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The year in retrospect –
an introduction by the Chair and Chief Executive, Dr Ian Clements and Mr John Compton

This report places on record the work and finances of the Health and Social Care Board during its second full year of operation, the period from April 2010 until March 2011. This was once again a year of significant challenges which the report will describe in more detail. However, at a general level, the environment in which we work continues to face significant pressure from both the demand for health and social care services – and the availability of public funds to support them in the future. These are indeed difficult times and this context is likely to continue for some years in the light of much reduced public spending.

Nevertheless, in the past year at least, the Board has been able to sustain the availability of many important services and to successfully develop some others. While there is less prospect of this in the next few years, this sustainability has been an achievement and reflects well upon much work by the Board and its partner organisations.
across the health and social care sector. It also reflects very well upon our staff at all levels who have worked hard to maintain services to the community, and to whom our thanks are due.

The challenging working and financial context was stretched further during the past year by other salient factors. These included the impact of the coldest winter weather seen in Northern Ireland for many years – which coincided with the re-emergence of swine flu in the community. These factors placed enormous pressure upon GPs, the acute hospitals system and community social services. But they were responded to by a great deal of partner effort involving the Board, PHA, GPs, Health and Social Care Trusts, the Northern Ireland Ambulance Service Trust, and other organisations. Collectively, we all worked together to achieve a good outcome for the community and that, surely, is what the health and social services are all about.

We hope this annual report gives an indication of the range and impact of the work of the Health and Social Care Board during the past year, and we welcome comments from our readers.

We extend our thanks to our many partner organisations for their commitment during the past year, and we hope that this joint effort will be continued with renewed vigour in the even more challenging one that now faces us.

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 the year, 1st April 2010 - 31st March 2011:

**Non-Executive Directors**

- **Dr Ian Clements** Chairman, Mr Robert Gilmore
- **Mrs Elizabeth Kerr** Mr Stephen Leach
- **Dr Melissa McCullough** Mr Brendan McKeever
- **Mr John Mone** Dr Robert Thompson

**Executive Directors**

- Mr John Compton
  - Chief Executive
- Mr Paul Cummings
  - Director of Finance
- Mrs Fionnuala McAndrew
  - Director of Social Care and Children
- Mr Hugh Mullen
  - Director of Performance Management and Service Improvement (until May 2010)
- Ms Louise McMahon
  - Director of Performance Management and Service Improvement (from September 2010)
- Mr Dean Sullivan
  - Director of Commissioning (from June 2010)
The role of the Health and Social Care Board

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

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

2. To performance manage Health and Social Care Trusts that directly provide services to people 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 £3.9 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 responsible for the commissioning of health and social care services for the population of Northern Ireland, and is required by statute to prepare and publish each year a Commissioning Plan setting out the range of services to be commissioned and the associated costs of delivering these.

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

The PHA is represented on the HSC Board by its Medical Director and Director of Nursing and AHPs. All of the service teams responsible for commissioning services are comprised of HSCB and PHA staff, demonstrating the common agenda shared by both organisations and the close working with one another. The PHA is also represented on each of the five Local Commissioning Groups or LCGs.
Commissioning Directorate

Regional Strategic Planning
The Regional Office has a role in the strategic planning and commissioning of a number of specialist medical and social care services, ensuring that the appropriate skills are maintained and good practice standards are met. Because Northern Ireland has a relatively small population of 1.8m, the pattern of demand for such services may be unpredictable across the region and costly to maintain. Provision via a single arrangement supports a financial risk sharing approach across Northern Ireland.

In terms of planning, where facilities and specialist infrastructure are required to deliver the service it may be necessary to concentrate these on one specific site – examples being neurosurgery, kidney transplantation and intensive rehabilitation facilities for patients following significant trauma. The Regional Strategic Planning office takes the lead in planning and commissioning these services.

During 2010/11 the Regional Strategic Planning Office began to develop new methods of engagement with medical and social care professionals, service users, members of the public, and other key stakeholders to seek their influence in all stages for the commissioning process. This work encompasses the development of effective clinical linkages, through working arrangements with clinical networks and a range of other mechanisms.

Regional Health and Social Care Commissioning Arrangements
During 2010/11 the Board has begun to establish formal commissioning structures and processes across the HSCB and PHA to take forward the regional commissioning agenda. To this end a series of service teams have been formally constituted, which offer guidance on both local and specialist commissioning issues.

The Regional Commissioning Office of the Health and Social Care Board is responsible for developing consistent commissioning policies and governance and accountability arrangements for use by the 5 commissioning offices of the HSCB. The Regional Office develops standard documentation for contract documents and the Service and Budget Agreements (SBA) used with Health and Social Care Trusts in Northern Ireland.
The Regional Office develops the standard template, terms and conditions and clauses in the SBA which is used as the basis for agreement with each local Trust. In 2010/11 the Regional and Local Commissioning Offices engaged in a major project to fundamentally de-construct and re-base the acute activity schedules of the Service and Budget Agreements.

Regional Services
The Regional Office is responsible for commissioning those services where the local catchment is the entire population of Northern Ireland. It is also responsible for commissioning services to meet exceptional health and social care needs including the need for high cost drugs.

During 2010/11 the Regional Office developed systems to support these commissioning roles. A number of Service Teams were formally constituted to oversee the commissioning of specialist services across Northern Ireland.

Regional Social Care Commissioning Arrangements
A number of significant initiatives were progressed during 2010/11, including in relation to improving the procurement and provision of wheelchair equipment and adaptations for older people and people with physical disabilities and sensory impairment. This work will be co-ordinated and developed further in 2011/12 in conjunction with other agencies such as the Northern Ireland Housing Executive, volunteers and other independent sector providers. Current arrangements for the procurement of residential, nursing and domiciliary care have been reviewed and will be rationalised. The appointment of a regional social care procurement officer marks an important development in bringing a greater degree of co-ordination and focus to the task of achieving high quality and better value for money in these service areas.

Prison Health
Lead responsibility for prison health transferred to HSC on the 1st April 2008. Since then the Regional Office has 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. This work ensures that prisoners receive health services equivalent to those in the community. Work in 2010/11 was focused on developing medicines management arrangements, primary care services and patient information systems.
Engagement with the Voluntary and Community sectors

The Third Sector is an important provider of health and social services and some of its services are directly commissioned by the Board. In 2010/11 the Regional Office carried out a detailed review of the standard contracts used with Voluntary and Community organisations with Public Health Agency and Business Support Organisation (Directorate Legal Services). The Regional Office also further developed the regional database which records all the Board and PHA contracts agreed across the province, and engaged with an inter-departmental group led by the Department of Social Development group on commissioning services from the voluntary sector.

Specialist Commissioning

The Regional Office has the role in commissioning services to meet rare or exceptional health and/or social care needs. During 2010/11 work was undertaken to develop a more streamlined notification system for individual funding requests and a number of multi-disciplinary teams were established with responsibility for scrutinising these requests and responding on behalf of the Board.

The Belfast Local Commissioning Group

In its first full year of operation the LCG has established a new form of commissioning within Belfast. This centres around the formation of four Primary Care Partnerships (PCPs), covering North, South, East and West quadrants of the city. These networks of providers include GPs, Community Pharmacists, Belfast Trust, Belfast Health Development Unit, Area and Neighbourhood Community Partnerships as well as voluntary organisations and the Patient and Client Council.

The PCPs have taken a user’s-eye view of pathways to services. They have re-designed these from a service user’s perspective to provide services as locally as possible, to ensure those who need the services most are helped to access them and to support self management and self-directed recovery by patients. The pathways being re-designed at present include Type 2 Diabetes, Palliative Care, ENT surgery and Mental Health services.

Examples of user involvement in service re-design include involvement of the South Asian and Chinese communities where there is a higher risk of developing Diabetes, and the involvement of the Stroke Survivors
Forum in prioritising investment and further action to improve services. In both cases workshops were held at which round table discussions between Consultants, Community representatives, Specialist Nurses, voluntary organisations, Allied Health Professionals, service users, carers, GPs and Pharmacists led to a series of practical action plans to be followed through.

In West Belfast improvements in the coordination of statutory and community-delivered provision of psychological support for the recovery of patients is being taken forward by the PCP. This is being supported by the new Belfast Health Development Unit which has commissioned a survey and categorisation of all existing community provision. This will provide the basis for a network of support to which patients can be directed by GPs and will complement specialist Trust services. It will avoid unnecessary referral to Trust services, the delay this can cause and the high rate of missed appointments.

These examples illustrate the approach of the LCG, working with local people and service users, viewing services from their point of view, listening to their concerns and re-designing services for the benefit of all.
The South Eastern Local Commissioning Group

The South Eastern LCG undertook a wide range of commissioning activities in 2010/11. The Group continued its planned programme of needs assessment in order to support the development of the Local Commissioning Plan. This process was undertaken in conjunction with other Board Directorates, the Public Health Agency and through engagement with local and regional partner organisations. The LCG, since its inception, has been keen to ensure that it takes every opportunity to engage with the communities in the south east. Board workshops and public board meetings have been held in community settings and community groups have actively participated in those events.

The LCG’s Local Commissioning Plan for 2010/11 identified as its key priorities:-

• The need to understand and address the increasing demand for secondary care services and
• The trends in prescribing which could benefit from different medicines management approaches.

In addition the LCG also took forward the development of Primary Care Partnerships (PCPs), networks of independent contractors.

The LCG completed a lengthy engagement programme with independent contractors before establishing four primary care partnerships in the south eastern area. Lead GPs and pharmacists have now been identified to move forward the objectives of the PCPs in addressing the issues of increasing demand for both elective and unscheduled care. The need to address the pressures within the drug budget has also involved the LCG in developing and sharing information with GP practices on their prescribing trends.

On the ground, the new PCPs had the opportunity in 2010/11 to pursue some initial schemes, and as a result the LCG supported the North Down PCP in a community pharmacy led medicines management project, focused on reviewing prescribing for nursing home residents. While in the Down PCP area, GPs undertook a review of the patient pathway in respect of Dermatology. Both projects reflect the LCG’s aim to provide the primary care sector with better information on activity trends and promote enhanced integration with hospital based services.

In 2010/11 the South Eastern Trust developed a significant agenda around the reshaping of the mental health acute inpatient service, disability services, particularly in
the North Down and Ards localities and put forward proposals on the reshaping of their Emergency Care Departments, with specific proposals in regard to the Emergency Department at the Downe Hospital. After a lengthy consultation process both the LCG and the HSCB approved the proposals. Implementation of this reform and modernisation process will follow in 2011/12.

Northern Local Commissioning Group

During 2010/11 the Northern Local Commissioning Group has continued to develop and build knowledge and skills across the range of health and social care issues. Contributions from Board, Public Health Agency and Trust staff have been instrumental in that development.

Members have benefited from a range of presentations demonstrating the issues involved in the promotion of health and well being, including on the Tackling Health Inequalities project on the analysis of the information gathered to identify the causes contributing to low life expectancy in the Antrim, Carrickfergus, Cookstown and Larne Council areas; the work of the Managed Obesity Network in tackling the issue of obesity and the increasing pressure on services as a result, and on the work of the Northern Area Promoting Mental Health and Suicide Prevention Multi-Sectoral Steering Group in raising awareness and educating the population.

There has also been progress in the development of significant initiatives, including the resolution in August 2010, to support the Outline Business Case for the development of the Ballymena Health and Care Centre. The business case was given commissioner support by the Health and Social Care Board and was announced as a capital priority by the Minister in March 2011. The Health and Care Centre will be a state of the art facility incorporating primary and community care facilities together with outpatient and diagnostic services. Through ongoing discussions and liaison, the Local Commissioning Group has gained support from Ballymena Borough Council which will ensure that the Centre will also be of benefit to local community groups.

With the development of LCGs comes the responsibility to progress Primary Care Partnerships. PCPs are networks of primary care providers based on geographical communities. In particular their focus is on patient pathways and medicines management. Within the Northern LCG, a GP stakeholder event was held in September
2010 at which the concept was discussed and proposals for initial pathfinder schemes were initiated. Following this event, significant discussions took place with other key stakeholders.

A further workshop which was held in March 2011 and was well supported by GPs, allowed the establishment of four discrete localities to be confirmed. Within the localities it was agreed that a variety of areas for improvement could be progressed. These range from the development of dermatology services in primary care to the review of prescribing in nursing and residential homes and the review of a number of pathways. There was particular interest in reviewing unscheduled care pathways to manage the flow of patients into A&E.

The LCG has been engaging with local GP practices about the appropriateness of the range of products available on prescription. This has been taken further with the Patient and Client Council drawing up a questionnaire to canvas the views of the wider community. Feedback from this exercise will help inform prescribing initiatives that can be taken forward both locally and regionally.
Supporting the Prescription Waste campaign are members of the Southern Local Commissioning Group (from left) Sheelin McKeagney, Chair; Oriel Brown; Phillip Weir and Lyn Donnelly pictured with local pharmacist Turlough Hamill.

Southern Local Commissioning Group
The Southern Local Commissioning Group (LCG) continues to hold its monthly public meetings in accessible venues across the Southern area. Over the past year the LCG has held meetings in, Dungannon, Banbridge, Lurgan, Mullaghbawn and Portadown and has been pleased to welcome members of the public, community and voluntary groups and elected representatives as well as others to attend their meetings in public.

Details of forthcoming LCG meetings are listed on the Board’s website www.hscboard.hscni.net/lcg.

Topics presented and discussed at recent meetings include; Priorities for Action, developments in local Stroke Services, Carers’ Strategy implementation, Home Enteral Tube Feeding, Health Inequalities, Finance and the development of Primary Care Partnerships (PCPs) in the Southern area. The LCG has had detailed discussions on prescribing practices, mental health services in
the community, disability services and early intervention and prevention work with the Southern Health and Social Care Trust, representatives from the Health and Social Care Board and Public Health Agency in order to better understand the demand for and response to these issues.

During the year the LCG supported a regional prescription waste campaign entitled: ‘Don’t use it – don’t order it’. The purpose of the campaign was to urge patients not to order more medicines from their doctor than they need at any one time and to remind people of the need to take due care with their medicines. The campaign highlighted that many millions is each year lost on prescriptions waste – money that could be used to provide a range of much needed health and social care services.

The current focus of the Southern LCG’s work is the development of PCPs. The LCG has engaged with GPs, Dentists, Pharmacists, Optometrists and other organisations and local communities to develop these local Partnerships. The Partnerships will seek to understand and respond to rising demand for services and variations in patterns of referral and prescribing.

PCP progress to date has included the development of two pathfinder projects. Six GP Practices in the Newry and Rathfriland localities have come together to improve the prescribing of Oral Nutritional Supplements. Working closely with nursing, dietetic and pharmacy colleagues, they have agreed a prescribing protocol for these products to ensure they achieve the desired effect for appropriate patients.

In the Armagh locality, eight GP Practices have designed a care pathway for direct access OGD (examination of the upper intestine) referrals with a view to ensuring that their referral patterns reflect guidelines and best practice in the use of this procedure. A web based pathway has been developed and made available to all GPs in the Pathfinder.

Both Pathfinder projects will be evaluated and the learning from them distributed widely with the intention of rolling out successful approaches to other localities.

The LCG is looking forward to the continued development of PCPs in the Southern area.
Western Local Commissioning Group

Western LCG has placed an emphasis on getting its Primary Care Partnerships (PCPs) in place and making a difference to patients during 2010-11. There has been engagement of primary care professionals to gain support for PCPs with roadshows and close cooperation with the Local Medical Committee and members of Pharmacy Contractors Committee. With clinical leadership for the two PCPs agreed and a number of pathfinder projects in train, the LCG is now well positioned to redesign care pathways which are patient-centred and primary care focussed.

Central to the approach has been a drive to make prescribing savings which will underpin the resources necessary for reform. A pathfinder project to provide prescribing support to the highest prescribing GP practices saw community pharmacists working with GPs to maximise prescribing resources without compromising on patient care. In tandem, the LCG has mounted a campaign to drive down prescribing costs in the West. Through the Prescribing Efficiency Scheme, championed by the LCG Chair, 50 GP practices are reviewing their prescribing approaches and working with community pharmacists to make savings on hard pressed prescribing budgets.

Earlier in the year, the LCG pioneered GP peer review of referral practices in the face of rising demand for secondary care consultations. The approach required GPs in their own practice to reflect on referral patterns and consider if management in primary care could be maintained or an alternative service sought. The approach has now been rolled out to all GPs across Northern Ireland.

The GP referral peer review scheme raised questions about the ability of GPs to diagnose patients without secondary care referrals, particularly where diagnostic imaging was required. With this in mind, the LCG put in place the Rapid Access Ultrasound Scheme which enables GPs in the North-West to get a diagnostic report of an ultrasound scan within four days of referral. In its first four months, 188 patients benefited from this scheme.

The benefits of rapid access should be that a significant number of patients will not need to be referred for a consultant appointment at all. For those patients who still need to be referred to a consultant, they will have results and diagnosis at hand for their appointment. Furthermore better communication between
GPs and diagnostic services will result in reduced referrals for urgent diagnostics and ensure that patients are managed within a primary care setting.

The LCG is now going further and has piloted GP Direct Access to MRI scans for patients. Introduced on 1 March 2011, the scheme will provide GPs across the West with a diagnostic report with patient management advice within four weeks of referral and is likely to lead to patients being managed by their GPs rather than waiting to see a consultant and for onward diagnostic referral.

Beyond these, the LCG and its PCPs are discussing care pathways across a range of acute services, including gynaecology, endoscopy, and oral surgery and is closely engaged in plans to develop intensive rehabilitation services (reablement) in the Western area. The LCG has also maintained its commitment to engage with services users, carers and advocacy organisations undertaking six-monthly roadshows covering the five Council areas, supported by local community networks as well as meeting with community and voluntary organisations on a range of issues, such as community transport, carers support and out-of-hours urgent care.
The Performance Management and Service Improvement Directorate is responsible for supporting provider organisations to identify innovative ways of working and implement recognised good practice to deliver improvements for service users and carers, including to ensure the achievement of the Minister’s targets and standards. The Directorate is also responsible for the development of a wide range of ICT projects to improve the effectiveness of services, and for the provision of a high quality information management service for the Board.

**Performance**

The Board continued to meet regularly with all Trusts during 2010/11 to monitor progress towards the achievement of the Minister’s Priorities for Action targets and standards, and to agree action to be taken in response to identified risks.

Good progress has been made by Trusts across a range of standard and target areas, resulting in improved services for users and carers, in particular in relation to improving mental health services, reducing healthcare associated infections, improving services for people with a disability and improving children’s services.

However, performance in other areas has continued to present a challenge during 2010/11, in particular, waiting times for elective care services and at A&E departments.

In relation to elective care, the decision was taken to reduce the previous reliance on the independent sector during 2010/11, and invest available funding to expand health service capacity. Substantial investment was made during 2010/11 resulting in the appointment of approximately 250 additional staff. However the appointment of this number of staff takes time and most only took up post in the latter half of the year. This, together with the exceptionally adverse weather during the winter which resulted in much higher number of patients being able to attend their appointments and clinics being cancelled than is normal, all led to an increase in waiting times. The Board worked closely with Trusts and provided
additional non-recurrent funding to facilitate additional activity to achieve the best possible outcome for patients, and will continue to do so during 2011/12.

In relation to waiting times at A&E, breaches of the 12 hour standards have continued during 2010/11, and performance against the 4-hour standard remains below the required standard. Addressing this has been a top priority for the Board and will remain so in 2011/12. The Board held a workshop with senior clinical and managerial staff to identify the measures required to improve performance, and established an A&E Working Group to oversee progress towards the implementation of a range of these measures.

Service Improvement – Scheduled Care
The Board continued to support Trusts during 2010/11 to improve the elective patient pathway, and worked closely with clinical teams to develop regional standardised pathways in the areas of Dermatology, Fertility Services, Urology, Endoscopy and MRI.

In addition, support has been provided across Trusts to improve the productivity of services through the facilitation of the Day Surgery and the Pre Operative Surgery Networks.

A key priority during the year has been the identification and sharing of best practice elective patient pathways and productivity assumptions to support the Board’s SBA Capacity Programme.

Service Improvement – Unscheduled Care
The Unscheduled Care Improvement Team continued to undertake a programme of support and audit across all Trusts, including a period of extended support in the Western Trust. This involved undertaking detailed reviews across the whole patient pathway from arrival at A&E to discharge, to identify opportunities to improve processes and systems, leading to improved patient flow.

Work was also taken forward during 2010/11 to reform and improve the processes in relation to the timely discharge of patients, post-acute care, care management and long term condition management. This included improving data quality around these areas that will enable good practice to be highlighted, and areas where reform is most needed to be identified.
Service Improvement – Mental Health, Disability and Community Services

Adult mental health services underwent further reform during 2010/11 in keeping with the implementation of the Bamford Review:

The Releasing Time to Care project was extended to every acute psychiatric admission unit.

A pilot project involving community recovery teams was commenced, aiming at improving the access to and responsiveness of these services.

In partnership with service users and carers, implementation and evaluation plans for the Card Before You Leave Scheme were progressed to offer a next day fixed appointment system.

The Board has facilitated the Regional Psychological Therapies Network to complete an analysis of demand for these services and their capacity to meet that need.

Service Improvement work in services for people with autism has led to considerably improved access and reduced waiting times through a focus on the needs of children and the development of a single, integrated care pathway. This is now being implemented through the Regional Autism Implementation Taskforce.

ICT

During 2010/11 work progressed on a range of ICT projects that are delivering benefits to service users and carers, including:

The introduction of the Northern Ireland Picture Archiving and Communications Service (NIPACS) which provides a regional digital imaging service to capture, store, distribute and display electronic x-rays and scans, replacing costly x-ray film and allowing the secure sharing of images between clinicians across Northern Ireland.

The Electronic Care Record ‘proof of concept’ project (ECR) has proven to be very successful, bringing together patient level clinical information from a range of operational systems to support care delivery. Work is now underway to develop a business case for the regional roll-out of the system.

Other significant projects underway include the implementation of electronic referrals from GPs to hospitals, extending the Theatre Management System, and rolling out the Emergency Care Summary.
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, and 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
- Emergency Preparedness
- Governance
- Information Governance
- Communications

Corporate Business undertakes the annual review of HSC Board Standing Orders which govern the operation of the Board. Corporate Business is also responsible for ensuring compliance with Corporate Governance requirement and, in this regard, maintains Registers of Interests for Directors and Local Commissioning Groups, copies of which may be accessed on the HSC Board website www.hscboard.hscni.net.

Corporate Business also ensures that all issues relating to the management of HSC Board 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.

The HSC Board receives its Human Resources and Equality and Human Rights services through a Service Level Agreement with the Business Services Organisation and Corporate Business is the key contact for these services.
Human Resources

Throughout the last year there has been a strong and determined focus on completion of the Review of Public Administration process. The uncertainties of the RPA have created a difficult time for staff and it is to their credit that they have responded by continuing to contribute to the delivery of health and social care services in Northern Ireland reflecting their true public service values.

HR staff from the Business Services Organisation have been working in partnership with managers and trade unions to finalise structures and to bring the process to a conclusion. Significant effort has been concentrated on ensuring the minimum physical disruption to staff through the restructuring.

During the year work commenced on the arrangements relating to the achievement of the Human Resources Strategy which includes the development of a personal performance appraisal system and development plans as agreed by the Board at its September meeting.

A key element of the strategy is the development of a health and wellbeing strategy and whilst it is still in development, steps have been taken to ensure that staff have access to an organisation wide single Occupational Health Service and an independent counselling service to assist them in maintaining their health and wellbeing.

During the year the Board has received the report of the Staff Attitude Survey undertaken in autumn 2009. Whilst the report identified many positive issues, there was a clear message that staff wished to have an improved internal communication system in place. The introduction of the performance appraisals system in 2011/12 will also address the need to ensure staff receive appropriate training programmes for their work.

With the conclusion of the Review of Public Administration process we look forward to further investing in the development of staff to face the challenges ahead.

Equality and Human Rights

During the year a lot of activity has centred on the out workings of the Section 75 Equality Guidance issued from the Equality Commission in April 2010, namely the audit of inequalities and action plan, and the development of an equality scheme for the HSCB.

The HSCB and its partner organisations jointly consulted on their draft equality schemes and action plans, based on the outcomes of the audits, from December 2010 to March 2011. This involved a series of
face-to-face meetings with individuals and representatives of Section 75 groups. By the end of March, the analysis of consultation responses was underway.

This exercise was supported by an Advisory Group established for quality assurance of this process and convened jointly by the HSCB and nine other HSC organisations. The group met twice during this year with representation by the Head of Corporate Services.

Training has continued in order to increase staff confidence and competence in relation to equality and human rights. During the year, over 110 members of staff attended the training.

A regional screening template and guidance notes based on the new Equality Commission guidance was developed by a group of HSC representatives, led by the Equality Manager supporting the HSCB. These documents were issued to all staff in October and are used as part of the screening training.

The Equality, Human Rights and Diversity Forum members continued to support the agenda through the attendance at meetings; the provision of advice and the sharing of information with colleagues.
The HSCB Bulletin has included articles on audit activity and human rights implications. Accessible information guidance was disseminated to staff in July 2010. This is also supported in the HSCB guidelines on consultation. These are available for staff on the intranet.

Complaints and medical litigation

In line with DHSSPS guidance, all medical negligence files with little or no activity should be reviewed at least on an annual basis. Following the annual review of ongoing pre Trust (1993) cases during 2010, 190 cases were closed. The files are retained in order that they can be re-activated should further communication/instruction be received from the plaintiff. In addition nine cases were settled in year. The number of ongoing cases is now 174 which represents a significant reduction from 1 April 2009 (371). The HSCB procedure for the handling of Clinical Negligence Claims was developed and approved by the Governance and Audit Committee of the Board in October 2010. This procedure outlines the delegated authority levels within the HSCB for settlement of cases and associated payments. Authority is required from DHSSPS for cases settled above £250,000.

The Board’s first Annual Report on Complaints was approved by the Governance and Audit Committee in October 2010. Currently a ‘process evaluation’ of the new complaints procedure is being undertaken by the Board at the request of DHSSPS. This evaluation will look at what is working well with the new procedure and identify any changes required. The outcome will be communicated to DHSSPS in early 2011/12.

Emergency Preparedness

An integrated HSCB/PHA/BSO Emergency Preparedness and Response Plan has been developed through collaborative working. The HSCB has also built upon interim Business Continuity arrangements and has developed a fully operational Plan which will be further enhanced during 2011 to attain standard BS2599, as per DHSSPS requirements. An activation of the Business Continuity and Emergency Preparedness arrangements occurred during the adverse weather conditions during December 2010 and early January 2011, enabling all partner organisations to respond effectively during this time. The plan has subsequently been reviewed and enhanced to reflect the lessons learned from this joint activation. Wider HSC learning in respect of Winter 2010 will be disseminated in preparation for Winter 2011.
Governance

Governance Assurance Framework
It is vital the Health and Social Care Board (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 established and implemented an Interim Governance Assurance Framework during 2009/10. The framework continues to provide the systematic assurances required by the Board of Directors on the effectiveness of the system of internal control by highlighting the reporting and monitoring mechanisms that are necessary to ensure the commissioning of safe, quality health and social care.

During 2010/11 work commenced in establishing an overarching Governance Framework for the HSCB. A Governance Officer group has been established which is responsible for taking forward this important area of work during 2011/12.

Risk Register
To ensure the robustness of the HSCB’s system of internal control, the HSCB developed a fully functioning risk register at both directorate and corporate levels.

During 2010/11 both Corporate and Directorate registers were reviewed at the end of each quarter. The Corporate Register underwent a thorough review in December 2010 involving Directors and their senior staff, co-ordinated by senior Governance staff. This has resulted in substantive changes to the register and has provided an assurance mechanism to the Board of Directors that risks to meeting corporate objectives are being effectively managed.

Management and Follow up of Serious Adverse Incidents (SAIs)
The requirement on HSC organisations to routinely report SAIs to the Department of Health, Social Services and Public Safety (DHSSPS) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, transferred to the HSCB working in close partnership with the Public Health Agency (PHA) and the Regulation Quality Improvement Authority (RQIA).
In April 2010 the HSCB issued the procedure for the Reporting and follow up of SAIs for full implementation on 1 May 2010. The procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business. The procedure also details internal processes in relation to the nomination of Designated Review Officers (DROs) from both the HSCB and PHA.

A SAI workshop was held in November 2010 allowing stakeholders from across HSC organisations to put forward their views for a further revision of the procedure. A revised procedure is currently being drafted and will be consulted upon prior to being issued.

The Regional SAI Review Group meets on a bi-monthly basis to discuss SAIs in depth, and to identify trends and ensure the effective regional sharing of learning.
Controls Assurance Standards

In progressing the controls assurance agenda for 2010/11, 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. Progress in this standard has been limited due to staff capacity issues, and will be a focus for progress during 2011-12.

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

- Governance
- Risk Management
- Finance
- Emergency Planning.

Information Governance

Information Governance is the collective term given to the management of the information and records held or processed by an organisation. Primarily driven by legislation, it covers all personal information, for example, that relating to service users and employees, and all corporate information such as financial and accounting records or information on the commissioning of services.

Information Governance allows the Board to ensure that personal information is handled legally, securely, efficiently and effectively. Additionally it enables the Board to put in place procedures and processes for corporate information that support the efficient location and retrieval of corporate records where and when needed, in particular to meet requests for information and assist compliance with Corporate Governance standards.

During 2010/11 work has been progressing to develop a Board wide Information Governance Framework. Specific initiatives that have been progressed during this year have been:

- The ongoing management of requests for information under both Data Protection and Freedom of Information Legislation.
- Reducing the risk of Information loss with the introduction of new software to prevent use of unencrypted devices on Board computers.
- The roll-out of Encrypted USB Memory Sticks across the organisation to ensure the safe transfer of Board Information.
• The development of an Information Governance section on the Board's Intranet to allow staff to review Policies and guidance as and when required.

• Raising staff awareness to information risks and individual responsibilities through mandatory awareness training for all staff on Board Operational Policies;

During 2011-12 the Information Governance Team will continue to develop the Information Governance Framework across all directorates within the Board.

Communications

Good communication and the sharing of information is an integral part of the Board’s role and is used to keep the press, media, ‘stakeholder’ interests and the wider community fully informed about its work. During 2010-11, the Board’s communications team undertook further work to foster a better understanding of its role and responsibilities. The principal aspects of this work comprised the following:

The Board communicated many important aspects of its work directly to the press and media, and managed their interest in this through
facilitating interviews and providing a wide range of supporting information.

Specific communications initiatives were undertaken to promote the work of Board Partnerships including the Regional Autism Spectrum Disorder Network, the Children and Young People’s Strategic Partnership, the Think Family project, the Regional Acquired Brain Injury Group and the Northern Ireland Adult Safeguarding Partnership.

A range of wider Board initiatives that were promoted during the course of the year included the Medicines Management project, the Northern Childcare Partnership Conference, and new guidelines for domiciliary eye care. The Board also worked closely with a range of partner organisations to organise the inaugural Social Worker of the Year competition. This acknowledged expertise and good practice among social workers in Northern Ireland, and proved highly successful.

The Board actively communicated the work it undertook during the winter period to manage increased demand for hospital services against a background of seasonal illnesses that included swine flu. This period of heightened pressure upon hospital services required regular communication with the media and partner organisations to ensure that people were kept fully informed about the measures being taken to manage this position.

Further work was also undertaken to enhance an understanding of the role of the Board’s five Local Commissioning Groups in each of their respective areas, to successfully produce a range of publications, including the organisation’s first annual report, and to further develop its website.
Directorate of Social Care

Working with people, for people, and involving service users to ensure best practice. These are the aspirations of the Board’s social care directorate as it seeks to offer everyone in Northern Ireland access to professional social work services of the highest standard.

The involvement of service users is vital. With their input, services are changed to be more responsive to those who stand to benefit from them the most. For this reason, the Board is continually committed to providing opportunities for service users to be involved when improving social care services. Service users and carers were encouraged to highlight their effective involvement at the annual User Carer Conference in March 2011. Entitled ‘Listening and Learning Together’, the conference recognised the best service user and carer engagement and user lead projects that have resulted in service improvement.

This annual report provides an opportunity to further highlight the invaluable partnership between the Board and service users in improving Social Care Services.

Family and Childcare

The Children and Young People’s Strategic Partnership (CYPSP) was formed in January 2011. The CYPSP is a new regional group which stresses working in partnership across all organisations. This group provides an opportunity to engage with children and young people to ensure the most responsive services are available. In doing so the overall aim of the group can be better achieved, that is to improve wellbeing and address the rights and needs of children and young people across the region.

In November 2010 adoptive families were given the opportunity to share their experiences of parenting children adopted from Northern Ireland’s care system. The subsequent groundbreaking DVD, ‘Could you be an Adopter?’ was produced by the charity Adoption UK and commissioned by the Board. By viewing the experiences of other service users, the DVD will provide vital insights for prospective adopters and hopefully encourage them to fulfil their adoption ambitions.

In February 2011 the Board and Children in Northern Ireland (CiNI)
worked in partnership to stage the conference entitled, ‘A Safer Future’, which was held in anticipation of the new Safeguarding Board for Northern Ireland (SBNI). The conference was instrumental in allowing the voices of local participants from the voluntary and statutory sector to be heard. Their views will be important to inform the work of the SBNI as it continues to promote the welfare of children across Northern Ireland.

**Mental Health and Learning Disability**

The established Regional Autism Spectrum Disorder Network allows the Board to engage individuals with autism and their carers. Their active involvement has been essential, particularly regarding autism assessment and early intervention. Working in partnership with the Board and multidisciplinary groups, the last year has seen a dramatic reduction in waiting times for assessment and early intervention across the region from two years to thirteen weeks.

In line with the Bamford Action Plan, the Board relies on reference groups to involve service users when commissioning services that would benefit them the most. As a result, the Board has overseen the development of services that enhance care practices in relation to personality disorders and psychological therapies. This development means individuals can now receive responsive support while still living independently as valued members of their community.
As part of the ‘Think Child, Think Parent, Think Family’ approach to planning and delivery of services, an innovative survey approach has been designed to involve parents with mental health issues, their children and carers. In line with the principal aims of this project, the experiences of parents, children and carers collected from this survey will shape the future delivery of services that will improve the care and support of parents with mental health issues and their wider family circle.

Older People and Adults
Adults and older people have often expressed their desire to receive care and support while still living independently at home. In response, the Board is seeking to adopt the Re-ablement Model of Community Care. In doing so the Board will explore ways to provide earlier intervention and rehabilitation for individuals to ensure that they can receive the care and support required within their own homes.

The Board was instrumental in overseeing the development of The Northern Ireland Safeguarding Partnership (NIASP) and five Local Adult Strategic Partnerships (LASPs) who will be responsible for the safeguarding of vulnerable adults. It is essential that the voice of vulnerable adults is at the centre of safeguarding and protection systems and the newly established partnerships are in the process of forming a new Adult Safeguarding Forum to allow effective engagement with individuals in their communities.

The involvement of wheelchair users has been instrumental in the continued reform of the regional Wheelchair Service. In the last year, waiting times have been driven down for people who request a wheelchair and now the majority of individuals are seen within 13 weeks with a temporary loan service also available. Wheelchair users continue to be instrumental in informing and driving the reforms forward to develop a fairer, more accessible and responsive service.

Regional Social Work Awards
Cancer patients were at the heart of the innovative Jimmyteens TV Project, managed by the Oncology and Haematology Social work team, who were the overall winners at the first Regional Social Work Awards hosted by the Board in February 2011. This team were chosen from a group of 16 finalists, all of which recognised the value of service user involvement. The Board’s congratulations go to the winners and to all those who took part in this inaugural awards scheme.
Directorate of Integrated Care

The Directorate of Integrated Care manages services provided to patients through a range of practitioners – GPs, community pharmacists, dentists and opticians.

Integrated Care is about achieving “joined up” health and social care; the overarching theme being a more efficient patient journey secured through greater co-operation, the breaking down of professional boundaries and provision of services in the most efficient and cost effective way.

Primary Care Partnerships

The development of Primary Care Partnerships is a key initiative which has the real potential to transform service provision, resourcing the treatment of patients in the most appropriate setting. Central to success will be the building and maintaining of strong relationships between professional representatives and those who manage policy, strategy and operational working in the HSC, particularly as we embark on a further programme of efficiencies and the inevitable turbulence which will accompany that process. This vision can be achieved through inclusivity in working up service redesign, ensuring that the HSC rewards good practice and invests in those parts of the service which measure and achieve quality in service provision.

In 2010/11 the HSCB made substantial progress in establishing Primary Care Partnerships (PCPs) across all five Local Commissioning Group areas. Proposals to pilot new and innovative services are underway including the involvement of clinical professionals, the voluntary sector and service users. These pathfinder projects aim to provide more accessible and efficient local services. PCPs receive substantial multidisciplinary support from staff across all Directorates within the Board and PHA. This assistance will provide them with the information, professional advice and administrative expertise they require to reshape local services.

Pharmacy and Medicines Management

The year 2010/11 saw the Board continue to develop its structures to commission and deliver safe, effective and efficient medicines management across the HSC. An important element has been
the development of the Medicines Management Forum, a key advisory group for the Board on how medicines are used. In 2010/11, the group issued a number of important prescribing guidance materials which it is anticipated will assist optimum use of medicines across the service.

A major policy development undertaken by the Board has been the establishment of the Northern Ireland Formulary. This guidance will be launched early in 2011/12 and will serve to effect high quality prescribing and use of medicines.

Work continues to ensure the best use of resources through the Pharmaceutical Efficiency Programme. Overall, substantial efficiencies were planned for 2010/11 and it is anticipated this goal will be achieved. This has been delivered by frontline clinicians responding positively to guidance issued by the Board, supported by Board officers and Local Commissioning Groups. The general public has played its part too, heeding the messages in the national publicity campaign, particularly in relation to the ordering of repeat prescriptions.

Through the drive for efficiency, we have seen a reduction in the growth of prescribing costs as well as increases in generic dispensing, now comparable to Scotland. Moving forward, further work is planned to ensure that we get best value in the way medicines are used. We hope this work will be complemented by the development of a new community pharmacy contract currently being negotiated with community pharmacy representatives.

Safety in the use of medicines is a key issue for the Board and in 2010/11, the Board rolled out arrangements to improve the management of controlled drugs. In 2011/12, further work is planned to continue to develop systems which will support learning from medication incidents and improve the safety of medicines use.

**General Medical Services (GMS)**

The HSCB continues to commission General Medical (GP) Services (GMS) to national standards through the GMS Contract, now in its seventh year of implementation. The Board was required to deliver a substantive cash release efficiency in commissioning GMS in 2010/11. HSCB continues to work constructively with GP Practices and their representatives to ensure that all available funding is invested to maximum effect.

In spite of the financial constraints, much has been invested in chronic disease and primary care services
management through the Quality and Outcomes Framework, supporting professionals in General Practice to deliver a range of evidence based health promotion and disease prevention activity.

Substantial investment has also been made in Enhanced Services, targeting health improvement initiatives such as enhanced assessment of adults with severe learning difficulties, enhanced management of patients with depression, improving access for patients with difficulties communicating in English, and enhanced assessment of patients at cardiovascular risk, to name but a few.

The HSCB remains committed to working with the Public Health Agency and Local Commissioning Groups to improve existing services and explore new Enhanced Services, promoting long-term health improvement and addressing health inequalities.

Dental Services

In 2009 HSCB contracted with Oasis Dental Care Ltd to provide dental services from fourteen sites across Northern Ireland where local populations had been experiencing difficulty in obtaining Health Service dental care. By mid 2010 all fourteen practices were operational and were welcoming new patients. Access to local dental services, which had been a considerable issue for a number of years across Northern Ireland, improved considerably in 2010/11.

In July 2010, responsibility for the General Dental Services (GDS) budget transferred from the DHSSPS to the HSCB. The transfer of the budget has significantly altered the role of the Commissioner in relation to GDS.

The development of new GDS contracts continued in 2010-2011. There will be three separate contracts: general primary dental care, orthodontics and oral surgery. HSCB and DHSSPS have agreed with the British Dental Association (BDA) that the oral surgery contract should be the first to be piloted. The Board has now completed the consultation exercise on the enabling pilot arrangements and feedback has been largely positive. It is anticipated that before mid-2011 HSCB will be asking for expressions of interest from practices to participate in the oral surgery pilots.

In 2010/11 HSCB continued to work, under the aegis of the Northern Ireland Guidelines and Audit Implementation Network (GAIN) and with dentists from the community dental services and nursing home representatives, on the development
of oral health guidelines for the elderly. The final document is due to be released in mid-2010 and will help direct nursing homes in the oral health management of their residents ensuring that prevention is maximised and that, when problems do arise, they are detected early and handled appropriately.

HSCB continues to be a key partner in the Northern Ireland Caries Prevention in Practice (NIC-PIP) trial along with the University of Manchester, the Belfast Trust and the Northern Trust. This research project is the largest ever undertaken in primary care dentistry within the UK and aims to test the effectiveness and cost-effectiveness of a fluoride varnish in preventing dental decay among children. The project team has now recruited approximately half of the practices needed for the trial and practice staff have begun to be trained up in the skills necessary for a rigorous, randomised controlled trial of this type.

Optometry Services (GOS) 2010/11 has been a particularly busy year for GOS. Consolidation of the professional advisory support team has now been completed and will provide optometric advice and support for all 5 LCG areas.

Pictured at a training session for community optometrists to dispense glasses to very young children are: Professor Jonathon Jackson and Fiona North, Health and Social Care Board; Simon Rafferty, Dispensing Optician; John Paul Rice, Dispensing Optician; Rosie Brennan Western Health and Social Care Trust; Faith Donaldson, Optometrist, and Helen Carroll, Dispensing Optician from Dublin.
Major areas of work include the formulation of an integrated primary/secondary care plan for the detection and management of glaucoma across the region. This work has seen a multiprofessional clinical team work collaboratively with Trust and Board managers as well as HSCB in supporting a department led strategic review of eyecare services.

In addition to these major initiatives, important work has been undertaken in the fields of child vision and domiciliary eyecare – developing a specialist list of community optometrists trained to dispense glasses to very young children with complex needs and a children’s eyecare information leaflet, both of which are aimed at improving communication and continuity of care for children.

Working in partnership with GAIN, DHSSPS, the optometric profession and service users, the HSCB developed best practice guidance to enhance the current provision of eyecare to those in nursing and residential homes and day care facilities. The guidance was launched in October 2010 with the support of the Chief Medical Officer and was warmly welcomed by service users and the voluntary sector.

Exploratory work is ongoing on the potential for a new GOS contract, a future basis for developing a more managed approach to the commissioning of optometry services.

The Directorate of Integrated Care has therefore had a productive year, with staff managing to maintain a high level of service provision amidst the challenges of financial and organisational change. This has only been possible through the continued dedication and professionalism of frontline clinical and business support staff across the four ‘independent contractor’ services – GPs, community pharmacists, dentists and opticians.
Reports from Board Sub-Committees

The Board has four sub-Committees to scrutinise important aspects of its work:

- The Governance and Audit Committee
- The Reference Committee
- The Pharmacy Practices Committee and
- The Remuneration Committee

A report now follows from each of the Committees on their work during the past year.
1. 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, as specified in the Board’s Standing Orders. The GAC is made up of four Non-Executive Directors:

Stephen Leach (Chair)
Robert Gilmore
Mrs Elizabeth Kerr
Dr Robert Thompson

The Committee 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 staff. (Bernard Mitchell was replaced in March 2011 by Michael Bloomfield.) The Committee also liaises with the PricewaterhouseCoopers (PWC) who have been contracted to complete the audit on behalf of the external auditors, Northern Ireland Audit Office (NIAO). The Committee is grateful to all the Board officers and others who have supported its work in the past year.

2. In the course of 2010-11 the GAC completed the following main items of business in fulfilling its oversight responsibilities to the HSCB:

- It considered and approved the proposed Internal Audit (IA) Plan for 2010-11:
  - confirming that IA’s resources were focussed on the Board’s key work areas and risks;
  - checking on the progress of audits throughout the year;
  - scrutinizing IA reports and the level of assurance they provided; and
  - ensuring that areas awarded “priority” status were actively responded to and addressed by management.
• It received, examined and recommended to the full Board the HSCB Annual Accounts for the year ended 31 March 2010, which were given an unqualified opinion by the external auditors and the NIAO. The Committee considered in detail the external auditor’s Report to Those Charged with Governance, focussing particularly on the effectiveness of the new controls assurance systems, and met both the external and internal auditors for a discussion without Board officers present. It also considered the Plan by the external auditor for the audit of the 2010-11 Accounts.

• It satisfied itself that robust arrangements were in place for Health and Social Care (HSC) organizations to report Serious Adverse Incidents (SAIs) to the Board (a requirement which transferred from DHSSPS on 1 May 2010), and reviewed SAI reports on a quarterly basis.

• The Committee reviewed and considered updates to the HSCB Corporate Risk Register on a regular basis, and sampled Directorate Risk Registers in order to examine the operation of the underlying Risk Analysis Tool.

• It reviewed and approved the Mid-Year Assurance Statement setting out the HSCB’s internal controls and its compliance with the Department’s requirements in this area, and forwarded them to the Board and Accounting Officer.

• Recognizing the critical importance to the HSCB of the services provided to it by the Business Services Organisation (BSO), including services related to Family Health, procurement, payroll and financial transaction processing, the Committee regularly reviewed the relationship between the two bodies, and in particular the operation of the Service Level Agreement.

• Within the overall Governance framework for the HSCB, the Committee reviewed and approved the developing Governance arrangements specific to the Social Care and Children’s Directorate, including the mutual responsibilities of Board and Trust staff; as well as the HSCB systems for the management of controlled drugs in the primary care sector.
• On the basis of the new arrangements endorsed by the Committee at its March 2010 meeting, it received and approved the first annual Complaints Report for the HSCB.

• It reviewed and approved a number of key Corporate Governance policies for implementation throughout the Board, covering among other areas
  ○ ICT security
  ○ Health and safety
  ○ Physical security
  ○ Fire safety.

• The Committee also regularly reviewed reports from the HSCB Fraud Liaison Officer, and noted the progress being made in finalizing the new Board-wide Fraud Response Plan.

3. In the course of 2010-11 GAC members attended training workshops organized by the Department and others, and again completed a National Audit Office Self Assessment Checklist designed to assess its effectiveness and the scope for improvement. Flowing from this, the Committee will draw up a fresh Action Plan and continue to look for other ways to develop its skills and the quality of assurance it can provide. Subject to any changes in the overall framework which the Board may decide, and recognizing the challenges which will be posed by the 2011-15 Budget, the Governance and Audit Committee looks forward to continuing its work and supporting the HSCB in the coming year.

Stephen Leach
Chair of the Governance and Audit Committee
Report of the Reference Committee

This is the second year of the Reference Committee, which was established after the formation of the Health and Social Care Board (HSCB) in April 2009. The Committee concentrates on the performance of doctors, dentists, optometrists and pharmacists. Non Executive Directors and Directors of the HSCB with advisors carry out the business of the Committee which meets regularly throughout the year.

The emphasis and focus is always on the protection of the public and ensuring that public money is not misused or misspent. This results in a number of cases coming back to the Committee for examination on several occasions for updates and developments. Since it started its business, the Committee has dealt with seventeen new cases dealing with issues right across the designated professions.

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. Such support is critical to the working of the Committee and helps ensure that fairness and good governance is adhered to in any decision made.

In this current year, the Committee not only dealt with new cases but also made recommendations and suggestions to strategically enhance the processes involved. For example, concerns over the negative impact on cases of delays in dental cases referred to the Disciplinary Committee, were highlighted by the Reference Committee to the Health and Social Care Board. The Committee also sought to raise awareness of GP Complaints Procedures by engaging with the Patient Client Council, to gauge the level of understanding of these procedures.

Brendan McKeever
Chairman of the Reference Committee

Membership of the Reference Committee

Mr Brendan McKeever – Committee Chair
Dr Melissa McCullough – Non Executive Director
Mrs Fionnuala McAndrew – Executive Director/Director of Social Care & Children’s Services

In attendance - Dr Sloan Harper, Director of Integrated Care (for professional advice); and Mrs Carol Mooney, Secretary to the Committee.
Report of 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 Pharmacy Practices Committee which deals with applications to:
- Join the pharmaceutical list (to open a community pharmacy)
- Provide domiciliary oxygen services
- Non-minor relocations (where the proposed relocation of the pharmacy is in a different neighbourhood).

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 the period 2010/11 the Pharmacy Practices Committee dealt with the following applications:

Full applications:
- 15 (11 refused; 2 withdrawn; 2 pending)

Oxygen applications:
- 8 (all 8 approved)

Mr John Mone
Chair of the Pharmacy Practices Committee
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 (DHSSPS).

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, Chairman
Mrs Elizabeth Kerr
Dr Melissa McCullough

During the year 2010/11 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
The membership of the Remuneration Committee for the Health and Social Care Board consists of the Chairman and two of its Non-Executives.

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.

The performance of Senior Executives is assessed using a Performance Management System which is comprised of individual appraisal and review. Their performance is then considered by the Remuneration Committee and judgements are made to their performance banding in line with the departmental contract against the achievement of regional, organisation and personal objectives.
The relevant importance of the appropriate proportion of remuneration related to performance is set by the DHSS&PS under the Performance Management arrangements for Senior Executives.

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 2010/11 were on DHSSPS Senior Executive Contracts which are detailed and contained within the Circular HSS (SM) 2/2001 as amended from time to time.

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
Dr Sloan Harper, Director of Integrated Care commenced employment on 1st April 2010
Mr Dean Sullivan, Director of Commissioning commenced employment on 1st June 2010

Ms Louise McMahon, Director of Performance Management commenced employment on 1st September 2010

Non-Executive Directors
The following 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 1st October, 2009)

Mr Hugh Mullen, left his post of Director of Performance Management left the employment of the HSCB on 2nd May 2010.

Mr B Mitchell left his post under the arrangements relating to the Review of Public Administration on 26th March 2011 as set out in the section Premature Retirement Costs.
Retirement Age
Throughout 2010/11 employees were required to retire at age 65 although employees could have asked to work beyond this age in accordance with Equality (Age) Regulations (NI). Since 06 April 2011 the default retirement age has been abolished.

Premature Retirement Costs
Section 16 of the Agenda for Change Terms and Conditions Handbook issued on 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 the service. Further circulars have been issued by the Department of Health Social Services and Public Safety 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** *(Table 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 £000s</th>
<th>Total accrued pension at age 60 and related lump sum £000s</th>
<th>CETV at 31/03/10 £000s</th>
<th>CETV at 31/03/11 £000s</th>
<th>Real increase in CETV £000s</th>
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</thead>
<tbody>
<tr>
<td>Executive Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Compton</td>
<td>0 - 2.5 pension 5 - 7.5 lump sum</td>
<td>65 - 70 pension 200 - 205 lump sum</td>
<td>1,602</td>
<td>*</td>
<td>*</td>
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<tr>
<td>P Cummings</td>
<td>0 - 2.5 pension 5 - 7.5 lump sum</td>
<td>30 - 35 pension 100 - 105 lump sum</td>
<td>571</td>
<td>549</td>
<td>-22</td>
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<tr>
<td>H Mullen (left 02/05/10)</td>
<td>No calculation can be made as postholder left 2/5/2010.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>M Bloomfield (acting 01/04/10 - 30/08/10)</td>
<td>No calculation can be made as postholder in post on acting up basis from 1/4/10 to 30/08/10.</td>
<td></td>
<td></td>
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<tr>
<td>L McMahon (commenced 01/09/10)</td>
<td>No calculation can be made as postholder took up post on 1/9/10.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F E McAndrew</td>
<td>0 - 2.5 pension 2.5 - 5 lump sum</td>
<td>15 - 20 pension 45 - 50 lump sum</td>
<td>312</td>
<td>321</td>
<td>9</td>
</tr>
<tr>
<td>S Harper</td>
<td>2.5 - 5 pension 7.5 - 10 lump sum</td>
<td>35 - 40 pension 110 - 115 lump sum</td>
<td>637</td>
<td>645</td>
<td>8</td>
</tr>
<tr>
<td>B Mitchell (retired 26/03/11)</td>
<td>0 - 2.5 pension 5 - 7.5 lump sum</td>
<td>30 - 35 pension 90 - 95 lump sum</td>
<td>593</td>
<td>614</td>
<td>21</td>
</tr>
<tr>
<td>D Sullivan (commenced 01/06/10)</td>
<td>No calculation can be made as postholder took up post on 1/6/10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Mr Compton’s contributions ceased in 2010/11 therefore there is no CETV at 31/03/11.
As Non-Executive members do not receive pension remuneration, there will 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 particular point in time. The benefits valued are the member’s accrued benefits and 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.

Signed: ______________________ Chief Executive  Date: 02/06/11
Senior Employees’ Remuneration (Table Audited)

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

<table>
<thead>
<tr>
<th>Name</th>
<th>2010-11</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary £000s</td>
<td>Bonus / Performance pay £000</td>
</tr>
<tr>
<td><strong>Non-Executive Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Clements</td>
<td>30 - 35</td>
<td>0</td>
</tr>
<tr>
<td>S J Leach</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>M McCullough</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>R Gilmore</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>B McKeever</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>J Mone</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>E Kerr</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td>W R Thompson</td>
<td>5 - 10</td>
<td>0</td>
</tr>
<tr>
<td><strong>Executive Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Compton</td>
<td>140 - 145</td>
<td>0</td>
</tr>
<tr>
<td>P Cummings</td>
<td>105 - 110</td>
<td>0</td>
</tr>
<tr>
<td>H Mullen (left 02/05/10)</td>
<td>15 - 20</td>
<td>0</td>
</tr>
<tr>
<td>M Bloomfield (acting 01/04/10 - 30/08/10)</td>
<td>30 -35</td>
<td>0</td>
</tr>
<tr>
<td>L McMahon (commenced 01/09/10)</td>
<td>60 - 65</td>
<td>0</td>
</tr>
<tr>
<td>F E McAndrew</td>
<td>80 - 85</td>
<td>0</td>
</tr>
<tr>
<td>S Harper</td>
<td>120 - 125</td>
<td>0</td>
</tr>
<tr>
<td>B Mitchell (retired 26/03/11)</td>
<td>75 - 80</td>
<td>0</td>
</tr>
<tr>
<td>D Sullivan (commenced 01/06/10)</td>
<td>85 - 90</td>
<td>0</td>
</tr>
</tbody>
</table>
Statement on Internal Control

Scope of Responsibility
The Board of the Health and Social Care Board (HSCB) is accountable for internal control. As Accounting Officer the Chief Executive of the HSCB is responsible 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 he is responsible in accordance with the responsibilities assigned to him by the Department of Health, Social Services and Public Safety (DHSSPS).

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 HSCB for the year ended 31 March 2011, and up to the date of the approval of the Annual Report and Annual Accounts and accords with Department of Finance and Personnel guidance.

Access to the full statement on internal control
The full statement on internal control is included in the HSCB annual accounts for the year ended 31st March 2011.
Summary
Financial Statement

These accounts have been prepared in a form determined by the DHSSPS based on guidance from the Department of Finance and Personnel’s Financial Reporting Manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

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), Annual Report and Auditor’s Report for the year ended 31st March 2011 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
## STATEMENT OF COMPREHENSIVE NET EXPENDITURE for the year ended 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>Restated 2011</th>
<th>2010</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff costs</td>
<td>(23,316)</td>
<td>(26,635)</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,672)</td>
<td>(2,411)</td>
<td></td>
</tr>
<tr>
<td>Other Expenditures</td>
<td>(935,415)</td>
<td>(924,464)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(961,403)</td>
<td>(953,510)</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from activities</td>
<td>42,747</td>
<td>46,679</td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td>794</td>
<td>1,394</td>
<td></td>
</tr>
<tr>
<td>Transfers from reserves for donated property, plant, equipment &amp; intangibles</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Reimbursements receivable</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>43,541</td>
<td>48,073</td>
<td></td>
</tr>
<tr>
<td><strong>Net Expenditure</strong></td>
<td>(917,862)</td>
<td>(905,437)</td>
<td></td>
</tr>
</tbody>
</table>

Revenue Resource Limits (RRLs) issued (to)

<table>
<thead>
<tr>
<th>Trust</th>
<th>2011 £000s</th>
<th>2010 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belfast HSC Trust</td>
<td>(1,015,202)</td>
<td>(975,986)</td>
</tr>
<tr>
<td>South Eastern HSC Trust</td>
<td>(445,459)</td>
<td>(434,445)</td>
</tr>
<tr>
<td>Southern HSC Trust</td>
<td>(456,651)</td>
<td>(445,462)</td>
</tr>
<tr>
<td>Northern HSC Trust</td>
<td>(527,894)</td>
<td>(525,283)</td>
</tr>
<tr>
<td>Western HSC Trust</td>
<td>(438,484)</td>
<td>(421,104)</td>
</tr>
<tr>
<td>NIAS HSC Trust</td>
<td>(49,038)</td>
<td>(52,608)</td>
</tr>
<tr>
<td>NIMDTA</td>
<td>(1,070)</td>
<td>(763)</td>
</tr>
<tr>
<td>NIGALA</td>
<td>(51)</td>
<td>0</td>
</tr>
<tr>
<td>RQIA</td>
<td>(122)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total RRL issued</strong></td>
<td>(2,933,971)</td>
<td>(2,855,651)</td>
</tr>
</tbody>
</table>

Total Commissioner resources utilised

<table>
<thead>
<tr>
<th></th>
<th>2011 £000s</th>
<th>2010 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(3,851,833)</td>
<td>(3,761,088)</td>
</tr>
</tbody>
</table>

Revenue Resource Limit (RRL) received from DHSSPS

<table>
<thead>
<tr>
<th></th>
<th>2011 £000s</th>
<th>2010 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3,851,968</td>
<td>3,761,196</td>
</tr>
</tbody>
</table>

Surplus / (deficit) against RRL

<table>
<thead>
<tr>
<th></th>
<th>2011 £000s</th>
<th>2010 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>135</td>
<td>108</td>
</tr>
</tbody>
</table>

## OTHER COMPREHENSIVE EXPENDITURE

<table>
<thead>
<tr>
<th>Description</th>
<th>Restated 2011</th>
<th>2010</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net gain/(loss) on revaluation of Property, Plant and Equipment</td>
<td>(1,398)</td>
<td>(370)</td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of Intangibles</td>
<td>130</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of available for sales financial assets</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

## TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000s</td>
<td>£000s</td>
</tr>
<tr>
<td>TOTAL</td>
<td>(919,130)</td>
<td>(905,807)</td>
</tr>
</tbody>
</table>
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>2011 £’000</th>
<th>2010 (restated) £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Resource Limit (RRL) received from DHSSPS</td>
<td>3,851,968</td>
<td>3,761,196</td>
</tr>
<tr>
<td>Other Income</td>
<td>43,541</td>
<td>48,073</td>
</tr>
<tr>
<td></td>
<td><strong>3,895,509</strong></td>
<td><strong>3,809,269</strong></td>
</tr>
<tr>
<td>Expenditure (including RRLs issued to Trusts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Costs</td>
<td>(23,316)</td>
<td>(26,635)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(2,672)</td>
<td>(2,411)</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(3,869,386)</td>
<td>(3,780,115)</td>
</tr>
<tr>
<td></td>
<td><strong>(3,895,374)</strong></td>
<td><strong>(3,809,161)</strong></td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>135</td>
<td>108</td>
</tr>
</tbody>
</table>
STATEMENT OF FINANCIAL POSITION as at 31 March 2011

<table>
<thead>
<tr>
<th></th>
<th>2011 £000s</th>
<th>Restated 2010 £000s</th>
<th>Restated 2009 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant and Equipment</td>
<td>21,425</td>
<td>25,288</td>
<td>25,145</td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>1,560</td>
<td>1,531</td>
<td>1,059</td>
</tr>
<tr>
<td>Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Non Current Assets</strong></td>
<td>22,985</td>
<td>26,819</td>
<td>26,204</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assets classified as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inventories</td>
<td>8</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>3,902</td>
<td>6,750</td>
<td>3,166</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>1,493</td>
<td>944</td>
<td>117</td>
</tr>
<tr>
<td>Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>102</td>
<td>1,562</td>
<td>1,377</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>5,505</td>
<td>9,258</td>
<td>4,660</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>28,490</td>
<td>36,077</td>
<td>30,864</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other Payables</td>
<td>(201,637)</td>
<td>(209,726)</td>
<td>(173,188)</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>(201,637)</td>
<td>(209,726)</td>
<td>(173,188)</td>
</tr>
<tr>
<td><strong>Non Current Assets plus/less</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Current Assets / Liabilities</td>
<td>(173,147)</td>
<td>(173,649)</td>
<td>(142,324)</td>
</tr>
<tr>
<td><strong>Non Current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>(45,960)</td>
<td>(50,570)</td>
<td>(48,035)</td>
</tr>
<tr>
<td>Other Payables &gt; 1 yr</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Financial Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Non Current Liabilities</strong></td>
<td>(45,960)</td>
<td>(50,570)</td>
<td>(48,035)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td>(219,107)</td>
<td>(224,219)</td>
<td>(190,359)</td>
</tr>
<tr>
<td><strong>Taxpayers’ equity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donated Asset Reserve</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>11,476</td>
<td>12,744</td>
<td>13,114</td>
</tr>
<tr>
<td>General Reserve</td>
<td>(230,583)</td>
<td>(236,963)</td>
<td>(203,473)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(219,107)</td>
<td>(224,219)</td>
<td>(190,359)</td>
</tr>
</tbody>
</table>

Signed:______________________________________________ Chairman        Date: 02/06/11

Signed:__________________________________________ Chief Executive       Date: 02/06/11
### STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 MARCH 2011

<table>
<thead>
<tr>
<th>Cashflows from operating activities</th>
<th>2011 £000s</th>
<th>Restated 2010 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net expenditure after interest</td>
<td>(917,862)</td>
<td>(905,437)</td>
</tr>
<tr>
<td>Adjustments for non cash costs</td>
<td>10,403</td>
<td>13,668</td>
</tr>
<tr>
<td>Decrease/(increase) in trade and other receivables</td>
<td>2,299</td>
<td>(4,411)</td>
</tr>
<tr>
<td><strong>Net cash outflow from operating activities</strong></td>
<td><strong>(927,249)</strong></td>
<td><strong>(867,522)</strong></td>
</tr>
<tr>
<td><strong>Cashflows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Purchase of property, plant &amp; equipment)</td>
<td>(1,265)</td>
<td>(4,174)</td>
</tr>
<tr>
<td>Proceeds of disposal of property, plant &amp; equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds on disposal of intangibles</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds on disposal of assets held for resale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash (Outflow) from investing activities</strong></td>
<td><strong>(1,730)</strong></td>
<td><strong>(4,174)</strong></td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant in aid</td>
<td>927,519</td>
<td>871,881</td>
</tr>
<tr>
<td>(SoFP) PFI and other service concession arrangements</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net financing</strong></td>
<td><strong>927,519</strong></td>
<td><strong>871,881</strong></td>
</tr>
<tr>
<td><strong>Net increase (decrease) in cash &amp; cash equivalents in the period</strong></td>
<td><strong>(1,460)</strong></td>
<td>185</td>
</tr>
<tr>
<td>Cash &amp; cash equivalents at the beginning of the period</td>
<td>1,562</td>
<td>1,377</td>
</tr>
<tr>
<td>Cash &amp; cash equivalents at the end of the period</td>
<td>102</td>
<td>1,562</td>
</tr>
</tbody>
</table>
Finance Directorate

HSCB Funding 2010/11
The Board received a Revenue Spending Limit from the DHSSPS in 2010/11 of £3,841,564k (ex non-cash of £10,404k). In addition to this the Board also receives income from other sources.

The total Income including RSL for 2010/11 was calculated as £3,885,105k, of which £43,541k is related to other income.

HSCB Expenditure 2010/11
The HSCB expenditure falls into three main areas as seen below.
Commissioning

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

Commissioning Net Expenditure 2010/11

These resources are deployed across nine Programmes of Care and Family Health Services as follows:

Programmes of Care
Family Health Services
The Health and Social Care Board spent £838,858k on Family Health Services (FHS) in 2010/11 to meet the health and social care needs of local populations. The breakdown by service area is shown below.

FHS Expenditure 2010/11

HSCB Management Costs
At the centre of Health and Social Care Board are the staff who manage the delivery of these high quality services. The percentage breakdown by Directorate of the Health and Social Care Boards staff costs including goods and services is shown below.

HSCB Management Costs 2010/11
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>2011 Number</th>
<th>2011 Value £’000</th>
<th>2010 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total bills paid</td>
<td>17,975</td>
<td>69,430</td>
<td>15,868</td>
</tr>
<tr>
<td>Total bills paid within 30 day target</td>
<td>16,956</td>
<td>61,568</td>
<td>14,989</td>
</tr>
<tr>
<td>% of bills paid within 30 day target</td>
<td>94.3%</td>
<td>88.7%</td>
<td>94.5%</td>
</tr>
</tbody>
</table>

Comparative data by value is not available for 2010.

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.

Ms Fionnuala McAndrew (Director of Social Services HSCB) is a member of the Board of Directors of Children in Northern Ireland (CiNI) which is an organisation likely to do business with the HSC.

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 2010-2011 year is 2.89%.

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 notional audit fee for 2010-2011 was £54,944. An additional amount of £2,912 was paid to the Audit Office in respect of work carried on the National Fraud Initiative. This is reflected within miscellaneous expenditure in note 4 of the Annual Accounts.

HSCB Management Costs

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

<table>
<thead>
<tr>
<th></th>
<th>2011 £000</th>
<th>2010 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSCB Management Costs</td>
<td>30,628</td>
<td>35,747</td>
</tr>
<tr>
<td>Income:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RRL from DHSSPS</td>
<td>3,851,968</td>
<td>3,761,196</td>
</tr>
<tr>
<td>Less Non cash RRL</td>
<td>10,405</td>
<td>13,149</td>
</tr>
<tr>
<td>Other Income</td>
<td>43,541</td>
<td>48,073</td>
</tr>
<tr>
<td>Total Income</td>
<td>3,885,104</td>
<td>3,796,120</td>
</tr>
<tr>
<td>% of total income</td>
<td>0.79%</td>
<td>0.94%</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>2011 Total</th>
<th>2011 Permanently employed Staff</th>
<th>2011 Other Staff</th>
<th>2010 (restated) Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning of Health and Social Care</td>
<td>435</td>
<td>372</td>
<td>63</td>
<td>522</td>
</tr>
<tr>
<td>Less staff on outward secondments (ave)</td>
<td>8</td>
<td>8</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>TOTAL net (ave) persons employed</td>
<td>427</td>
<td>364</td>
<td>63</td>
<td>506</td>
</tr>
</tbody>
</table>

Signed:_______________________________ Chief Executive       Date:__________________ 02/06/11
Statement of the
Comptroller and Auditor General
to the Northern Ireland Assembly

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 2011 set out on pages 52 to 55.

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.

In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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 2011 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
Northern
BT7 1EU

29 June 2011
Glossary of Terms

Acute care - Specific care for diseases or illnesses that is provided in a hospital.

Best practice - Producing the highest quality service and treatment based on the best clinical evidence currently available.

Chronic - Term used to describe a disease, condition or health problem which persists over a long period of time. The illness may recur frequently and in some cases may lead to partial or permanent disabilities. Examples include arthritis, diabetes and hypertension.

Capital - Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles.

Care package - Following an assessment, a care package is agreed to enable a patient to receive care appropriate to their needs. Where necessary this covers both NHS and social care.

Care plans - Written agreements setting out how care will be provided within the resources available for people with complex needs.

Care pathway - A pre-determined plan of care for patients with a specific condition.

Clinical governance - The system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

Commissioning - The process in which local need for services is identified and assessed against the available public and private sector provision. Priorities are decided and services are purchased from the most appropriate providers through contracts and service agreements. As part of the commissioning process services are subject to regular evaluation.
**Chronic conditions** – illnesses such as diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

**Delayed discharge** - Patients who are medically fit to leave hospital but who cannot be discharged because arrangements to provide for their ongoing care in the community have been delayed.

**Domiciliary care** - Homecare that helps people cope with disability or illness and allows them to maintain independence.

**Elective care** - Care provided at a planned or prearranged time rather than in response to an emergency.

**Generic medicines** - Medicines marketed without a brand name.

**GMS contract** – a national agreement between the government and GPs that specifies what GPs provide to their patients.

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

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

**Independent sector** - An umbrella term for all non HSC bodies delivering health care, which includes a range of private companies and voluntary organisations.

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

**Primary Care Partnerships** – These are provider networks built around local communities - typically serving populations of circa 100,000 people, and will include GP Practices, Pharmacists, nurses and other providers of health and care in their area. They will have a key and central relationship with the five Local Commissioning Groups and will provide a more local expression of need into the commissioning process.
**Primary care** – The care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

**Public health** - Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.

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

**Secondary care** - The collective term for services to which a patient is referred to by a consultant. Usually this refers to hospitals offering specialised medical services and care.

**Commonly used abbreviations**

- **AHP**  
  Allied Health Professions
- **BSO**  
  Business Services Organisation
- **COPD**  
  Chronic Obstructive Pulmonary Disease
- **DHSSPS**  
  Department of Health, Social Services and Public Safety
- **FoI**  
  Freedom of Information
- **GP**  
  General Practitioner
- **HAZ**  
  Health Action Zone
- **HSC**  
  Health and Social Care
- **HSCB**  
  Health and Social Care Board
- **HSE**  
  Health Service Executive
- **IfH**  
  Investing for Health
- **LCG**  
  Local Commissioning Group
- **NIAS**  
  Northern Ireland Ambulance Service
- **PCC**  
  Patient and Client Council
- **PCP**  
  Primary Care Partnerships
- **PfA**  
  Priorities for Action
- **PHA**  
  Public Health Agency
- **PPI**  
  Personal and Public Involvement
- **PSNI**  
  Police Service of Northern Ireland
- **RPA**  
  Review of Public Administration
- **SAI**  
  Serious Adverse Incident