in radiotherapy in Northern Ireland and the Republic of Ireland in the future. Building work on the South-West Hospital is well-advanced and the LCG is turning its attention to the additional revenue monies needed to open the hospital in 2012. The plans for the Omagh Local Enhanced Hospital will soon be finalised following
a period of scrutiny to ensure the models of care and financial requirements are appropriate.

The LCG is mindful that Learning Disability Services will complete the resettlements programme in 2010 with the opening of two Intensive Support Units which will house 24 people currently living long-term in hospital. This is a significant achievement to a programme which has taken a decade to complete. The LCG has commissioned intensive crisis support to complement this and prevent others who are admitted to hospital for treatment from having their discharge delayed.

In light of an increasingly difficult financial context, the LCG took the decision to ensure that Western Urgent Care live within its budget for providing GP out-of-hours services after midnight. The Commissioning Lead has robustly defended the decision to reduce the number of GPs working after midnight when patient numbers are small and where the impact on patient care throughout the night will be minimal. Concerns have been raised among politicians that the savings will undermine the delivery of an accessible services but the LCG has sought to reassure councillors and MLAs that quality standards will be maintained. The LCG plans to produce a fortnightly report to evidence the continued effectiveness of this important service.

Engaging

The LCG has embarked on a proactive stakeholder engagement programme which sets out to engage meaningfully with a wide range of interests across the Western area. The programme enables the LCG raise awareness of the commissioning challenges it faces and to gain understanding of the priorities various stakeholders hold which need to be taken into account in developing commissioning plans. Almost 200 people participated in stakeholder events arranged with councils, community networks and partnerships.

The engagement has confirmed many of the priorities the LCG is looking to take forward in the next year and brought a focus on the importance of issues such as carer support, autism, domestic violence, domiciliary care, respite care and transport. It also highlighted the importance of working in partnership to deliver health and social care effectively; the imperative to commissioning ‘upstream’, including earlier intervention across a range of programmes; the need to take forward the conclusions of the Bamford Review; and challenges facing acute hospital services in maintaining services in a difficult financial context in the face of problems recruiting and retaining medical staff. The LCG has considered a report of the issues raised which is available on the HSCB website. A further round of meetings is planned in Spring 2010.

Looking Ahead

As part of its stakeholder engagement programme, the LCG produced an outline local commissioning plan to stimulate discussion. The paper was well received and highlighted the challenges facing the LCG in 2010 and onwards and has proven a useful tool in raising
awareness of the challenges facing Health and Social Care and in feeding local priorities into the Commissioning Plan.

The LCG has expressed a determination to commission ‘upstream’, through greater emphasis on health promotion, prevention, self-care and Primary Care. In particular, the LCG has highlighted the importance of the Investing for Health agenda and its focus on tackling health inequalities and promoting mental health. The LCG has recognised the significant work underway to address suicide and self-harm in the West which it is committed to driving forward.

The LCG wishes to further develop cross-border relationships with health and social care partners in the Republic of Ireland. The Commissioning Lead has joined the Board of CAWT (Cooperation and Working Together) and the LCG is represented on a series of project boards delivering Inter-regional funds to improve health and wellbeing in the Border area.

The LCG recognises that the next few years will be financially challenging and that difficult commissioning choices will be necessary. This first year has provided the foundations for meaningful relationships with key stakeholders which will ensure a collaborative approach in taking forward Health and Social Care services in the West.

Dr Brendan O'Hare (back row left), Chair of the LCG, with colleagues at a seminar organised by CAWT, to whose work it is lending support.
Corporate Services

Corporate Services are integral to the effective working of an organisation and to the work and accountability of the Chief Executive and the Board. They support the business processes and assist in the decision making of the organisation.

The Programme Director of Corporate Management, as a member of the Senior Management Team, has responsibility for the provision of Corporate Services to the HSCB. These include:

- Corporate Business Services
- Human Resources (provided to the HSCB through a Service Level Agreement with the Business Services Organisation)
- Equality and Human Rights (provided to the HSCB through a Service Level Agreement with the Business Services Organisation)
- Complaints and medical litigation
- Governance
- Information Governance
- Communications

Corporate Business Services

Support to the Board and its Committees

Key achievements during 2009/10 included:

- Corporate Business staff supported the establishment of the HSCB and Board’s annual calendar of public meetings held across its geography. Staff also supported meetings of the five Board Committees, including the public meetings of the five Local Commissioning Groups, (LCGs) from September 2009.

- The production of the HSCB Standing Orders and the subsequent review in October 2009.

- The establishment and maintenance of the HSCB Register of Board Members’ and LCG Members’ Interests in line with the Code of Conduct and Accountability.

Facilities Management

Corporate Business Services also ensures that all issues relating to the management of HSCB buildings and estate comply with relevant legislation and statutory standards and that staff and visitors have access to a safe environment. This includes responsibility for
health and safety, fire safety, security, environmental and facilities management issues.

Key achievements during 2009/10 include:

- Health and Safety inspections carried in HQs and Local Offices.
- The annual Fire Safety Awareness training programme was delivered to staff. In addition, Specialised Fire Safety Refresher training was provided to relevant Nominated Fire Officers and Deputy Fire Officers.
- Fire Risk Assessments were undertaken in HSCB premises and remedial action identified has been or will be taken forward in 2010/11.
- Security arrangements were reviewed in HQs and Local Offices.
- Training programmes held for staff in first aid were held for staff.

**Human Resources, Equality and Human Rights**

The HSCB receives both its Human Resources and Equality and Human Rights services through a Service Level Agreement with the Business Services Organisation.

**Human Resources**

Key achievements during 2009/10 include:

- The recruitment of Tiers 2 and 3 posts to the HSCB structure. Preparation is underway for the recruitment/allocation of posts at Tiers 4 and 5.
- Work is underway to develop a Human Resources Strategy for HSCB.
- A Commissioner Development Programme commenced during 2009/10 to build capacity, capability and competency in the HSCB, in the LCGs and the commissioning system.

**Equality, Human Rights and Diversity**

The development of training aids has played an important role in delivering the Equality agenda.
An action plan was developed, approved and reviewed regularly by the HSCB for progressing key activity.

An Equality, Human Rights and Diversity Forum was established for the Board, inclusive of staff in each Directorate and across the four geographical locations of the HSCB.

Training was held to support staff who are involved in the screening of policies and decisions for equality impacts.

Complaints and Medical Litigation

On 1 April 2009, a new procedure, Complaints in HSC: Standards and Guidance for Learning, became effective. The new procedure places increased emphasis on enhancing resolution at local level, removed the independent review stage from the process and placed responsibility with the HSC Board for the monitoring and performance management of complaints and the provision of support and advice to Family Practitioner Services in respect of complaints.

To undertake the monitoring role, address areas of concern in respect of patient safety and experience, and identify learning and service improvements on a regional basis, the Board, with the Public Health Agency, established a Regional Complaints Group which has met 3 times this year. The Group’s membership also includes the Local Commissioning Group leads, the Patient Client Council, the Trusts, Corporate Services staff, and is chaired by the Director of Social Care and Children. Where possible, improvements in services will be channelled through existing routes and if necessary will be followed up by the PMSI Directorate. The Group reports on a quarterly basis to the Senior Management Team and to the Governance and Audit Committee twice a year. Arrangements are in hand to conclude the remaining legacy independent review work and for the follow up of implementation of recommendations from Panels.

The first HSCB Annual Report on Complaints activity will be presented to the Board (Governance and Audit Committee) in September 2010.

There are 371 ongoing pre Trust (1993) medical negligence cases that require to be concluded. Settlement of these cases is funded from a central DHSSPS fund. Given the HSC Trusts’ expertise in the management of such cases, along with the accessibility of clinical opinion at Trust level, the HSC Board and Trusts have discussed the transfer of the management of outstanding cases to the Trusts within an agreed framework of delegated authority that will be supported by a service level agreement. The HSC Trusts will be required to submit quarterly reports to the HSC Board on the status of cases and those cases that have settled, with early notification to the HSC Board of those cases progressing to the DHSSPS for settlement in excess of £250,000. It is hoped that the management of these cases will transfer to the Trusts on 1 June 2010. There will be reporting on a twice a year basis to the Governance and Audit Committee along with the Board being advised of any significant settlements.
Governance

**Interim Governance Assurance Framework**

It is vital the HSCB discharges its functions in a way that ensures risks are managed as effectively and efficiently as possible to meet corporate objectives and to continuously improve the quality of services. Good governance hinges on having clear objectives, sound practices, a clear understanding of risks run by the organisation and effective monitoring arrangements.

In meeting these obligations, the HSCB has established and implemented an Interim Governance Assurance Framework during 2009/10. The framework provides the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

During 2010/11, and when organisational structures are fully embedded, the interim framework will be replaced by an overarching Governance Framework. It will cover all domains of governance associated with the commissioning of health and social care services, and provide direction for the HSCB in terms of meeting governance requirements placed upon it by DHSSPS and other statutory bodies.

**Risk Register**

To ensure the robustness of the HSCB’s system of internal control, a process has been developed during 2009/10 to put in place a fully functioning risk register at both directorate and corporate levels.

The process involved workshops with each directorate enabling risks to be identified, controls and/or gaps in controls highlighted and where relevant action required to mitigate the risk. The exercise allowed for escalation of risks to the corporate register and for the identification of shared risks across a number of directorates.

**Management and Follow up of Serious Adverse Incidents (SAIs)**

The responsibility for the management and follow up of serious adverse incidents will transfer from DHSSPS to the HSCB (working in close partnership with PHA) from 1 May 2010.

In order to effectively manage this transition, the HSCB held a workshop in February 2010 allowing stakeholders from across HSC organisations to put forward their views in order to develop and shape the new SAI procedure.

**Controls Assurance Standards**

In progressing the controls assurance agenda for 2009/10, the Board has systematically self assessed the levels of compliance for the 14 standards that are applicable to the organisation for this period. The required level of substantive compliance has been
achieved in all, with the exception of records management. Whilst considerable progress towards achieving substantive compliance with this standard was made in the latter part of 2009/10; the requirement for a specialised training programme will not be implemented until 2010/11.

As per departmental guidance five of the 14 standards have also been subject to independent verification by internal audit, namely:

- Governance
- Risk Management
- Finance
- Information Communication and Technology
- Records Management.

**Information Governance**

Information Governance is a collective term given to the management of the information and records held or processed by the Health and Social Care Board. Primarily driven by legislation, it covers all personal information, for example, that relating to patients/service users and employees and all corporate information.

During 2009/10, work has been progressing to develop a Board wide Information Governance Framework. Specific initiatives that have been progressed during the first year of operation include:

- The ongoing management of requests for information under both Data Protection and Freedom of Information Legislation.

- The development of a suite of interim Information Governance Policies, namely:
  - Data Protection and Confidentiality Policy;
  - Records Management Policy;
  - Retention and Disposal of Records Schedule;
  - Interim Freedom of Information Protocols and Internal review Policy;
  - HSCB ICT Security Policy.

- Raising staff awareness to information risks and individual responsibilities via:
  - Mandatory awareness training for all staff on Board Operational Policies;
The publication and distribution to all staff of an information leaflet entitled ‘Information Governance - what you need to know’. The leaflet, provided to all Board staff, provides clear guidance to staff on all aspects of Information Governance.

During 2010/11 the Information Governance Team will continue to develop the Information Governance Framework across all Departments within the Board; a first step will be the production of an Information Governance Strategy which will help outline the direction of Information Governance within the Board over the coming year.

**Communications**

The important and influential role of the Health and Social Care Board requires it to have a capacity to communicate effectively with a wide range of interest groups both within and beyond the health and social services. These include the media, partner agencies, elected representatives and community organisations.

In this first year of operation, the Board has sought to reach these constituent interest groups in a number of ways. These have included:

- The active promotion of its initiatives in the press and media, a function discharged through a small in-house communications team both during and outside of office working hours.

- The facilitation of requests for information and interviews from the press and media, a function again discharged through its in-house communications team.

- Providing active assistance to bodies closely allied to its role - principally the Public Health Agency, The Department of Health, Social Services and Public Safety, and each of the five Health and Social Care Trusts in Northern Ireland. This was particularly important and of immense value during the H1N1 (swine) influenza pandemic which affected Northern Ireland and many other parts of the world between April and December 2009.

- The development of specific communications plans on regional service improvement schemes such as autism, acute hospital urology, GP out of hours care and the provision of enhanced NHS dentistry in Northern Ireland.

- The ongoing development of the Board’s internet website - www.hscboard.hscni.net - an important area of work that will be expanded in the future. A similar and parallel programme of work is also being undertaken to development of the Board’s internal intranet as a communications resource for staff.

- The profiling of the Board’s five Local Commissioning Groups or LCGs, which bring a community based focus to its role as a regional commissioning body. This work is particularly important as the LCGs consolidate their role and begin the important process of commissioning care services in each of their localities.
■ The preparation and production of a wide range of publications such as this annual report, and other communication initiatives such as briefing papers for the media and other interest groups.

■ The development of a longer term communications strategy, on which work continues, that will give an enhanced public profile to its work, and that of its local commissioning arms, the Local Commissioning Groups.
Directorate of Social Care and Children

Working in Partnership

It is well recognised that partnership approaches to supporting and safeguarding children and adults provides the best outcomes and ensures a holistic way of meeting people’s needs.

The focus of the work in social care in 2009 - 2010 has been to sustain and further develop such partnerships on a regional basis.

Working with service users and carers

The Board was pleased to be awarded first prize in the HSC Engage Award for its work in the review and reform of wheelchair services. The award acknowledges how health and social care organisations are working in partnership with stakeholders and recognises innovative work in personal and public involvement.

The wheelchair reform group is made up of service users, professional staff and representatives from statutory, voluntary and community organisations.

The aim of the group is to develop a person-centred, accessible, responsive and equitable service so that people are provided with a wheelchair as soon as possible after assessment. The award illustrates how service user, carer and other stakeholder involvement is an essential element of today’s health and social care decision making process.

Working together for children and young people

In November 2009, the Board established a Regional Child Protection Committee, which replaced the existing four Area Child Protection Committees. The Committee provides a multi-agency forum to determine the strategy for safeguarding children and to develop policies and procedures for Northern Ireland. In particular the Committee will be responsible for taking forward the recommendations from Case Management Reviews and broader inquiries into child protection services.
The Committee will in time be replaced by a new Safeguarding Board for Northern Ireland when the Assembly brings forward the necessary legislation.

New arrangements have been agreed for a Northern Ireland wide partnership to take forward integrated planning for children and young people, linked to locality planning groups. The Board will establish the regional structures for this work in 2010-2011 and this inter-agency partnership will take forward a regional plan to help children achieve the six outcomes identified by Government in 2006 in its ten-year strategy, ‘Our Children - Our Pledge,’ and to implement the recommendations in the ‘Families Matter’ strategy aimed at providing early intervention and support to families.

The Board has also continued to enhance and develop the childcare and play experiences of children up to 14 years through the Childcare Partnerships in each area, including the development and monitoring of Sure Start projects.

working together for adults and vulnerable people

The protection of vulnerable adults has become increasingly important and the need for a multi agency approach has been consolidated in the setting up of a Regional Adult Protection Forum. Much progress has been made in awareness raising, policy and procedure development and inter agency collaboration under the auspices of the Forum. In 2010 - 2011 the Forum will take forward new Departmental guidance that will require partner agencies to work together to make improvements to the current adult protection arrangements.

The Directorate has worked collaboratively with the Northern Ireland Office and the Police Service to set up a scheme to support young people and vulnerable adults who may be interviewed about criminal offences. The Appropriate Adult Scheme is managed by MindWise and has helped to reduce the response time for a request for an appropriate adult to attend a police station and the length of interviews for the vulnerable person.

A range of partnership groups are taking forward service reform and re-design with the active participation of stakeholders. The key objective of these groups is to bring forward service changes that enhance the responsiveness, efficiency and service user experience of the services. This includes ongoing work in relation to the wheelchair service, services for people with a brain injury, and sensory disability services.
Directorate of Performance Management and Service Improvement

Performance

2009/10 has been a challenging year in terms of performance for the HSC, mainly as a result of the financial position. Good progress has been made across a range of target areas, in particular, mental health, disability and children’s services. However, elective access and A&E performance have been particularly challenging for all Trusts.

In relation to elective access, end of month breaches of the maximum waiting time standards have been ongoing throughout 2009/10 across all Trusts. The Board allocated an additional recurrent funding in 2009/10 and it is expected that this level of investment will address the capacity gaps in a number of specialties.

However, the impact of this funding is not expected to be realised in full until 2010/11. As a result, where it was clear that Trusts would not be in a position to deliver the current maximum waiting time standards for assessment and/or treatment by the end of March 2010, the Board agreed maximum ‘backstop’ waiting time positions to be achieved by end of March.

Similarly in relation to A&E, breaches of the 12-hour A&E standard have continued during 2009/10, and performance against the 4-hour standard remains well below the required standard of 95%. In order to secure improvements in A&E performance, the Board is continuing to work with Trusts to implement a series of key reform actions to improve patient flows, including the 18 key actions for unscheduled care and the recommendations of the Rolling Audit and Improvement Programme reports. In addition, the Board is arranging additional external support for Trusts in the form of the NHS Interim Management and Support (IMAS) Team. This Team will work with Trusts to support them to make the necessary improvements.

Service Improvement - Scheduled Care

Care pathways are aiding the process by which patients receive their treatment.

During 2009/10, the Board completed elective pathway reviews at all hospital sites in the
Belfast and South Eastern Trusts. This followed on from reviews undertaken in the other three Trusts in the previous year. The reviews focused on the systems and processes in which elective patients are managed from the time of their referral to the time of their assessment and/or treatment, and examine areas such as booking arrangements, the demand for services, and how resources are used to meet this demand. Action plans have been agreed with Trusts and the Board continues to monitor their implementation.

The Scheduled Care Service Improvement Team has also led a number of regional groups including Pre-operative Assessment, Audiology, Radiology, and Allied Health Professionals, resulting in improved standardising of pathways, access criteria and identification of best practice.

The Board has continued to support Trusts to achieve the 31 and 62 day cancer access standards on a consistent basis. The focus of this work has been the continued emphasis on the understanding of the patient pathway, the proactive management of patients, establishment of robust administrative processes and the effective use of the cancer multidisciplinary team. These are all needed to ensure the timely completion of appropriate investigations, the agreement of treatment options and scheduling of treatments for each patient. This has also included the ongoing rollout of a Cancer Patient Pathway System, which supports and enhances the communication across the clinical team and provides a source of information to monitor the cancer outcomes for patients.

In 2009/10 the Board appointed a clinical lead for day surgery and established a regional network. The network worked with Trusts to agree a best practice pathway for day surgery patients and has supported Trusts in increasing their day surgery rates across the British Association of Day Surgery recommended basket of 24 procedures. By January 2010 the regional day surgery rates has increased to 68%.

The team has continued to support the development of robust pre-operative assessment services across the region. The focus on appropriate and timely patient pre-operative assessments has helped reduce the number of cancelled operations and increased the admissions on day of surgery. By January 2010 admissions on the day of surgery for inpatient procedures had increased to 59% - an increase of 13% from March 2009.

A review of Integrated Assessment and Treatment Services (ICATS) undertaken during 2009/10 identified the opportunity and need for the further streamlining of the patient journey from referral to treatment. This review is now being taken forward in conjunction with Trusts to further modernise and integrate the patient pathway across Primary and Secondary Care.

Service Improvement – Unscheduled Care

The work of the Board’s Unscheduled Care Team extends beyond the acute setting and much of the focus has been on working with primary and community care.

During 2009/10, the Unscheduled Care Audit Team completed reviews in all acute Trusts on the appropriateness of emergency patients to require a hospital bed at noon on the
day following admission. These reviews led to the production of Trust specific reports containing a series of recommendations which if implemented will deliver improvements in the flow of patients through the unscheduled care pathway.

To further support Trusts to improve performance, the Board facilitated a series of learning visits by local Trusts to comparable sites in GB where consistently high performance is achieved. Through these visits evidenced based good practice has been observed and the Board will continue to work with Trusts to implement these.

A regional escalation plan was developed in 2009/10 to equalise demand between Trusts during periods of increased pressure. In addition, the Board has supported Trusts to take forward initiatives to improve the delivery of efficient, safe, and quality discharge processes.

In relation to Healthcare Associated Infection, the Board supported Trusts to deliver a 35% reduction in the number of C.Difficile and MRSA infections during 2009/10 by facilitating a programme of work developed and supported by the NHS Cleaner Hospitals Team.

Service Improvement – Mental Health, Disability and Community Services

In partnership with Trusts, the Board developed a minimum dataset to provide robust and reliable data on activity in mental health and learning disability services, thereby promoting clinical and professional audit, a better informed approach to the operational management of services and enhanced regional performance with less reliance on manual data returns.

Working in partnership with the Beeches Management Centre and the NHS Institute for Innovation and Improvement, the Board launched the Releasing Time to Care Project in September 2009.

Regional resettlement targets for patients awaiting discharge to the community in adult mental health and learning disability were either achieved or exceeded during the year with 75 patients successfully resettled. During the year, the Board took over the leadership of the Learning Disability Regional Resettlement Group from the Department and this is now meeting on a regular basis to maintain a focus on resettlement and the elimination of delayed discharges.

Access to Child and Adolescent Mental Health services across all Trusts has improved with the introduction of the Choice and Partnership Approach and the current nine week maximum waiting time target has been achieved across all five Trusts. Further work is now progressing aimed at enhancing access, choice and quality.

Work has commenced to review the operation of the enhanced service in primary care for people with mild to moderate depression and support is being given to the implementation of computerised cognitive behaviour therapy through the Beating the Blues scheme.
The Board supported the introduction of the ‘Card Before You Leave’ scheme aimed at improving the response given to adults and children following an episode of self harm or discharge from inpatient care. People are offered a next day assessment if necessary following an incident of self harm and community services are aiming to provide a home visit within seven days of discharge from in-patient care, or earlier if required. This scheme is now operational in all Trusts.

ICT

The Board has responsibility for HSC ICT Planning, Commissioning and Performance Management, and recognises that ICT has a major role to play in improving the effectiveness and safety of care as well as providing the information to plan, monitor and manage the delivery of services. Working collaboratively with the regional Business Services Organisation and HSC Trusts, the Board has invested significantly (in both capital and revenue) in ICT services and developments over the past year.

During the year the Board has struck a careful balance between maintaining and enhancing existing services, improving Trust ICT infrastructure, taking forward a number of new ICT systems and services and developing business cases for the implementation of a number of new services over the next two years.

The ongoing investment in Trust infrastructure and in the replacement PCs is significantly improving Trust data network performance and is providing increased access to information systems and at the same time is reducing the maintenance and management overhead of the ICT departments.

NIPACS is helping to modernising the HSC imaging services while the regional Theatre Management system is providing the information and tools to modernise and improve the management of theatres.

The refreshment of the Patient Administration System technology platform will improve the resilience of this vital system and will ensure that it has the capacity to serve the HSC for the next 5 years. The implementation of the Cancer Patient Pathways System is providing valuable patient information to the clinical team and is helping to monitor cancer outcomes. Development work continues on the regional data warehouse adding data from more operational systems and providing access to this data for use in planning, monitoring and managing the delivery of services.

The Board’s highest priority in terms of ICT development over the next few years is in the Community, Social Services and Mental Health areas. The Board is supporting Community Information System projects in the Belfast and Southern Trusts with both of these Trusts engaged in producing business cases from the procurement and implementation of Community Information Systems.

The Board is also supporting an Electronic Care Record proof-of-concept pilot project that is bringing together patient level clinical information from a range of operational
systems, including GP system, and presenting this data as a structured and comprehensive patient record to doctors in the pilot sites (Ulster and Belfast City hospitals and two local GP practices). The pilot will be evaluated over the coming months and if it proves successful, a business case will be developed for regional rollout.
Directorate of Integrated Care

April 2009 marked the start of a critical year in the restructuring of Health and Personal Social Services in Northern Ireland and this important process – part of the Review of Public Administration - included the Family Practitioner Units that each formed part of four former legacy Health and Social Services Boards.

Originally set up to manage the introduction of the 1990 GP Contract, their responsibilities and areas of operation continued to expand over the next twenty years, with 2009/10 seeing the development of a Directorate of Integrated Care (HSCB), for the commissioning and managing of General Medical, Dental, Optometric and Pharmaceutical Services, as well as working at the interfaces of these services with acute and community care services provided by local Trusts.

‘Integrated care’ removes organisational and professional boundaries and promotes coordination and cooperation, the end goal being ‘person-centred’ health and social care - the right care, by the right person, in the right place, at the right time: evidence-based, timely and cost-effective, a more efficient patient journey.

New referral options, managed clinical networks, and a shift in emphasis to the enhanced local provision of services within the primary care setting, all have the potential to transform our service; resourcing the diagnosis, treatment and holistic care of the majority of patients within a local setting rather than in hospital. Central to success will be the building and maintenance of strong relationships between professional representatives and those who manage policy, strategy and operational working in the HSC.

Pharmacy and Medicines Management

The health and social care response to the H1N1 pandemic dominated a large part of the work within primary care during 2009/10 and the HSCB led the development of business continuity arrangements across each of the family practitioner services.

In July 2009, the HSCB assumed operational control of the supply of antiviral medication. Pharmacy and Medicines Management staff developed stock management arrangements to ensure that all antiviral collection points (community pharmacies, out-of-hours centres and hospital trusts) had sufficient medication to meet the rising demand.

Work was initiated with other bodies, such as the District Councils, to identify venues that could be used to support the distribution of antivirals. This experience of working collaboratively with District Councils will provide a useful basis for future emergency planning.
In spite of the considerable investment of time and resources in supporting the response to H1N1, “normal” business continued as usual: the HSCB supported the delivery of the community pharmacy minor ailments service where it is anticipated that as many as 350,000 consultations will be delivered by community pharmacies. The HSCB is working with stakeholders to evaluate the impact and so inform future commissioning decisions.

Work continues to develop a new pharmacy contract. It is hoped that a future agreement between the DHSSPS and representatives of the profession will deliver a platform for future service development, improving the quality and range of services provided.

**General Medical Services (GMS)**

As with the other contractor services, responding to H1N1 impacted heavily on GMS. GP Practices, the Royal College of GPs (NI), Local Medical Committees and the Northern Ireland General Practitioners’ Committee worked closely with Board officers in assisting with communications, planning and facilitating training. Through the annual clinical governance planning cycle, practices produced business continuity pandemic plans, and General Practice absorbed significant additional demand, including the national pandemic vaccination programme and additional consultation pressures, with minimal down turn of core service delivery and performance goals.

Now in its 6th year, the “new” GMS Contract generated significant HSCB investments in the GMS Quality and Outcomes Framework (QOF), 2009/10, supporting professionals in General Practice to deliver a range of evidence based services; substantial investment was also made in ‘Enhanced Services’, targeting health improvement initiatives such as improved patient access to surgeries outside contracted opening hours; practice-based cognitive behavioural therapy for patients with depression; and clinical and medication review for patients resident in nursing or residential homes, to name but a few.

Board officers value the opportunity to work with Local Commissioning Groups and the Public Health Agency to improve existing and develop new services, promoting long term health improvement and addressing the health implications of social inequality e.g. reviewing ‘Enhanced Services’ in general practice to ensure effectiveness, equality of access, and value for money; engagement with professionals across health and social care is actively delivering the objectives of service frameworks, with staff directly involved in shaping the Cardiovascular and Respiratory Services Framework implementation programmes.
Dental Services

Staff in Dental Services have been working on a range of initiatives to raise the profile of dental health promotion. The HSCB has engaged with the PHA and local communities to encourage more parents to be aware of their own and their children’s dental hygiene.

In November 2009, The Minister for Health and Social Services, Mr Michael McGimpsey MLA, launched the Northern Ireland Caries Prevention in Practice trial (NIC-PIP). The research team for this project is led locally by Dr Michael Donaldson (Consultant in Dental Public Health, HSCB) and is made up of representatives from the University of Manchester, the Clinical Research Support Centre (Belfast Trust), the Community Dental Service of the Northern Trust and the British Dental Association. This regional trial aims to evaluate the efficacy and cost-effectiveness of a topical fluoride intervention for children aged 2 to 4 years. It is expected to run for the next four years and is the largest primary care-based dental research trial ever undertaken in the UK.

The HSCB is keen to improve access to dental services across the region, and improve the quality of care provided and so to this end, significant investment has also been made in enhancing access to dental care through partnership with the private sector. In September 2009 the Board entered into a contract with Oasis Dental Care Limited, to provide dental services in areas of Northern Ireland where patients have had difficulty in accessing an NHS dentist. To date, eight Oasis practices have been opened, and it is hoped that before the end of 2010 a further six will be operational. Together, these practices will provide dental care for approximately 55,000 people who were previously unable to obtain health service dental care.

The HSCB has formally joined negotiations between the DHSSPS and the British Dental Association to develop a new dental contract for General Dental Practitioners in Northern Ireland. The HSCB would intend that the new contract will significantly improve access to health service dental care, while improving the level of oral health and reducing oral health inequalities. It is hoped that the new contract will begin to operate in pilot form towards the end of 2010.
Optometry

During the course of 2009/2010, HSCB Optometric Advisors have been working with colleagues at the Board, DHSSPS, BSO and HSC Trusts to explore how relationships between primary and secondary eye-care providers can be developed and so deliver accessible, cost effective ophthalmic care for our population.

Through a multiprofessional workshop “20/20 in 2040” planned for April 2010, professional representatives involved in eye-care, together with DHSSPS / HSC management teams, will seek to improve their understanding of demand from patients with cataract, diabetic eye disease, age related macular degeneration, glaucoma and refractive error. Service redesign will help to optimise the use of skills and make eye services more responsive to demand.

In addition to new initiatives under consideration, the Board’s Optometric Advisory team have, throughout 2009/10, continued to undertake a broad range of governance, probity, continuing education, training and service development initiatives.

Conclusion

Staff in Integrated Care have coped well with maintaining service provision alongside the challenges of organisational change. This has only been possible through the dedication and professionalism of frontline clinical and business support staff across the four independent contractor services, who have absorbed significant additional demand associated with the influenza pandemic, while supporting continued delivery of high quality primary care services.
**Finance Directorate**

The Finance directorate is uniquely responsible for providing financial support to not only the HSCB, but also the Public Health Authority. It works closely with the Business Services Organisation which is responsible for all transitional processes.

The 2009/2010 year presented many challenges for the finance function on a number of fronts:

- The financial pressures experienced by providers resulted in having to work over the autumn on several contingency plans to ensure that the HSC system delivered on its primary duty to live within the resources available.

- The provision of accurate and timely financial information based on four legacy board systems involved a complex process of disaggregating PHA and Board expenditure from each system and then consolidating expenditure with expenditure incurred on our behalf by several other bodies.

- Regrettably, the structural changes in staffing required have been slow to achieve. This resulted in the loss of several experienced staff prior to the implementation of new structures.

- This year saw the first implementation of both accounts that reflect our non-departmental public body status and the new International Financial Reporting Standards.

Despite these challenges the staff within Finance made a significant contribution to the delivery of effective health care by ensuring that financial information to support our decisions was available and delivered statutory accounts against a very challenging timetable. The Board is indebted to staff for their diligence and positive response in these circumstances.

**Report from the Governance and Audit Committee**

The purpose of the Governance and Audit Committee (GAC) is to provide assurance to the Health and Social Care Board (HSCB) that effective risk management and internal control arrangements are in place in respect of finance, corporate governance and related areas. The Board established the GAC as an early priority in May 2009. It comprises four Non-Executive Directors:

Stephen Leach (Chair)
Robert Gilmore
Elizabeth Kerr
Robert Thompson
and is supported by senior Board officials, including in particular Paul Cummings and Bernard Mitchell (Finance and Corporate Services Directors), Catherine McKeown (Head of Internal Audit), and their respective staffs. (The Committee also liaises with PricewaterhouseCoopers appointed by the Northern Ireland Audit Office, and with NIAO itself.)

The Committee decided early on (in conjunction with the GAC of the Public Health Agency) to strengthen its expertise by recruiting up to two independent lay advisers with qualifications and experience in finance and governance. Interviews have now been completed and an announcement will be made shortly.

The GAC held **four meetings** in 2009-10, with the following main outcomes:

**May 2009**

**The Committee**

- considered the Annual Accounts for the four legacy Area Boards for the year ended 31 March 2009. Taking into account the views of the former Finance Directors of the legacy Boards, and the advice of the external auditors (NIAO), who gave an unqualified opinion on all four sets of Accounts, it approved the Accounts for submission to the full Board;

- approved the HSCB's draft Annual Report (including the four legacy Boards' Annual Reports) for 2008-09, and recommended this to the Board;

- reviewed and commented on the first draft of the Corporate Risk Register; and

- approved the Internal Audit Plan for 2009-10.

**October 2009**

**The Committee**

- assessed in more detail the progress made on the recommendations from the auditors on issues in the legacy Board Accounts, and agreed that there had been a satisfactory management response;

- reviewed the progress made by Internal Audit and the assurance they were able to give in the Mid-Year Assurance Statement;

- considered and amended the draft Standing Financial Instructions (SFIs), and approved them for submission to the Board;

- approved an Interim HSCB Corporate Risk Register;

- reviewed and endorsed Interim Frameworks for Governance and Controls Assurance; and
discussed the Review of Standing Orders and proposed a number of changes for consideration by the full Board.

December 2009

The Committee

- reviewed and amended the Risk Register;
- noted the format and timetable for the final Accounts for 2009-10;
- considered a Fraud Update Report and endorsed the implementation in HSCB of the National Fraud Initiative;
- approved a number of Interim Information Governance policies for implementation throughout the Board; and
- made arrangements to complete a National Audit Office Self Assessment Checklist, to assess the GAC’s effectiveness in its work and the scope for improvement.

March 2010

The Committee

- discussed and approved the Plan by the external auditor (NIAO) for the audit of the HSCB Annual Accounts for 2009-10;
- considered and accepted (following a number of amendments and subject to revision in the light of experience) the draft Service Level Agreement between the Board and the Business Services Organisation (BSO);
- reviewed the Risk Register and approved a Risk Analysis Tool to develop it further;
- considered updates on HSCB compliance with the Department’s requirements for Risk Management and Controls Assurance;
- assessed and endorsed the arrangements for handling complaints and historic clinical negligence cases; and
- reviewed progress on the Action Plan arising from the Board’s Self Assessment exercise.

The GAC looks forward to continuing its work in 2010-11, and – on the basis of positive relationships with Executive Directors and Internal and External Auditors – to delivering further results and adding value to the HSCB.
Report from the Reference Committee

Summary

The main functions of the Committee are to ensure that public money is not misused or misspent and that at all times members of the public are protected. It has a specific focus on professionals working as doctors, dentists, optometrists and pharmacists. The Committee has met on nine occasions since the establishment of the Board on 1st April 2009.

The Committee considers information on cases presented to it by a range of professional/Board officers. It also receives legal advice, additional information and support from other Board officials, advisors and Secretariat.

Within its first six months of operation (five meetings), a protocol for carrying out business has been developed between the Executives, Board officers and advisers.

Information

All decisions are based on information presented. However there are different levels of information depending on the circumstances. In the summary of the minutes sent out in advance to Committee members, summaries of cases are updated and presented in a short concise manner. All cases now are anonymised and have a unique reference number to protect confidentiality. This has resulted from recommendations made by the Committee.

Accurate record keeping is critical in information provision and the administration back-up offered to the Committee reflects the expertise, knowledge and professionalism of the staff involved.

Administrative documents have been developed to ensure that cases are constantly examined, updated and acted upon. Of course they also provide a very accessible way for Committee members to continue to familiarise themselves with specific cases.

The Cases

When cases are presented to the Committee by a wide range of professionals, information is provided usually in advance to Committee members. A standard template for the presentation of the case has been developed and provides clear guidance to those collating information on specific cases.

All of this information is enhanced by the person making the presentation of the case. If required, legal and other specialist advice can be drawn upon by Committee members considering the case. It is envisaged that this robust approach to considering cases will lead to fair and informed decisions.
Committee members are not experts in providing the range of services represented in the cases. They are not supposed to be. What they do offer is their expertise in making independent judgements based on the facts presented and taking on board legal and other specialist advice and guidance. They do hold Board officers to account but this is in a positive partnership working way, trying to ensure that the information provided is as full as possible, accurate, up to date and relevant.

By systematically using templates and agreed guidance, the work of the Committee can be carried out efficiently and methodically. There are no hidden agendas and the process is as transparent as it can be. People presenting cases and those preparing information know what to expect. Those considering the cases also know what to expect. Seldom are there any surprises.

The Committee (usually at regular monthly meetings) hear evidence from various sources including specialist Board officials, practitioners, and legal experts. This evidence relates to contractors providing services to the public which may not be as appropriate or as professional as they should be. The professions under scrutiny include dentists, pharmacists, doctors and optometrists.

**Conclusion**

In all deliberations Committee members ensure that they have sufficient appropriate information upon which to make a judgement. If there is any doubt or perceived gap, then further information is sought before a decision is made. This helps to develop a robust way of working which is both transparent and which people are accountable for.

Brendan McKeever  
Chair  
HSC Board Reference Committee

**Membership of the Reference Committee**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Brendan McKeever</td>
<td>Committee Chair</td>
</tr>
<tr>
<td>Dr Melissa McCullough</td>
<td>Non Executive Director</td>
</tr>
<tr>
<td>Mrs Fionnuala McAndrew</td>
<td>Executive Director/Director of Social Care &amp; Children's Services</td>
</tr>
</tbody>
</table>

**In attendance:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Sloan Harper</td>
<td>Director of Integrated Care, HSCB – professional advice</td>
</tr>
<tr>
<td>Mrs Carol Mooney</td>
<td>Secretary to the Committee, Corporate Services (HSCB Western Office)</td>
</tr>
</tbody>
</table>
Report from the Pharmacy Practices Committee

The HSC 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 Pharmaceutical Committee which deals with applications to join the pharmaceutical list and non-minor relocations (where the proposed relocation of the pharmacy is in a different neighbourhood).

The HSC Board decides upon minor 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 HSC Board has constituted the Committee under the Chair and Vice-Chair into four panels.

For period 09/10 the Pharmacy Practices Committee dealt with the following applications:

1. Full Applications/Non-Minor Relocations
   Total 27
   - Eastern Area 10 Approved 1
   - Northern Area 4 Approved 1
   - Southern Area 6 Approved 0
   - Western Area 7 Approved 0

2. Oxygen Applications
   Total 11
   - Eastern Area 3 Approved 3
   - Northern Area 3 Approved 3
   - Southern Area 4 Approved 4
   - Western Area 1 Approved 1

A number of key pharmacy officers retired during the year, Ms Andre McCollum and Mr Philip McErlean in the Eastern office and Dr Denis Morrison in the Northern office. Their leadership, professionalism and support to the committee is greatly appreciated. The continuing professional input and support from Mr Joe Brogan and Mrs Deidre Quinn is also greatly appreciated.
Membership of the Pharmacy Practices Committee

Mr John Mone - (Chair) Non-Executive Board Member

Mr Hugh Mullen - Director of Performance Management and Service Improvement

Board officers representing a range of its professional functions also contributed to, and attended meetings of the committee during the course of the year.
Remuneration Report for the year ended 31 March 2010
(Audited)

Scope of the Report

Article 242B and schedule 7A of the Companies (NI) Order 1986, as interpreted for the Public Sector requires HSC bodies to prepare a Remuneration Report containing information about Directors remuneration. The Remuneration Report summarises the Remuneration Policy of the Health and Social Care Board (HSCB) and particularly its application in connection with Senior Executives. The report also describes how the HSCB applies the principles of good corporate governance in relation to Senior Managers Remuneration in accordance with HSS (SM) 3/2001 issued by the Department of Health, Social Services and Public Safety (DHSS&PS).

Remuneration Committee

The Board of the HSCB as set out in its standing orders has delegated certain functions to the Remuneration Committee. The membership of this committee is as follows:

Dr Ian Clements - Chair
Mrs Elizabeth Kerr
Dr Melissa McCullough

During the year 2009/10 the Committee met on two occasions to agree its terms of reference and consider the implementation of the relevant pay award for senior executives.

Remuneration Policy

1. The membership of the Remuneration Committee for the Health and Social Care Board consists of the Chairman and two of its Non-Executives.

2. The Policy on Remuneration of the HSCB Senior Executives for current and future financial years is the application of terms and conditions of employment as provided and determined by the DHSS&PS.

3. Performance of Senior Executives is assessed using a Performance Management System which comprises of individual appraisal and review. Their performance is then considered by the Remuneration Committee and judgements are made to their banding in line with the departmental contract against the achievement of regional organisation and personal objectives.

4. The relevant importance of the appropriate proportion of remuneration is set by the DHSS&PS under the Performance Management arrangements for Senior Executives.
5. In relation to the policy on duration of contracts, all contracts of Senior Executives in the HSCB are permanent and contain a notice period of 3 months.

Service Contracts

Senior Executives in the year 2009/10 were on DHSSPS Senior Executive Contracts which are detailed and contained within the circular HSS (SM) 2/2001.

Directors

Mr John Compton appointed Chief Executive on 1st April 2009

Mr Paul Cummings, Director of Finance with effect from 1st April 2009

Mrs Fionnuala McAndrew, Director of Social Care and Children with effect from 1st April 2009

Mr Hugh Mullen, Director of Performance Management and Service Improvement appointed with effect from 1st April 2009

Non-Executive Directors

The Non-Executive Directors were appointed for a period of 4 years with effect from 1st April 2009:

Dr Ian Clements, Chairman
Mr Robert Gilmore
Mrs Elizabeth Kerr
Mr Stephen Leach
Dr Melissa McCullough
Mr Brendan Mc Keever
Mr John Mone
Dr Robert Thompson (appointed 01.10.2009)
No other persons served at Board Director level during 2009-10.

A notice period of three months notice is provided by either party except in the event of dismissal. There is nothing different either party waiving the right to notice or from accepting payment of lieu of notice.

Retirement Age

Currently, employees are required to retire at age 65 although employees can ask to work beyond this age in accordance with Equality (Age) Regulations (NI) 2006.
Premature Retirement Costs

Section 16 of the Agenda for Change Terms and Conditions Handbook (issued 14th February 2007 under cover of the Department’s Guidance Circular HSS AfC (4) 2007 sets out the arrangements for early retirement on the grounds of redundancy and in the interest of this service. Further circulars have been issued by the Department of Health Social Services AfC (6) 2007 and HSS AfC (5) 2008 set out changes to the timescale of the operation of the transitional protection under these arrangements.

Under the terms of section 16 of the Agenda for Change terms and conditions handbook individuals who were members of HPSS Superannuation Scheme prior to 1st October 2006, are over 50 years of age and have at least 5 years membership of HPSS superannuation scheme qualify for transitional protection. Staff who qualify for transitional protection are entitled to receive what they would have received by way of pension and redundancy payment had they taken redundancy retirement on 30th September 2006. This includes enhancement of up to 10 years additional service (reduced by the number of years between September 2006 and the actual date of retirement) and a lump sum redundancy payment of up to 30 weeks pay (reduced by 30% for each year of additional service over 6 2/3 years). Alternatively staff made redundant who are members of the HSS Pensions Scheme, have at least 2 years continuous service and 2 years qualifying membership and have reached the minimum age currently 50 years can opt to retire early without a reduction in their pension as a alternative to a lump sum redundancy payment of up to 24 months pay. In this case the cost of the early payment of pension is paid from the lump sum redundancy payment, however, if the redundancy payment is not sufficient to meet the early payment of pension cost the employer is required to meet the additional costs.
Pensions (Audited)

The assessed capital value of the pension scheme benefit of the most senior members of the HSCB are as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase in pension and related lump sum at age 60 £'000</th>
<th>Total accrued pension at age 60 and related lump sum £'000</th>
<th>CETV at 31/3/09</th>
<th>CETV at 31/3/10</th>
<th>Real increase in CETV £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Executive Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Clements</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>S J Leach</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>M McCullough</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>R Gilmore</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>B McKeever</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>J Mona</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E Kerr</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>W R Thompson</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Executive Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Compton</td>
<td>10-12.5 pension 30-32.5 lump sum</td>
<td>60-85 pension 185-200 lump sum</td>
<td>1,246</td>
<td>1,596</td>
<td>254</td>
</tr>
<tr>
<td>P Cummings</td>
<td>0-2.5 pension 2.5-5 lump sum</td>
<td>30-35 pension 90-95 lump sum</td>
<td>468</td>
<td>533</td>
<td>25</td>
</tr>
<tr>
<td>H Mullen</td>
<td>* See note below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F E McAndrews</td>
<td>0-2.5 pension 5-7.5 lump sum</td>
<td>10-15 pension 40-45 lump sum</td>
<td>244</td>
<td>308</td>
<td>41</td>
</tr>
<tr>
<td>S Harper</td>
<td>0-2.5 pension 0-2.5 lump sum</td>
<td>30-35 pension 95-100 lump sum</td>
<td>568</td>
<td>625</td>
<td>10</td>
</tr>
<tr>
<td>B Mitchell</td>
<td>2.5-5 lump sum</td>
<td>35-40 pension 110-115 lump sum</td>
<td>702</td>
<td>788</td>
<td>26</td>
</tr>
</tbody>
</table>

* H Mullen joined the scheme on 1 September 2009. BSO’s Superannuation Branch has indicated that due to the fact that he has not completed a full year in the scheme it was not possible to calculate his pension entitlement.

As Non-Executive members do not receive pension remuneration, there are no entries in respect of pensions for non-executive members. Cash equivalent Transfer Value (CETV) is the actuality assessed capital value of the pension scheme benefits accrued by a member of a particularly point in time. The benefits valued as a member accrued benefits in any contingent spouse’s pension payable from the scheme. 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 showing relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures, and from 2004-05 the other pension details, 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 them purchasing additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines of 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 employees (including the value of any benefits transfer from another pension scheme or arrangement) and uses column market valuation factors for the start and end of the period.

A number of the senior executives of the legacy organisations remained on the payroll for a short period of time for administrative purposes and these included:

<table>
<thead>
<tr>
<th>Legacy Board</th>
<th>Director</th>
<th>Date Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Mr S McDonnell</td>
<td>15 April 2009</td>
</tr>
<tr>
<td></td>
<td>Mrs L McNair</td>
<td>16 April 2009</td>
</tr>
<tr>
<td>Western</td>
<td>Peter McLaughlin</td>
<td>30 September 2009</td>
</tr>
<tr>
<td></td>
<td>Mr W McConnell</td>
<td>31 July 2009</td>
</tr>
<tr>
<td>Eastern</td>
<td>Dr P Kilbane</td>
<td>30 April 2009</td>
</tr>
<tr>
<td></td>
<td>Mr RES Adams</td>
<td>14 May 2009</td>
</tr>
<tr>
<td></td>
<td>Mr H Connor</td>
<td>30 April 2009</td>
</tr>
<tr>
<td></td>
<td>Ms A Paisley</td>
<td>28 February 2010</td>
</tr>
<tr>
<td></td>
<td>Ms A Lynch</td>
<td>30 April 2009</td>
</tr>
<tr>
<td></td>
<td>Mrs M Waddell</td>
<td>30 April 2009</td>
</tr>
<tr>
<td></td>
<td>Dr S Adair</td>
<td>07 April 2009</td>
</tr>
<tr>
<td></td>
<td>Mr W Maxwell</td>
<td>30 April 2009</td>
</tr>
<tr>
<td>Southern</td>
<td>Mr E Ritson</td>
<td>31 March 2008 (still on HSCB payroll - to be transferred to PHA)</td>
</tr>
</tbody>
</table>
Statement on Internal Control

Scope of responsibility

The Board of the Health and Social Care Board is accountable for internal control. As Accounting Officer and Chief Executive of the Board, I have responsibility for maintaining a sound system of internal control 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.

As Chief Executive, I exercise my responsibility by ensuring that an adequate system for the identification, assessment and management of risks is in place. I have in place a range of organisational controls, commensurate the officers’ current assessment of risk, designed to ensure the efficient and effective discharge of Board business in accordance with the law and departmental direction. Every effort is made to ensure that the objectives of the Board are pursued in accordance with the recognised and accepted standards of public administration.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of organisational policies, aims and objectives;
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Health and Social Care Board for the year ended 31 March 2010, and up to the date of the approval of the Annual Report and Annual Accounts and accords with Department of Finance and Personnel guidance.

The Board of the Health and Social Care Board exercised strategic control over the operation of the organisation through a system of corporate governance, which included:

- A schedule of matters reserved for Board decisions, some of which may have been delegated to Committees.
- A scheme of delegation, which involved decision making authority within set parameters to the Chief Executive and other officers.
- Standing Orders and Standing Financial Instructions, which set out the Board’s governance regulations.
The operation of a Governance and Audit Committee (comprised of Non Executive Directors) to assure adherence to those regulations; and,

The operation of a Remuneration and Terms of Service Committee (also comprised of Non Executive Directors) to ensure appropriate remuneration of Senior Executives and Consultants within Departmental policy.

The full Statement on Internal Control is included in the Annual Accounts.

Some priority areas of need identified in local communities are:

- Suicide prevention and good mental health
- Vulnerable children and young people
- Social isolation among older people
- Barriers to services for marginalised groups
- Alignment of service planning, funding and provision.
Summary Financial Statement

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.

This Summary Financial Statement does not contain sufficient information for a full understanding of the activities and performance of the HSCB. For further information, the full Accounts (including the Statement of Internal Control), and Annual Report and Auditor’s Report for the year ended 31 March 2010 should be consulted.

Copies of the full accounts are available from:

Director of Finance
Health and Social Care Board
12 – 22 Linenhall Street
Belfast
BT2 8BS
## NET EXPENDITURE ACCOUNT FOR YEAR ENDED 31ST MARCH 2010

<table>
<thead>
<tr>
<th></th>
<th>2010 £000s</th>
<th>Restated 2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff costs</td>
<td>(26,635)</td>
<td>(28,314)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,411)</td>
<td>(3,008)</td>
</tr>
<tr>
<td>Other Expenditure</td>
<td>(918,708)</td>
<td>(3,621,561)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(947,754)</td>
<td>(3,652,883)</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from activities</td>
<td>46,679</td>
<td>49,726</td>
</tr>
<tr>
<td>Other Income</td>
<td>1,394</td>
<td>1,491</td>
</tr>
<tr>
<td>Reimbursements receivable</td>
<td>9,967</td>
<td>4,763</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>58,040</td>
<td>55,980</td>
</tr>
<tr>
<td><strong>Net Expenditure</strong></td>
<td>(889,714)</td>
<td>(3,596,903)</td>
</tr>
<tr>
<td>Credit reversal of notional costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of capital</td>
<td>(5,891)</td>
<td>(4,936)</td>
</tr>
<tr>
<td>Notional costs (audit fees)</td>
<td>66</td>
<td>105</td>
</tr>
<tr>
<td><strong>Net expenditure for the financial year</strong></td>
<td>(895,539)</td>
<td>(3,601,734)</td>
</tr>
<tr>
<td><strong>Summary of Revenue Resource Outturn</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net expenditure</td>
<td>(889,714)</td>
<td>(3,596,903)</td>
</tr>
<tr>
<td><strong>RRL’s Issued (to)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belfast HSC Trust</td>
<td>(975,986)</td>
<td></td>
</tr>
<tr>
<td>South Eastern HSC Trust</td>
<td>(434,445)</td>
<td></td>
</tr>
<tr>
<td>Southern HSC Trust</td>
<td>(445,462)</td>
<td></td>
</tr>
<tr>
<td>Northern HSC Trust</td>
<td>(525,283)</td>
<td></td>
</tr>
<tr>
<td>Western HSC Trust</td>
<td>(421,104)</td>
<td></td>
</tr>
<tr>
<td>NIAS HSC Trust</td>
<td>(52,608)</td>
<td></td>
</tr>
<tr>
<td>NIMDTA</td>
<td>(762)</td>
<td></td>
</tr>
<tr>
<td><strong>Total RRL issued</strong></td>
<td>(2,855,651)</td>
<td>(3,596,903)</td>
</tr>
<tr>
<td><strong>Total Commissioner resources utilised</strong></td>
<td>(3,745,365)</td>
<td>(3,596,903)</td>
</tr>
<tr>
<td><strong>RRL’s received from</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHSSPS (cash and non cash)</td>
<td>3,745,473</td>
<td>3,596,883</td>
</tr>
<tr>
<td><strong>Surplus/deficit against RRL</strong></td>
<td>108</td>
<td>(20)</td>
</tr>
</tbody>
</table>

*The equivalent of RRL’s issued to Trusts in the financial year ended 31 March 2009 are included within Other Expenditure.*
**Revenue Resource Limit**

Resulting from the introduction of the Non Departmental Public Body (NDPB) format of accounts, the Revenue Resource Limit (RRL) has been introduced as a means of setting a cash limit to the amount of funding to be drawn directly from the DHSSPS by the Trust in relation to the costs of providing services to Board residents. This RRL mechanism replaced the Service and Budget Agreement previously in place which allowed for cash to be paid directly to the Trusts by the legacy Boards for the costs of services provided to the legacy Board residents.

The memorandum below expresses the HSCB ‘Net Expenditure Account’ in a traditional income and expenditure format.

<table>
<thead>
<tr>
<th></th>
<th>Restated 2010 £000s</th>
<th>Restated 2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RRL received from DHSSPS</td>
<td>3,745,473</td>
<td>3,596,883</td>
</tr>
<tr>
<td>Other income</td>
<td>58,040</td>
<td>55,980</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>3,803,513</td>
<td>3,652,863</td>
</tr>
<tr>
<td><strong>Expenditure (including RRLs issued to Trusts)</strong></td>
<td>(3,803,405)</td>
<td>(3,652,883)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>(26,635)</td>
<td>(28,314)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,411)</td>
<td>(3,008)</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td>(3,774,359)</td>
<td>(3,621,561)</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>108</td>
<td>(20)</td>
</tr>
</tbody>
</table>
### STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

<table>
<thead>
<tr>
<th>NOTE</th>
<th>2010 £000s</th>
<th>2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Restated</td>
</tr>
<tr>
<td>NON CURRENT ASSETS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>25,288</td>
<td>25,169</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>1,531</td>
<td>1,035</td>
</tr>
<tr>
<td>TOTAL NON CURRENT ASSETS</td>
<td>26,819</td>
<td>26,204</td>
</tr>
<tr>
<td>CURRENT ASSETS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>50,647</td>
<td>37,231</td>
</tr>
<tr>
<td>Other current assets</td>
<td>944</td>
<td>117</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>1,562</td>
<td>1,377</td>
</tr>
<tr>
<td>TOTAL CURRENT ASSETS</td>
<td>53,155</td>
<td>38,728</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>79,974</td>
<td>64,932</td>
</tr>
<tr>
<td>CURRENT LIABILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(209,726)</td>
<td>(173,188)</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL CURRENT LIABILITIES</td>
<td>(209,726)</td>
<td>(173,188)</td>
</tr>
<tr>
<td>TOTAL ASSETS LESS CURRENT LIABILITIES</td>
<td>(129,752)</td>
<td>(108,256)</td>
</tr>
<tr>
<td>NON CURRENT LIABILITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>(50,570)</td>
<td>(48,035)</td>
</tr>
<tr>
<td>Other payables &gt; 1 year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL NON CURRENT LIABILITIES</td>
<td>(50,570)</td>
<td>(48,035)</td>
</tr>
<tr>
<td>ASSETS LESS LIABILITIES</td>
<td>(180,322)</td>
<td>(156,291)</td>
</tr>
<tr>
<td>RESERVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>12,744</td>
<td>13,114</td>
</tr>
<tr>
<td>General reserve</td>
<td>(193,066)</td>
<td>(169,405)</td>
</tr>
<tr>
<td>TOTAL RESERVES</td>
<td>(180,322)</td>
<td>(156,291)</td>
</tr>
</tbody>
</table>

I certify that the attached Financial Statements and Annual Report were approved by the Board of Directors on: 7th June 2010

Signed: [Signature] Date: 7th June 2010
Health and Social Care Board

STATEMENT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I have examined the summary financial statement for the year ended 31 March 2010 set out on pages 54 to 63

Respective responsibilities of the Health and Social Care Board, Chief Executive and Auditor

The Health and Social Care Board and Chief Executive are responsible for preparing the summary financial statement.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the full annual financial statements, and its compliance with the relevant requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health, Social Services and Public Safety directions made thereunder.

I also read the other information contained in the Annual Report, and consider the implications for my certificate if I become aware of any apparent misstatements or material inconsistencies with the summary financial statement. The other information comprises only the sections on Public Sector Payment Policy, Audit Services, Management Costs and Staff Numbers.

Basis of audit opinions

I conducted my work in accordance with Bulletin 2008/03 ‘The auditors’ statement on the summary financial statement in the United Kingdom’ issued by the Auditing Practices Board. My report on the Health and Social Care Board full annual financial statements describes the basis of my audit opinions on those financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion, the summary financial statement is consistent with the full annual financial statements of the Health and Social Care Board for the year ended 31 March 2010 and complies with the applicable requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health, Social Services and Public Safety directions made thereunder.

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

30 June 2010
### STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 MARCH 2010

<table>
<thead>
<tr>
<th>Cashflows from operating activities</th>
<th>2010 £000s</th>
<th>2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net expenditure after cost of capital and interest</td>
<td>(889,714)</td>
<td>(3,596,903)</td>
</tr>
<tr>
<td>Adjustments for non cash costs</td>
<td>7,776</td>
<td>8,915</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>(14,243)</td>
<td>9,284</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Increase/(decrease) in trade payables</td>
<td>36,073</td>
<td>18,076</td>
</tr>
<tr>
<td>Less movement in payables relating to capital</td>
<td>465</td>
<td>342</td>
</tr>
<tr>
<td>Use of provisions</td>
<td>(7,881)</td>
<td>(8,513)</td>
</tr>
<tr>
<td><strong>Net cash outflow from operating activities</strong></td>
<td>(867,523)</td>
<td>(3,568,797)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cashflows from investing activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase of property, plant and equipment</td>
<td>(4,171)</td>
</tr>
<tr>
<td>Purchase of intangible assets</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds of disposal of property, plant and equipment</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds on disposal of intangibles</td>
<td>-</td>
</tr>
<tr>
<td>Interest Received</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash inflow/(Outflow) from investing activities</strong></td>
<td>(4,171)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash flows from financing activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant in aid</td>
<td>871,879</td>
</tr>
<tr>
<td><strong>Net financing</strong></td>
<td>871,879</td>
</tr>
</tbody>
</table>

| Net increase (decrease) in cash and cash equivalents in the period | 185 | 381 |
| Cash and cash equivalents at the beginning of the period | 1,377 | 996 |
| Cash and cash equivalents at the end of the period | 1,562 | 1,377 |
Management Board

The management Board responsible for setting the direction of the HSCB is made up of the following individuals:

Executive members:
John Compton
Paul Cummings
Hugh Mullen
Fionnuala McAndrew

Non-executive members:
Ian Clements (Chairman)
Stephen J Leach
Melissa McCullough
Robert Gilmore
Brendan McKeever
John Mone
Elizabeth Kerr
William R Thompson

Equal Opportunities

The HSCB has in place an equal opportunities policy to promote and provide equality between persons of different genders, marital or family status, religious belief or political opinion, age, disability, race or ethnic origin, nationality or sexual orientation, between persons with a disability and persons without, between persons with dependents and persons without, between men and women generally, and irrespective of Staff Organisation membership. This policy applies to the recruitment, promotion, training, transfer and other benefits and facilities.
Public Sector Payment Policy – Measure of Compliance

The Department requires that the HSCB pays their non HSC trade creditors in accordance with the CBI Prompt Payment Policy and Government Accounting Rules. The HSCB’s payment policy is consistent with the CBI prompt payment codes and Government Accounting rules and its measure of compliance is:

<table>
<thead>
<tr>
<th></th>
<th>2010 Number</th>
<th>2009 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total bills paid</td>
<td>15,868</td>
<td>13,680</td>
</tr>
<tr>
<td>Total bills paid within 30 day target</td>
<td>14,989</td>
<td>13,143</td>
</tr>
<tr>
<td>% of bills paid within 30 day target</td>
<td>94.5%</td>
<td>96.1%</td>
</tr>
</tbody>
</table>

Related Party Transactions

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.

Directors Interests

Details of company directorships or other significant interests held by directors where those directors are likely to do business, or are possible seeking to do business with the HSCB where this may conflict with their managerial responsibilities are held on a central register. A copy is available from HSCB’s internet site.

Charitable Donations

The HSCB did not make any charitable donations during the financial year.

Post Balance Sheet Events

There are no post balance sheet events which have a material impact on the accounts.

Sickness Absence Information

The percentage figure for sickness absence for the 2009-2010 year is 2.61%.

Personal Data Related Incidents

There were no personal data related incidents requiring disclosure.
Audit Services

The HSCB's statutory audit was performed by PricewaterhouseCoopers on behalf of the Northern Ireland Audit Office. The nominal audit fee for 2009-2010 was £66k.

Statement on Disclosure of Audit Information

All directors can confirm that they are not aware of any relevant audit information of which the HSCB's auditors are unaware.

HSCB Management Costs

HSCB management costs as a percentage of total income is detailed in the table below:

<table>
<thead>
<tr>
<th></th>
<th>2010 £000s</th>
<th>2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCB Management Costs</td>
<td>35,747</td>
<td>34,762</td>
</tr>
<tr>
<td>Income:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RRL from DHSSPS</td>
<td>3,745,473</td>
<td>3,596,883</td>
</tr>
<tr>
<td>Less Non cash RRL</td>
<td>(2,574)</td>
<td>(739)</td>
</tr>
<tr>
<td>Other Income</td>
<td>58,040</td>
<td>55,980</td>
</tr>
<tr>
<td>Total Income</td>
<td>3,806,087</td>
<td>3,653,602</td>
</tr>
<tr>
<td>% of total income</td>
<td>0.94%</td>
<td>0.95%</td>
</tr>
</tbody>
</table>

Staff Numbers

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

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No.</td>
<td>522</td>
<td>562</td>
</tr>
<tr>
<td>Staff No.</td>
<td>479</td>
<td>411</td>
</tr>
<tr>
<td>Others No.</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>Total No.</td>
<td>621</td>
<td>624</td>
</tr>
</tbody>
</table>

Commissioning of Health and Social Care

Salary (Audited)

The salary and the value of any taxable benefits in kind of the most senior members of the HSCB were as follows:
### 2009-10

<table>
<thead>
<tr>
<th>Name</th>
<th>Salary, including Performance Pay £000s</th>
<th>Benefits in Kind (Rounded to nearest £100)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Executive Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Clements</td>
<td>30-35</td>
<td>-</td>
</tr>
<tr>
<td>S J Leach</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>M McCullough</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>R Gilmore</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>B McKeever</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>J Mone</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>E Kerr</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td>W R Thompson</td>
<td>5-10</td>
<td>-</td>
</tr>
<tr>
<td><strong>Executive Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Compton</td>
<td>145-150</td>
<td>400</td>
</tr>
<tr>
<td>P Cummings</td>
<td>105-110</td>
<td>2,800</td>
</tr>
<tr>
<td>H Mullen</td>
<td>115-120</td>
<td>*24,500</td>
</tr>
<tr>
<td>F E McAndrews</td>
<td>80-85</td>
<td>100</td>
</tr>
<tr>
<td>S Harper</td>
<td>85-90</td>
<td>600</td>
</tr>
<tr>
<td>B Mitchell</td>
<td>70-75</td>
<td>-</td>
</tr>
</tbody>
</table>

*2009-10 benefits in kind for Mr H Mullen includes the cost of flights from Mr Mullen’s home in Manchester to Belfast.
Alternative Formats
In an effort to make information as accessible as possible, this report can also be made available in alternative formats: large print, computer disk, Braille, audio tape or translation.

For an alternative format, please contact the Health and Social Care Board on (028) 9032 1313.

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Belfast BT2 8BS

October 2010

www.hscboard.hscni.net