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HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2013

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

On 28 June 2013

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

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This publication is also available for download from our website at:
www.hscboard.hscni.net

ISBN: 9780337098857

PC3243 07/13

Printed in the UK by The Stationery Office on behalf of the Controller of Her Majesty's Stationery Office

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For an alternative format, please contact:
Communications Department, tel: 028 9055 3626

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Chairman and Chief Executive's Overview

We are pleased to present the Annual Report of the Health and Social Care Board for 2012/13. The year has been characterised by the launch of a number of major public consultations on the future shape and provision of key services including *Transforming Your Care: Vision to Action*; Paediatric Cardiac Surgery and Interventional Cardiology; GP and Social Work Out of Hours, and the number of Emergency Departments in Belfast.

Significant work has been made in progressing *Transforming Your Care.* (TYC). This contains proposals for the biggest reform of health and social care in decades. It heralds new ways of working across the whole of the Health and Social Care system and at every level to deliver better outcomes for patients, service users and their carers. A major shift from acute and institutional care to an emphasis on community based services; greater user involvement in how care is provided and continued innovation to ensure services are fit for the future for everyone who needs them, is planned.

Board staff are currently working with Department of Health, Social Services and Public Safety colleagues to design new Integrated Care Partnerships. These will involve collaborative networks of nurses, social workers, doctors, pharmacists and allied health professionals, working together with the voluntary sector and users to improve outcomes for frail elderly people and patients with respiratory disease, diabetes, stroke and end of life care.

We are also embracing new systems and technology to streamline how we do business. Innovation continues through new connected health projects which use technology to provide healthcare in patient homes. The development of a Northern Ireland wide Electronic Care Record system will transform how healthcare professionals working in acute, primary or community care will have access to up to date patient information and allow improved patient care.

The Board has worked in 2012/13 to improve access to hospital and community services. While there have been a number of successes, waiting times for certain services remain too long and this will continue to be a key Board priority in 2013/14.

The Health and Social Care system has experienced increased financial pressures as a result of the economic downturn. The entire system has embraced this challenge by ensuring we secure value for money by transforming the services we provide. It is vital that, as a system we continue to plan to live within the resources we are provided with in 2013/14 and beyond.

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Once again, we wish to acknowledge the valued contribution and commitment made by all our members of staff to the work of the Board. Only by working together and in partnership with the Public Health Agency and other organisations and interests, can we continue to deliver better health and care for everyone.

Dr Ian Clements
Chairman

Mr John Compton
Chief Executive

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Who's Who…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 1 April 2012 – 31 March 2013:

Non Executive Directors[1]

Dr Ian Clements
Chairman

Mr Robert Gilmore

Mr Stephen Leach

Dr Melissa
McCullough

Mr Brendan
McKeever

Mr John Mone

Dr Robert Thompson

Mrs Elizabeth Kerr[1]

[1] Mrs Elizabeth Kerr was a Non-Executive Director up to July 2012.

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Executive Directors[2]

Mr John Compton
Chief Executive

Mr Paul Cummings
Director of Finance

Mrs Fionnuala McAndrew
Director of Social Care and Children

Mr Dean Sullivan
Director of Commissioning

Mr Michael Bloomfield
Director of Performance and Corporate Services (with effect from 19 November 2012)

Ms Louise McMahon
Director of Performance Management and Service Improvement [2]

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

Dr Sloan Harper	Director of Integrated Care, Health and Social Care Board
Mrs Pamela McCreedy	Director of Transforming Your Care, Health and Social Care Board
Dr Carolyn Harper	Executive Medical Director/Director of Public Health, Public Health Agency
Mrs Mary Hinds	Director of Nursing and Allied Health Professionals, Public Health Agency

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

[2] Ms Louise McMahon is Director of Performance Management and Service Improvement and was in role up to 31 October 2012 when she accepted an 18 month secondment to the Leadership Centre with effect from 1 November 2012. During this period, Mr Michael Bloomfield will discharge the Executive Director role.

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What We Do… The role of the Health and Social Care Board

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

- 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.
- To performance manage Health and Social Care Trusts that directly provide services to people and support service improvements in pursuit of optimal quality and value for money, in line with relevant government targets.
- 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 potential to reach everyone at some point in their lives – its expenditure amounts to around £10 million on every single day of the year – as it strives to ensure that services provided daily to people in their homes, by their GP, or in hospital deliver what is expected of them.

The 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 (PHA). The Board and PHA take forward the regional commissioning agenda through a series of integrated service teams. The Board's commissioning processes are underpinned by the five Local Commissioning Groups (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.

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

The Board also commissions provision from voluntary and community organisations. This feeds directly into local economies and is responsive to local demands. The Board is also exploring opportunities to procure provision from Social Enterprises and to encourage and build social capital through community development opportunities. These approaches are underpinned by effective stakeholder engagement and patient and public involvement (PPI).

DIRECTORS' REPORTS: PLANNING REGIONAL AND LOCAL SERVICES: DIRECTORATE OF COMMISSIONING

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

Regional Commissioning

A key success for the Commissioning Directorate this year has been to implement a new process which ensures the timely implementation of NICE guidance endorsed by the Department of Health, Social Services and Public Safety (DHSSPS). The new process means that patients are benefiting from more timely access to specialist drugs and that evidence-based guidance designed to promote good health and prevent and treat a range of conditions is being actively implemented by Trusts.

More generally, this year the Commissioning Directorate has also:

- led a consultation process to consider the arrangements for the future commissioning of Paediatric Cardiac Surgery and Interventional Cardiology for the population of Northern Ireland.
- identified a long term model for the future provision of Emergency Departments within Belfast, which is currently out for consultation.
- completed a review of Primary Percutaneous Cardiac Intervention (pPCI) services and put in place arrangements to implement an emergency pPCI service for the population of Northern Ireland from September 2013.
- continued to progress plans for the development of a new radiotherapy centre in the North West by 2016.
- secured with colleagues from the Board's Performance Management and Performance Improvement Directorate, further significant reductions in elective waiting times.

Local Commissioning Groups

The five Local Commissioning Groups (LCGs) of the Board cover the same geographical areas as those served by the five Health and Social Care Trust organisations. Their role, as committees of the Board, is to ensure that services which are commissioned at a local level, are sensitive to the needs of social and community issues, and are influenced by the involvement of both professional practitioners and local representatives. The five LCGs have all worked this year to further develop health and social services in their respective areas. A summary of this programme and its outcome is as follows.

Belfast LCG

This year, successful work by the Belfast LCG has included:

- The launch of a new management support pack for Type 2 Diabetes in South Belfast. The pack, developed in partnership with patients and the community, provides a range of tools designed to improve the management of Type 2 diabetes. It includes:
    - guidance on preventing Type 2 diabetes in patients identified as "at risk";
    - education material to support the delivery of self-management programmes in the community, and
    - protocols to enable appropriate patients to be treated and monitored closer to home.
- The implementation of a new evidence-based Stroke Pathway has been developed in partnership with the Stroke Users and Carers Forum. The pathway includes the development of integrated working between primary and secondary physicians, the consolidation of two stroke units into one, enhanced access to TIA clinics, 24-hour specialist medical cover, intensive rehabilitation, early supported discharge and psycho-social support for stroke survivors and carers living with stroke involving the voluntary sector.
- Significant progress in the development of a Primary Mental Health Service which will provide integrated care across sectors. A referral hub has been commissioned which will test this new way of working between GPs, Trust specialists and the community and voluntary sector in relation to the provision of a range of therapeutic interventions for common mental health conditions.

Northern LCG

This year, successful work by the Northern LCG has included:

- The opening of a new Acute Medical Assessment Area at Antrim Area Hospital which facilitates direct access to advice and treatment for GP referred patients.
- A GP hub is being developed within Antrim Area Hospital to include access to consultant advice and treatment across a range of medical specialties.
- The Northern LCG is also actively piloting a number of Primary Care Partnership (PCP) initiatives, these include:
    - Dermatology PCP: providing GPs with the skills to manage more routine skin conditions in a primary care setting (across Mid Ulster, Antrim/Ballymena and East Antrim localities).

- Dermatology Photo Triage Service (Causeway).
- Direct Referral Endoscopy (all localities).
- Tele-Neurology (all localities).
- Direct Access Echocardiology which provides information on the heart function (Mid Ulster).
- Direct Access Holter Tape - 24 hour heart monitoring (all localities).

- Reablement has been introduced in the Northern area with initial positive results in respect of successful rehabilitation of older people.

Southern LCG

This year, successful work by the Southern LCG has included:

- An integrated care pilot which will enable GPs, community and hospital staff to work more closely to improve the management and care of older people, has begun. The pilot aims to improve patient outcomes by preventing unnecessary hospital admissions and re-admissions.
- In order to address demographic pressures within the Southern area, significant investments were made in palliative care, child health programmes and transition services, particularly for young people with disabilities.
- A number of referral pathways have been developed and agreed with GPs and secondary care in the southern locality for both scheduled and unscheduled care, including headaches, acne, acute kidney injury, Acute Physician of the Day, Access to Emergency X-Rays and Near Patient Testing for DVT.
- Following a regionally agreed position on the capacity and demand gap across both assessments and elective treatments for the main surgical specialties, targeted investments have been made to increase capacity and improve waiting times.
- Significant improvements in waiting times have been achieved across outpatient appointments, inpatients or day case treatments, diagnostics (including endoscopy) and Allied Health Professionals (AHPs).

South Eastern LCG

This year, successful work by the South Eastern LCG has included:

- A positive pilot of a primary care asymptomatic Sexually Transmitted Infection (STI) testing service which enables patients to be tested closer to home, reducing pressure on hospital services.

- The development of an electronic system which allows GPs to seek advice from a hospital consultant prior to making a hospital referral - potentially avoiding unnecessary referrals to secondary care. The system is being made available to practices across the LCG and for access to consultant advice within urology, endocrinology and neurology.
- Starting in November 2012, five GPs commenced training to administer rheumatology soft tissue joint injections. This training is being held in hospital outpatient departments alongside consultant led clinics. From early 2013/14, these GPs will deliver a primary care based service for patients who need rheumatology treatment, allowing patients to be treated nearer to home.
- Starting in April 2013, a primary care based initiative designed to improve patient access and the quality of dermatology services in the Down locality will be implemented. The service will be provided by a nominated GP Practice that will provide practice based clinics across the 12 practices in the locality. An important component of the service will be the development of enhanced GP dermatology skills. This process will be led by the provider practice and will be supported by new training opportunities and links with consultant dermatologists in the South Eastern Trust.

Western LCG

This year, successful work by the Western LCG has included:

- The transfer and extension of services to the new South West Acute Hospital, which opened in June 2012.
- An increase in capacity within community nursing, including additional district and rapid response nurses, and the introduction of electronic case load weighting tool (eCATS) for community nursing and integrated teams.
- A reduction in gastroscopies due to availability of h-pylori breath-testing in community pharmacies.
- Establishment of comprehensive assessment for older people in hospital through provision of an Older People's Assessment and Liaison Service.
- Extension of dementia services through a network of memory clinics across the Western area.
- 'Invest to Save' scheme for innovative carer support with carer representatives centrally involved in service planning.
- Introduction of an agreed musculoskeletal pathway with a single 'front door' for referrals to orthopaedics, rheumatology, pain management and physiotherapy.
- The introduction of early supported discharge for patients following a stroke.
- Mainstreaming of a pilot which extended genitourinary medicine services, increasing provision in Altnagelvin hospital and providing a new clinic in Omagh.

IMPROVING PERFORMANCE AND QUALITY: DIRECTORATE OF PERFORMANCE MANAGEMENT AND SERVICE IMPROVEMENT

The Board's Directorate of Performance Management and Service Improvement is responsible for supporting Trusts to achieve the targets and standards set by the Minister and any additional requirements set by the Board. It also supports organisations to improve the delivery of services by improving practice and by identifying innovative and efficient ways of working.

The Directorate is also responsible for the strategic development of Information and Communication Technology projects to improve the effectiveness of services, and for the provision of a comprehensive information management service for the Board.

Overview of service performance

Good progress has been made across a range of standards and targets during 2012/13 including:

- significant reductions in pre-arranged scheduled care waiting times.
- a high level of performance in the 14 and 31 day cancer pathway waiting times.
- reducing the incidence of MRSA.
- increasing the number of care leavers aged 19 years who are in education, training or employment.

However, continuing performance challenges include:

- the need for further significant improvement in ED waiting times. This is being addressed through the work of the joint Board/Public Health Agency Emergency Department Improvement Action Group (EDIAG) and remains a top priority for the Board.
- waiting times in relation to the 62 day cancer standard. The Board has worked closely with Trusts to improve performance and overall waiting times have reduced as the year progressed.
- waiting times for psychological therapy services for which actions and additional investment have been agreed with Trusts.
- making improved progress in mental health and learning disability resettlement programmes so that these are completed by 2015. The Board has established a new Steering Group, co-chaired by the Board's Director of Social Care and Children and the Northern Ireland Housing Executive, to oversee this process.

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Service Improvement in 'Scheduled Care'

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

- the introduction of quality standards in Audiology.
- all joint replacements carried out in Northern Ireland being registered on the National Joint Register (NJR), facilitating improved governance and easier recall of patients.
- the implementation of a primary care Optometry Electronic Referral Pilot in the Southern Health and Social Care Trust area to support improved communication between primary and secondary care and greater integration of health and social care provision.

Service Improvements in 'Unscheduled Care'

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

A key focus during 2012/13 has been in supporting the work of the Emergency Department Improvement Action Group (EDIAG) which works with Trusts to develop sustainable improvements in performance and quality in EDs including in relation to:

- 4 and 12 hour performance
- ambulance turnaround times
- effective discharge arrangements
- patient experience.

The team has also supported improvements in other areas of emergency treatment including improving patient pathways in fracture services.

Service Improvements in Mental Health, Disability, Children's and Community Services

Key achievements included:

- introduction of SMART Board technology. This improves patient safety through the presentation of information at a glance at ward level.
- development of primary care talking therapies and adult health service models alongside investment of over £1 million by the Board to improve earlier access to care.
- implementation of the RQIA Child and Adolescent Mental Health services (CAMHS) Review recommendations, including significant investment by the Board, and enabling a significant reduction in the number of young people being admitted to adult psychiatric wards.

- development of a new care pathway for adults with autism.
- roll out of the Choice and Partnership approach across all community mental health services. This assists mental health services to more effectively manage care and improve the experience and outcomes for people using the services.

Information and Communication Technology (ICT)

The Board's ICT team oversees the strategic development of ICT services across the region. During the past year the Board continued to invest in ICT systems and services to support transformational change. Achievements in 2012/13 include:

- the development of a new Stroke Register system.
- the electronic Northern Ireland Single Assessment Tool has begun to be rolled out.
- a contract for the development of the Northern Ireland-wide Electronic Care Record.

In addition the team has also supported the development of business cases for:

- a new regional information system for oncology and haematology
- a new Community Information System for the Western Trust, and
- a new system for family practitioner payments.

Information Management

The Information Management team provides an information and analysis service that supports the performance management, service improvement, commissioning and financial management work of the Board. The team's roles include:

- developing business intelligence tools to analyse data using consistent, standardised, regionally agreed data definitions and definitional guidance.
- turning data into tailored management information and analysis.
- making best use of ICT developments to develop efficient, timely automated access to data for key decision makers.

Over the past year, the team's work has included:

- provision of information and analysis to support demand/capacity work with Trusts and investment decisions in elective services.

- supporting the continued regular performance monitoring and reporting of over 60 key performance indicators.
- development and expansion of the scope of service data across emergency care, radiology and theatre services available via the regional data warehouse.
- improvements in the timeliness, depth and consistency of the coding of hospital activity.
- supporting the development of local population health plans as part of the implementation of *Transforming Your Care*.

PROMOTING NEW PARTNERSHIPS OF CARE: DIRECTORATE OF INTEGRATED CARE

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

Integrated Care Partnerships

Transforming Your Care (TYC) recognises that if we are to sustain safe and accessible services to patients with complex co-morbidities, then clinical and social care professionals need to work together with representatives of the voluntary sector, users and carers, and agree how best to manage and plan the care of these vulnerable groups.

Building on the development of Primary Care Partnerships, the Board has been working through the TYC consultation process and with the Department of Health, Social Services and Public Safety (DHSSPS) to design a process to deliver integration. Integrated Care Partnerships (ICPs) will be local collaborative networks of nurses, social workers, doctors, pharmacists and allied health professionals, working with the voluntary sector and users to improve outcomes for:

- the frail elderly,
  and patients with
- respiratory disease
- diabetes
- stroke
- end of life care as it relates to the above.

ICPs will be resourced to improve the sharing of clinical information to support patient care, the identification and proactive support of patients in the community at greatest risk from these conditions, and the agreement of care plans between clinicians in primary and community care.

The potential to secure greater involvement from the voluntary sector, from patients and their carers through an agreed care plan, will enhance the capacity of services in the community and the scope of care provided in the home environment. ICPs will be an important enabler for major capital investments in clinical care such as the Northern Ireland Electronic Care Record, electronic monitoring of patient care through telehealth, and the development of health and care centres to improve the capacity of primary care infrastructure.

Each Partnership will cover a population of around 100,000 people with a total of 17 Integrated Care Partnerships across Northern Ireland. Roll out will commence in April 2013.

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Family Practitioner Services

The Board's Directorate of Integrated Care manages the contracts which the Board holds with over 1,500 independent contractors - GPs, dentists, community pharmacists and optometrists. The resource related to these services, some £830m, includes £500m to cover the supply of medicines by GPs and community pharmacists. Linked to contract management, the Directorate also manages processes related to clinical governance and service improvement for Family Practitioner Services.

Pharmacy and Medicines Management

During 2012/13 there were a number of notable achievements in meeting the twin challenges of maintaining prescribing quality in line with good practice whilst delivering efficiency in clinical decision making:

- A Northern Ireland Formulary is now available to guide prescribers of medicines and in 2013/14 the Board will seek to integrate the formulary with electronic clinical systems.
- The level of generic prescribing and dispensing continues to grow, releasing funding for the commissioning of other hard pressed services.
- Arrangements to maintain the formulary such as the managed entry of new medicines are being developed and will help to support the most effective choice of therapy.
- A project to improve the timeliness of payments to community pharmacists (from 60 to 30 days) is making good progress - the result of huge efforts on behalf of staff in the Business Services Organisation and local pharmacies to streamline their administrative processes.
- Following agreement with Community Pharmacy Northern Ireland (CPNI)[3] on remuneration and related processes, significant progress has been made in developing new services which will enable community pharmacists to play an important role in delivering TYC, for example, medicines review of patients on multiple medication targeted at respiratory patients initially.
- A major challenge for the coming year will be to develop the level of integration of community pharmacy with the wider health and care system through connectivity and links to the HSC net.

General Medical (GP) Services

As the focus of integrated care, the GP practice will be central to delivering enhanced care to those with long term conditions including older people. During 2012/13 the Board, through the GP contract, invested in services to identify patients most at risk from their illness and enable a joint response from GP and community nursing teams. Participation in ICPs will create the potential for collaborative working with community as well as with hospital clinicians.

Medical revalidation was introduced by the General Medical Council in November 2012. This will require the Board to make recommendations on the relicensing, on a five year cycle, of around 1,650 doctors in general practice.

[3] CPNI is the representative body of community pharmacy in Northern Ireland

The processes which support revalidation need to be carefully and objectively managed to ensure that doctors feel that revalidation is fair to them and, ultimately, protects patients. A first wave of medical leaders are undertaking their revalidation requirements.

The development of IT systems to enable the sharing of clinical information between health professionals involved in the direct care of a patient continues to gather pace. The sensitivity of personal medical information is something which demands the utmost care so that the confidential nature of the relationship which a patient has with his or her doctor is protected. The rollout of the Emergency Care Summary across all Northern Ireland GP practices means that GP Out of Hours services, Emergency Departments and hospital pharmacies, can accurately assess a patient's medications and allergies.

General Dental Services

In 2012/13 the Board finalised arrangements to pilot a new contract for oral surgery provision outside hospital. This, together with a review of dental care provided through the Board's contract with Oasis Dental Care, will help inform the planned review of the contract which the Board holds with around 390 'high street' dental practices. The focus will be on prevention and improving the quality of care whilst maintaining access to health service dentistry.

Optometry Services

The DHSSPS launched the regional strategy "Developing Eyecare Partnerships" in 2012/13. The Board and the Public Health Agency will lead on implementation in 2013/14 and success will include the development of new referral pathways for eye conditions. Significant progress was made over the past twelve months in reforming the way that care is provided to patients with glaucoma, enabling the provision of more care by community optometrists and freeing up the time of hospital specialists to manage complex cases.

Health and Care Centre Development

A key element of TYC is the development of infrastructure, including integrated facilities, to bring together clinical and care professionals involved in delivering a broader range of services to patients and clients outside hospital. A Health Infrastructure Board, led by DHSSPS, is overseeing a programme of health and care centre development across Northern Ireland. Two pathfinder projects, in Newry and Lisburn, will assist in identifying best practice in terms of design and procurement and are currently at business case stage.

A cycle of engagement with Trusts and independent contractors is underway that will collectively secure maximum benefit for patients from this exciting programme - one which has the potential to significantly transform the way in which health and care is provided.

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SUPPORTING ADULTS AND CHILDREN: DIRECTORATE OF SOCIAL CARE AND CHILDREN

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

Services for Adults

- Improved assessment of individuals by implementing the Northern Ireland Single Assessment Tool and securing funding for an ICT solution for collating integrated assessment information.
- Established project structures, developed action plans and identified funding to take forward implementation of the regional Dementia and Physical Disability and Sensory Impairment strategies.
- Continued development of more effective and coordinated safeguarding arrangements at regional and Trust level to respond to abuse.
- Formation of Carers Strategy Implementation Group and allocation of funding for carer support services.

Services for Children and Families

- Development of jointly commissioned supported accommodation projects for young people leaving care and homeless were successfully developed. These included supported accommodation facilities in Londonderry, Belfast and Coleraine.
- Development of a Leaving Care website. The website provides a regional resource offering accessible specialist information and support on all leaving care issues for young people, professionals, carers, students and service providers.
- Regional Adoption and Fostering Taskforce (RAFT). This Board led group in partnership with Adoption UK undertook a survey into the views and experiences of individuals who have adopted children and the findings will be used to shape future development of policy and services. A 'Learning Together' resource booklet aimed at parents and teachers was also launched.
- Development of a regional plan for the provision of residential care services for children and young people for implementation in 2013.
- Ongoing development of Family Support hubs to signpost families to appropriate early intervention and family support services at a local level.

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Services for individuals with a Learning Disability

- Development of a regional Day Opportunities Programme model to maximise independence and social inclusion.
- Working with primary care colleagues to roll out the Directed Enhanced Service for Learning Disability across Northern Ireland. This will ensure all individuals with a learning disability receive an annual physical and well being check with their GP and the completion of an evaluation of this service.
- Implementation of the Guidance for Commissioners on Advocacy (DHSSPS). Further reduction of the long stay population in learning disability hospitals by 52 patients.
- Enhancement of community infrastructure through investment in services to reduce unnecessary hospital admissions and promote timely discharges from learning disability hospitals.
- Development of a costed Forensic Learning Disability model to support the very small number of individuals with an offending behaviour.
- Parents and carers of people with a learning disability joined the Board/PHA Learning Disability Service Team.

Services for individuals with a Mental Health problem

- Securing agreement across Trusts to develop recovery based care through a regionally coordinated development process using evidence based methodologies.
- Completion of a regional audit of 720 service users and carers' experiences of mental health services using the Sensemaker tool (GAIN audit).
- Continuing to promote good mental health and self-harm/suicide prevention regionally. A wide range of initiatives were delivered on a regional basis including commencement of the Sudden Death Notification process in partnership with PSNI, bereavement support, suicide surveillance and Community Response Plans.
- Investment was secured to further develop the capacity to provide psychological therapies, including the funding of additional therapists and training opportunities to provide such care.
- Further reduction of the long stay population in mental health hospitals by 37 patients.
- A Substance Misuse Services Commissioning Framework was developed and associated work was progressed to consolidate the provision of Tier 4 service provision models. This has included screening and brief interventions within primary care (for hazardous/harmful drinking).
- 'Experts by Experience' - people who use mental health services joined the Board/PHA Mental Health Service Team.
- Development of a multiagency forensic training needs analysis.

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BUSINESS AND ORGANISATIONAL SUPPORT: BOARD CORPORATE SERVICES

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

Governance and Information Management

In order to ensure a sound system of internal control, effective internal governance arrangements continued to remain a priority task for the Board this year alongside the implementation of an effective Information Governance framework.

Within Governance, work has focused largely upon maintaining an overarching Governance Framework which encompasses a robust Assurance Framework, a fully functioning risk register, and the continued development of relevant controls assurance standards. The Governance Statement is published in full within this combined document.

Management and Follow Up of SAIs

The Board has continued to effectively monitor the reporting and follow up of Serious Adverse Incidents (SAI); and in consultation with relevant stakeholders has commenced a review of the current SAI procedure, which will be implemented during 2013/14. Working with colleagues in the PHA, the Board has continued to ensure learning from SAIs is identified and disseminated throughout Health and Social Care (HSC) via learning newsletters and a bi-annual SAI Learning Report. In addition, a new protocol has also been developed for the implementation and assurance of Safety Alerts and related correspondence.

Information Governance continued its focus on implementing actions identified in both the Records Management and Information Governance action plans. Key developments included reviewing information risk processes, enhancing the security of Board information, developing e-learning programmes to increase staff awareness and upgrading the Board's electronic document and records management system. There were no personal data related incidents in the Board during the 2012/13 year.

Freedom of Information and Subject Access Requests

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

- FOI requests received from 1 April 2012 to 31 March 2013 = 100
- In addition the HSCB received and responded to 9 Subject Access Requests during this period.
- No major personal data protection incident occurred during 2012/13.

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Corporate Business

Corporate Business continued to provide Secretariat Services to the HSC Board and its 11 Committees, five of which are Local Commissioning Groups and to support the public meetings of the Board and Local Commissioning Groups held in venues throughout Northern Ireland.

Corporate Business undertakes the annual review of the Board's Standing Orders which govern the operation of the organisation and is responsible for ensuring compliance with Corporate Governance requirements, including maintenance of Registers of Interests for Directors and Local Commissioning Groups (copies of which are available to download from www.hscb.hscni.net).

Staff organised the recruitment to Local Commissioning Groups throughout the year and this will continue into 2013/14 as successors to the five Local Commissioning Group Chairs and a number of outgoing Members are appointed.

The introduction of the Business Services Transformation Project (BSTP) in November 2012 signalled a major change in the way goods and services are procured and paid for and the second phase which relates to Human Resources, Travel Payment and Subsistence went live in March 2013 and affected every member of staff. The Board's BSTP Business Readiness Group led by Corporate Business was established to oversee the process.

Sustainability

The HSCB has a commitment to Sustainability, Environmental, Social and Community issues and to support this a number of key policies and documents were produced in line with Controls Assurance Standards. The principles are also embedded within the business of the HSCB and highlighted throughout this document. A Waste Management policy was approved by the Governance Committee in September 2012. The policy outlines how the Board meets its legal obligations and mandatory requirements in respect of the management of waste. Guidance on the 'principles and procedures for the management of waste' was subsequently issued to all staff and a number of initiatives undertaken.

A complementary policy on Environmental Management was approved by the Governance Committee in December 2012 and reflects the nature, scale and environmental impacts of the activities of the Board as a commissioner of health and social care services. A number of initiatives will be developed and rolled out in the 2013/14 year.

It is anticipated that both policies will assist the Board in meeting its responsibilities of contributing to the NI Executive target of reducing Greenhouse Gas Emissions, meeting the objectives of the NI Sustainable Development Strategy Implementation Plan for reducing water usage and waste disposal and complying with the Carbon Reduction Commitment Energy Efficiency Scheme (2010).

HSC Complaints Management

The Board has responsibility for the monitoring and performance management of HSC complaints. Through agreed mechanisms, the Board has oversight of all HSC complaints raised at HSC Trust and Family Practitioner Services (FPS) level. The analysed information is received by the Regional Complaints Group on a quarterly basis and the Board has produced its third Annual Report on Complaints.

Implementation of recommendations from Evaluation of 'Complaints in HSC'

In June 2010, the Department of Health, Social Services and Public Safety (DHSSPS) requested that the Board undertake a 'Process Evaluation' of 'Complaints in HSC' to establish if the new complaints handling arrangements had been fully implemented and to identify any strengths and weaknesses within the new arrangements. This process evaluation was undertaken by reviewing information, policies and procedures and through engagement with key stakeholders and service users.

The Evaluation report acknowledged that whilst significant progress had been made to implement the principles within the Guidance, further steps could be taken to further enhance this process. These areas for improvement were highlighted within 14 recommendations. An Action Plan has subsequently been developed outlining how each of these recommendations will be taken forward. The Board has responsibility for ensuring the implementation of all the recommendations and an Evaluation Implementation Group (EIG) has been established to oversee taking forward those pertaining to Health and Social Care.

The EIG, which meets quarterly, is chaired by the Director of Social Care and Children and membership includes representatives of the Board, PHA, Patient Client Council (PCC), Regulation and Quality Improvement Authority (RQIA), Independent Lay Persons as well as from FPS and Trusts. Three subgroups have been established to address three specific recommendations: developing a regionally agreed method of disseminating learning from complaints; developing a regional mechanism for receiving user satisfaction feedback in relation to complaint resolution; and looking at innovative methods in attempting to address the issues of communication, staff attitude and behaviour.

Equality, Human Rights and Diversity

In addition to its ongoing agenda of screening activity and developing staff capacity through training, the Board launched its Disability Action Plan for consultation. The plan which was developed by a working group of staff with disabilities and those with a particular interest in disability, provides practical advice aimed at promoting positive attitudes and participation in public life. Staff from across the Board's Directorates also contributed to the development of the Board's Equality Action Plan for 2013/18.

The Board is also working with the Human Rights Commission to pilot a model for human rights based commissioning within the field of sensory disability.

To celebrate achievements in equality, human rights and diversity, the Board participated in a collaborative event to showcase on-going initiatives in February 2013.

The Board has in place a policy of Equality of Opportunity for all employees, including those with a disability. The policy is available on the Board's website www. hscb.hscni.net

Human Resources

The Human Resources or HR service is provided to the Board by staff in the Business Services Organisation. It manages a wide portfolio of policy and procedural matters that relate to staff management, workforce planning, training and development, and liaison with staff-side and trade union organisations.

Sickness Absence

The percentage figure for sickness absence during the financial year was 3.8%.

Emergency Planning and Business Continuity

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

The Board, PHA and Business Services Organisation (BSO) work collaboratively to continually review and enhance emergency preparedness arrangements. A Flu, Weather and Major Events Group has been established to oversee the co-ordination of Health and Social Care (HSC) operational preparedness for flu and adverse events, as well as the preparation required across the service for high profile events such as those planned for 2013, which will include a test of HSC emergency preparedness plans.

The Board/PHA/BSO Joint Emergency Plan was activated at level 2 in March 2013 in response to the severe weather conditions. The Board worked with other organisations in the multi-agency response to ensure an effective response was provided to those affected and that essential services were maintained.

The Board's Business Continuity Plan, which has been developed to meet the BS25999 Standard, has been shared with staff, along with guidance on actions to be taken in a business continuity situation.

Board Communications

The role of the Board's communications department is to provide open and accessible information about the work of the Board and the services it commissions to patients, clients, staff, the general public, media and the full range of stakeholders.

During 2012/13, communications staff worked closely with Board colleagues in responding to a significant number of national and local media enquiries, and provided statements in relation to a range of issues, including pressures on emergency departments, commissioning of services and HSC performance.

The communications department also provided support for a range of major consultations including *Transforming Your Care*; future commissioning of Paediatric Cardiac Surgery and Interventional Cardiology; and GP Out of Hours arrangements. This involved publicising the consultation in the media; responding to press enquiries; supporting public meetings and focus groups; and using new channels, including social media and the internet, to effectively engage with a wide range of stakeholders.

In the year ahead, the communications department will continue to develop new and innovative channels to ensure that internal and external stakeholders and the wider public continue to be fully informed about the role and work of the Board.

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

TRANSFORMING YOUR CARE

In December 2011, the Minister for Health, Social Services and Public Safety presented the report of the independent review of Health and Social Care in Northern Ireland – *Transforming Your Care (TYC)*. This report highlights the need for change so that we make the best use of the resources we have in order to meet everyone's needs in the future, against a backdrop of a changing demographic and advances in technology, treatments and care models. It sets a vision for wide ranging change across our health and social care system with the aim of implementing a more integrated model of care with the individual firmly at the centre. This would mean:

- People will get support to stay healthy, make good health decisions and manage their own conditions.
- More services will be provided locally with opportunities to access specialist hospitals where needed.
- Where it's safe and appropriate to do so, more people will be cared for at home.
- People will have more choice and greater control over the types of services they are able to access.
- Investment in new technology will help people stay at home or receive care locally rather than in hospitals.
- Doctors, nurses, social workers and everyone providing care will work together in networks called Integrated Care Partnerships to help keep people healthy and prevent them going to hospital when that's not necessary.
- Our current acute hospitals will operate as part of network to support each other
- Everyone working in health and social care services will be supported in helping to make the changes set out in *Transforming Your Care*.

The majority of the 99 recommendations set out in Transforming Your Care, have been delegated to the Health and Social Care Board for implementation, and in this year we have made significant progress in doing so:

1. Investing in and developing our capacity to deliver: The Transforming Your Care Programme Board and Team have been established, bringing together key parts of the health and social care system to focus on achieving the TYC vision. The first year of Transitional Funding was secured to support investment in TYC – demonstrating a real commitment across government to achieving change in health and social care.

2. Draft Population Plans and Strategic Implementation Plans: Each of the health localities, led by the Local Commissioning Groups working closely with the Trusts and through local engagement, developed draft Population Plans setting out how they propose to take forward key service changes to deliver TYC over the next three years. The Board also developed a Strategic Implementation Plan to provide a regional overview to the TYC implementation. These plans were made available to everyone in draft form in July 2012.

3. Vision to Action: Following consideration of the draft plans, the Board was asked by the Minister to lead public consultation on the proposals for service change on his behalf. This took place in October 2012 – January 2013 and included:

    - Distribution of an information leaflet to every household in Northern Ireland.
    - Extensive use of new Social Media channels – a first for the Board.
    - A range of public and stakeholder meetings across Northern Ireland - attended by around 800 people.
    - 2,242 consultation responses were received and analysed to support informed decision making about the way forward.

In March 2013, the Minister for Health announced the publication of the Post Consultation Report prepared by the Health and Social Care Board on the TYC Vision to Action proposals. He reaffirmed his vision of implementing TYC and delivering a safe, high quality and sustainable service now and into the future. Following this endorsement, the Board will now move forward to implement these plans over the next 3-5 years, working closely with a broad range of partner organisations.

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

REPORTS FROM THE BOARD'S COMMITTEES

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

- Reference
- Governance
- Audit
- Pharmacy Practices
- Remuneration & Terms of Service Committee Report 2012/13

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

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Report of the Board's Reference Committee

The role of the Board's Reference Committee is to monitor the professional standards of family care practitioners – GPs, dentists, pharmacists and opticians – to consider complaints about any related matters, and to refer any such cases for further investigation. Depending on the nature of any deficiency, subsequent investigation can involve the Board, other agencies or relevant professional bodies such as the General Dental Council or the General Medical Council.

The Reference Committee has met twice during 2012/13 and has received regular updates on cases throughout the year. The Committee has established processes to ensure that any cases coming before it are considered in a fair and confidential manner and, with Board professional leads, is currently reviewing the operation of these processes to ensure they are fit for purpose.

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

- Failings in professional standards
- Serious Adverse Incidents involving a practitioner
- Matters referred by the police, the Coroner, or other legal entities

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

Mr Brendan McKeever
Chair of the Board Reference Committee

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

In attendance:
Mr Brendan McKeever, Chair of the HSCB Reference Committee
Dr Sloan Harper, Director of Integrated Care, HSCB - professional advice
Mrs Carol Mooney, Corporate Secretariat Manager, Health and Social Care Board

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Report of the Board's Governance Committee

At its meeting on 2 June 2011, the Board approved the division of its Governance and Audit Committee into two separate bodies. The Governance Committee is made up of four Non Executive Directors: Stephen Leach (Chair), Dr Melissa McCullough, Dr Robert Thompson and Mr John Mone. To ensure an integrated understanding of risks across the organisation, the Non Executive membership of both Committees is broadly the same. However, the Governance Committee includes a Non Executive member with a professional nursing background.

In addition, the Board's Senior Management Team is in attendance at all meetings of the Governance Committee.

During the 2012/13 financial year, the Governance Committee met on five occasions: on 7 June; 11 June; 6 September; 29 November 2012 and 28 March 2013. In addition to these scheduled Committee meetings, the Committee also met on 18 April 2012 to consider the draft Statement of Internal Control and a joint meeting of the Governance and Audit Committee was held on 16 October 2012 to consider the Mid Year Assurance Statement.

The Governance Committee provides assurance to the Board across a broad area, including:

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

During the 2012/13, the Committee considered a range of important issues, including the Board's Business Continuity Plan, Learning Reports from Serious Adverse Incidents (SAIs), Corporate Risk Register and various HR and Information Governance Policies. The Committee also receives briefings on Case Management Reviews at each meeting as well as reports from professional leads. Once approved by the Committee, minutes of Governance Committee meetings are brought to the attention of the full Board at the subsequent public Board meeting.

Stephen Leach
Chair of the Governance Committee

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Report of the Audit Committee

Within the 2012/13 financial year five meetings of the Audit Committee were held.
The Audit Committee advised the Board and Accounting Officer on the following:

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

Membership of the Audit Committee:

Mr Stephen Leach (Chair)
Dr Robert Thompson
Mr Robert Gilmore
1 vacant Non Executive (this position, vacant since July 2012, is currently in the final stages of recruitment)

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

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Report of the Pharmacy Practices Committee

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

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

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

In 2011/12, in order to facilitate those making applications, the PPC decided to introduce for a six month pilot period, the provision for applicants and objectors to use audio-visual materials in their presentations. While no-one took up this option, the PPC has continued to allow this facility and will consider further in 2013/14.

The 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 Board has constituted the Committee under the Chair and Vice-Chair into four panels.

The service provided by the members of the committee is greatly appreciated.

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

For the period 2012/13 the Pharmacy Practices Committee dealt with the following applications:

Full applications: 3 (3 refused)
Oxygen applications: 0
Change of hours: 12 (12 approved)

Mr John Mone
Chair of the Pharmacy Practices Committee

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Remuneration Report 2012/13

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

While the salary structure and the terms and conditions of service for Senior Executives is determined by the Department of Health Social Services and Public Safety (DHSSPS), the Remuneration & Terms of Service Committee has a key role in assessing the performance of Senior Executives and, where permitted by DHSSPS, agreeing the discretionary level of performance related pay. A Pay circular for the period 2012/13 was issued on 27 February 2013 and implemented accordingly.

The salary, pension entitlement and the value of any taxable benefits in kinds paid to both Executive and Non Executive Directors is set out overleaf. It should be noted that Non Executive Directors do not receive pensionable remuneration and therefore there will be no entries in respect of pensions for Non Executive members.

Early Retirement and Other Compensation Schemes

There were no early retirements or payments of compensation for other departures relating to Senior Executives during 2012/13.

Membership of the Remuneration & Terms of Service Committee:

Dr Ian Clements (Chair)
Dr Melissa McCullough
Mr Robert Gilmore

Senior Management Remuneration (Table Audited)

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

	2012/13			2011/12		
Name	**Salary £000s**	**Bonus/ Performance pay £000**	**Benefits in Kind (Rounded to nearest £100)**	**Salary £000s**	**Bonus / Performance pay £000**	**Benefits in Kind (Rounded to nearest £100)**
Non-Executive Members						
I Clements	30-35	0	200	30-35	0	200
S J Leach	5-10	0	100	5-10	0	100
M McCullough	5-10	0	100	5-10	0	100
R Gilmore	5-10	0	200	5-10	0	200
B McKeever	5-10	0	100	5-10	0	100
J Mone	5-10	0	300	5-10	0	300
W R Thompson	5-10	0	0	5-10	0	0
E Kerr (01/14/12 - 19/07/12)	0-5	0	0	5-10	0	100
Executive Members						
J Compton	145-150	0	0	140-145	0	1,800
P Cummings	105-110	0	1,100	105-110	0	1,600
F E McAndrew	80-85	0	0	80 - 85	0	300
S Harper	115-120	0	900	115-120	0	700
D Sullivan	100-105	0	800	100-105	0	800
M Bloomfield (Head of Corporate Services & acting Director of PMSI since 19/11/12)	80-85	0	0	75-80	0	300
P McCreedy (appointed 01/07/12)	65-70	0	0	0	0	0
L McMahon (01/04/12 - 31/10/12 - seconded to the Leadership Centre from 01/11/12)	60-65	0	100	105-110	0	300

Median Salary (Table Audited)

The relationship between the remuneration of the most highly paid director and the median remuneration of the workforce is set out below. There has been no significant change to the ratio mainly due to the continuing public sector pay freeze.

	2013 **£**	**2012** **£**
Band of Highest Paid Director Total Remuneration	147,500	142,500
Median Salary	31,206	31,787
Median Total Remuneration Ratio	**4.7**	**4.5**

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Pensions of Senior Management (Table Audited)

	2012/13				
Name	**Real increase in pension and related lump sum at age 60 £000s**	**Total accrued pension at age 60 and related lump sum £000s**	**CETV at 31/03/12 £000s**	**CETV at 31/03/13 £000s**	**Real increase in CETV £000s**
Executive Members					
J Compton	0	70 - 75 pension 200 - 205 lump sum	0	0	0
P Cummings	0 - 2.5 pension 2.5 - 5 lump sum	35 - 40 pension 115 - 120 lump sum	656	708	15
F E McAndrew	0 - 2.5 pension 0 - 2.5 lump sum	15 - 20 pension 50 - 55 lump sum	357	391	13
S Harper	0 - 2.5 pension 0 - 2.5 lump sum	40 - 45 pension 125 - 130 lump sum	770	815	5
D Sullivan	0 - 2.5 pension	0 - 5 pension	34	54	18
M Bloomfield (Head of Corporate Services & acting Director of PMSI since 19/11/12)	0 - 2.5 pension 2.5 - 5 lump sum	20 - 25 pension 70 - 75 lump sum	355	390	15
P McCreedy* (appointed 01/07/12)	0	0	0	0	0
L McMahon (01/04/12 - 31/10/12 - seconded to the Leadership Centre from 01/11/12)	0 - 2.5 pension 0 - 2.5 lump sum	10 - 15 pension 25 - 30 lump sum	165	204	24

**No real increase in pension figures as appointment within this financial year.*

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines prescribed by the institute and Faculty of Actuaries.

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

Mr John Compton
Chief Executive

Date

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

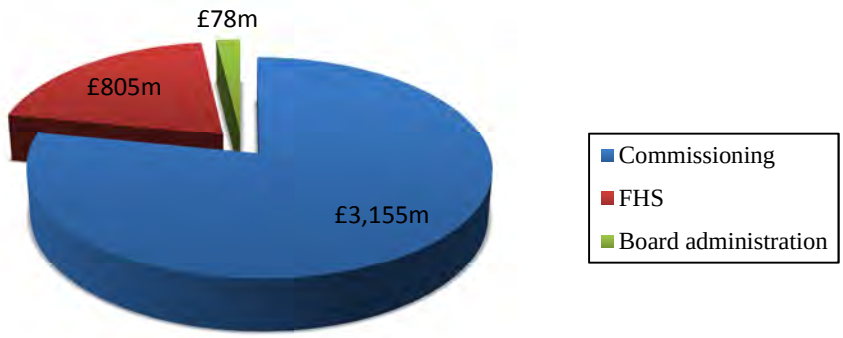
HSCB Expenditure

The Board received a Revenue Spending Limit from the DHSSPS in 2012/13 of £4,019,453k (excluding non-cash of £18,420k). In addition to this the Board also receives income from other sources, which in 2012/13 was calculated as £48,084k.

HSCB Funding 2012/13

The HSCB expenditure falls into three main areas as shown in the chart below.

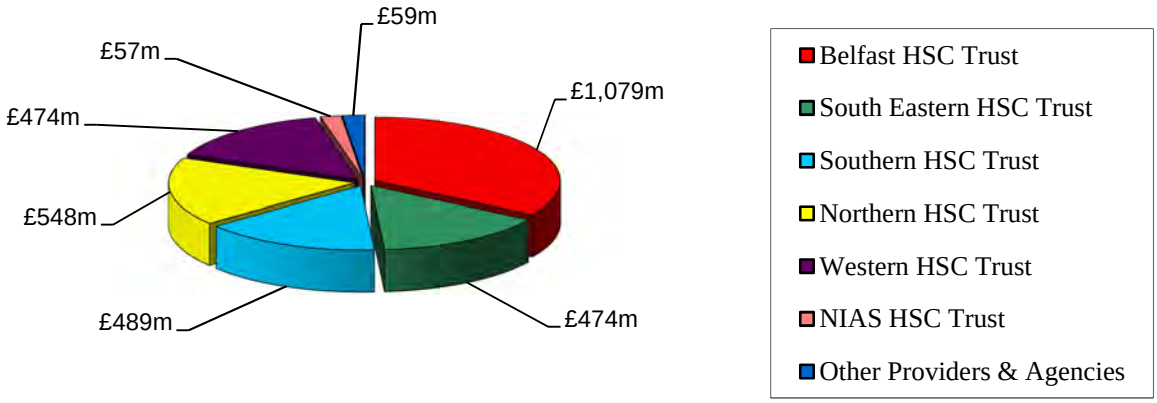
HSCB Expenditure 2012/13



Commissioning

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

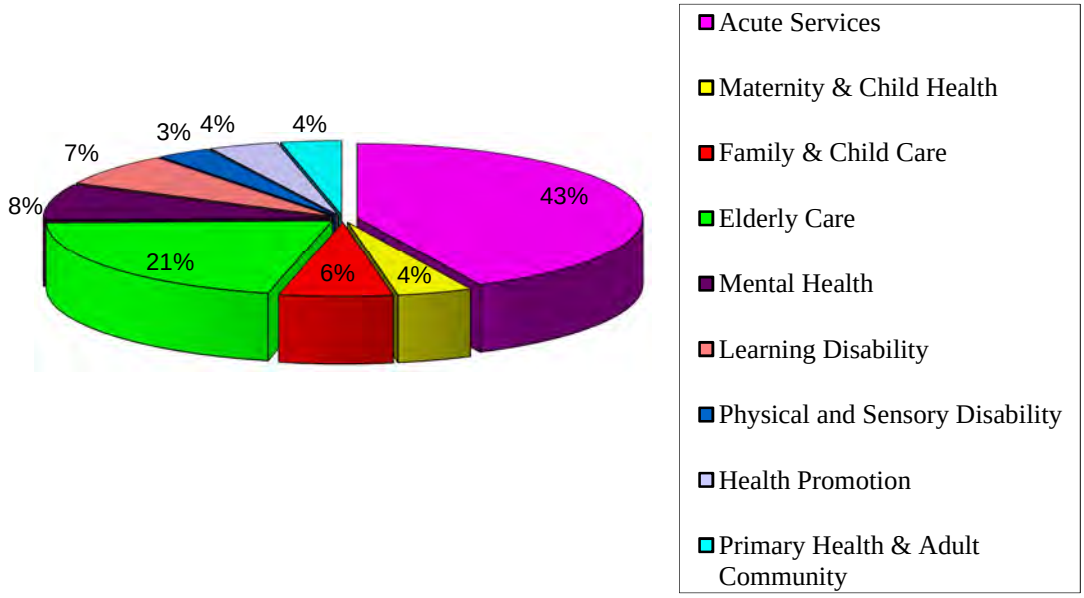
Commissioning Expenditure 2012/13



Programmes of care

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

Investment by Programmes of Care 2012/13*

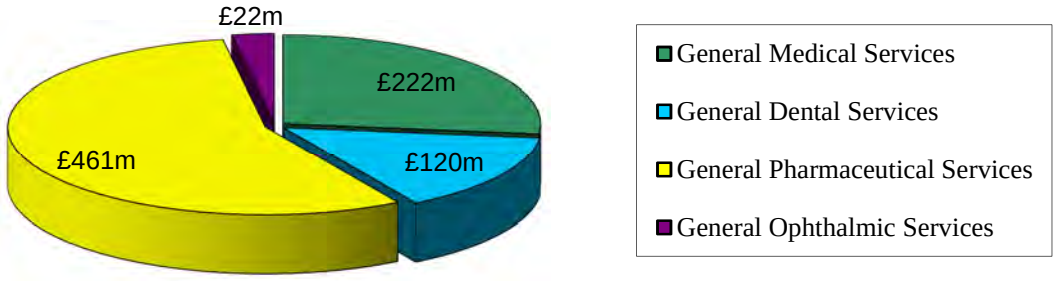


**Source of data Strategic Resource Framework 2011/12*

Family Health Services

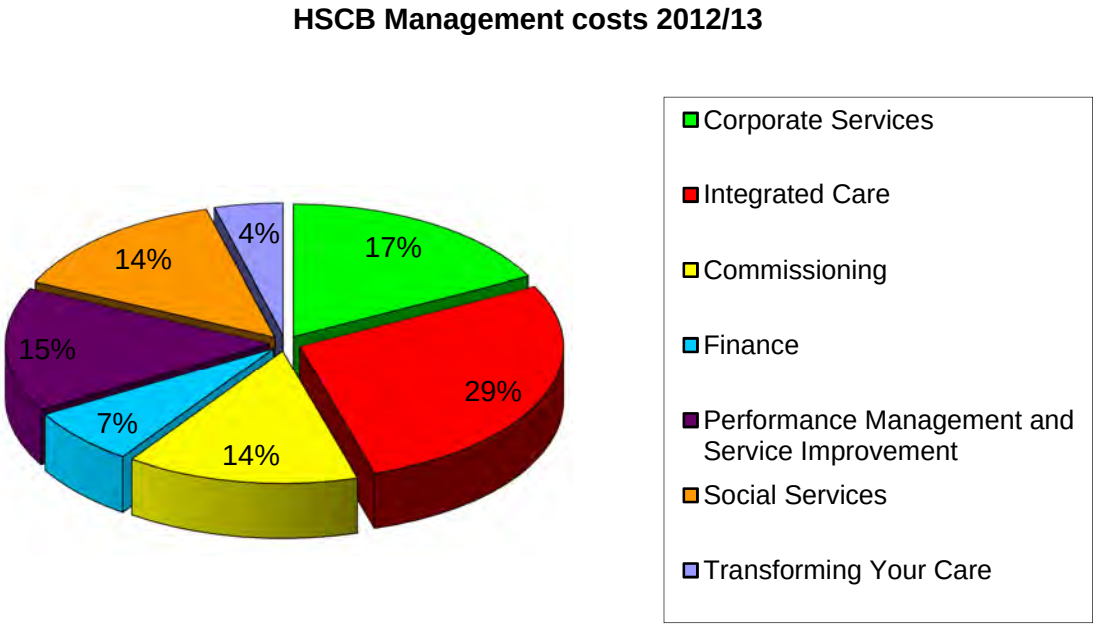
The Health and Social Care Board spent £825m on Family Health Services (FHS) in 2012/13 to meet the health and social care needs of local populations. The breakdown by service area is shown in the chart below:

FHS Expenditure 2012/13



HSCB Management Costs

At the centre of the 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:



HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

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 can be found within note 15 of the Annual Accounts within this combined document.

Related Party Transactions

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

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

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

Director's Interests

Details of company directorships or other significant interests held by Directors, where those Directors are likely to do business, or are possibly seeking to do business with the HSCB where this may conflict with their managerial responsibilities, are held on a central register. A copy is available on the HSCB website www.hscb.hscni.net . Further information may also be found in note 23 to the Annual Accounts within this combined document.

Charitable Donations

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

Audit Services

The HSCB's statutory audit was performed by PricewaterhouseCoopers LLP on behalf of the Northern Ireland Audit Office and the notional charge for the year ended 31 March 2013 was £57,000, this is reflected within Non-Cash Expenditure within note 4 of the annual accounts. An additional amount of £1,119 was paid to the Audit Office in respect of work carried out on the National Fraud Initiative.

Audit Disclosure

The directors are not aware of any relevant audit information of which the auditor is not aware.

Governance Statement

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

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

Staff Numbers
The Annual Accounts for the year ended 31st March 2013 are contained within this combined document.

Pension Liabilities
Information may be found within notes to the accounts (1.20) within this combined document.

Preparation of Accounts

The HSCB has prepared a set of accounts for the year ended 31 March 2013 and these can be found within this combined document.

Mr John Compton
Chief Executive

Date

HEALTH AND SOCIAL CARE BOARD

ANNUAL REPORT FOR THE YEAR 2012/13

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

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

Chief Executive, Mr John Compton
Mr Compton was appointed Chief Executive Designate of the Health and Social Care Board in January 2009, before taking on the full and substantive role in April of that year. He trained as a social worker and was educated at Queen's University Belfast and the University of Ulster, before going on to lead a number of health and care social bodies in Northern Ireland at the highest management level.

Mr Robert Gilmore OBE, Non Executive Director
Mr Gilmore lives in Banbridge and is a self employed Public Sector Management Consultant and former Chief Executive of Banbridge District Council. He is a Non Executive Director of Banbridge District Enterprises Ltd and part time Business Development Manager of Solace Enterprises.

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

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

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

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

Dr Robert Thompson, Non Executive Director
Dr Thompson lives near Craigavon. After qualifying in medicine at Queen's University Belfast, he worked for some 20 years as a GP in Lurgan, Co Armagh. He later served the former Southern Health and Social Services Board in a senior capacity where he assisted with the development of many services provided to patients by GPs.

Director of Finance, Mr Paul Cummings
Mr Cummings trained as an accountant with Northern Ireland Electricity before joining the health and social services. This role has taken him to a range of senior financial management posts across a number of organisations. In 2003 Paul served as the National Chairman of the Healthcare Financial Management Association (HFMA), the first person outside the NHS in England to receive such an honour. He is also a member of Sport NI.

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

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

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

Glossary of Terms

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

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.

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

Emergency Department Implementation Action Group - A multi disciplinary Improvement Action Group set up by the Health and Social Care Board and Public Health Agency to work closely with Trusts to support them in reducing waiting times at Emergency Departments and in continuing to provide safe and quality care to patients.

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

Integrated Care Partnerships (ICPs) – collaborative network for local health and social care professionals, working as part of a multi-disciplinary team to come together and work in a more integrated way to provide care and support on a more complete range of services.

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

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

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

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

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

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

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

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

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

HEALTH AND SOCIAL CARE BOARD

ANNUAL ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2013

HEALTH & SOCIAL CARE BOARD

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

FOREWORD

These accounts for the year ended 31 March 2013 have been prepared in a form determined by the Department of Health, Social Services and Public Safety based on guidance from the Department of Finance and Personnel's Financial Reporting manual (FReM) and in accordance with the requirements of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

HEALTH & SOCIAL CARE BOARD

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

STATEMENT OF ACCOUNTING OFFICER RESPONSIBILITIES

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department of Health, Social Services and Public Safety has directed the Health and Social Care Board (HSCB) to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of the affairs of the HSCB of its income and expenditure, changes in taxpayers equity and cash flows for the financial year.

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

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

- make judgements and estimates on a reasonable basis.

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

- prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the HSCB will continue in operation.

- keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the HSCB.

- pursue and demonstrate value for money in the services the HSCB provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated Mr John Compton of the HSCB as the Accounting Officer for the HSCB. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the HSCB's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health, Social Services and Public Safety.

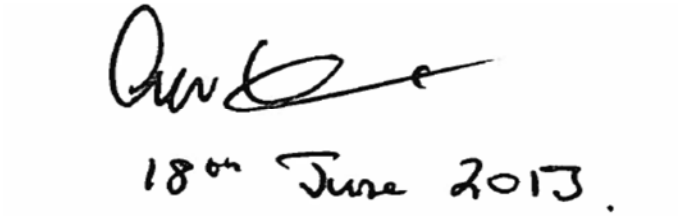
HEALTH & SOCIAL CARE BOARD

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

CERTIFICATES OF DIRECTOR OF FINANCE, CHAIRMAN AND CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 96 to 141) which I am required to prepare on behalf of the Health and Social Care Board (HSCB) have been compiled from and are in accordance with the accounts and financial records maintained by the HSCB and with the accounting standards and policies for HSC Bodies approved by the Department of Health, Social Services and Public Safety.

Owen Harkin **Director of Finance (Acting)**



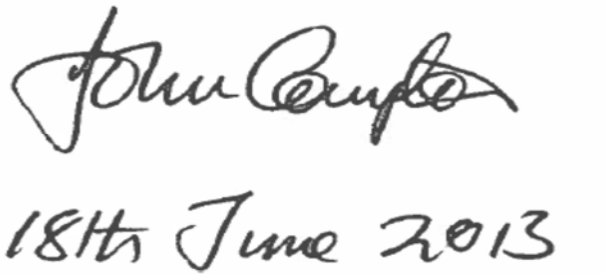
Date

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 96 to 141) are prepared in accordance with the above requirements have been submitted to and duly approved by the Board.

Ian Clements **Chairman**

Date

John Compton **Chief Executive**



Date

HEALTH AND SOCIAL CARE BOARD

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I certify that I have audited the financial statements of the Health and Social Care Board for the year ended 31 March 2013 under the Health and Social Care (Reform) Act (Northern Ireland) 2009. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Statement of the Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to examine, certify and report on the financial statements in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Financial Reporting Council's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Health and Social Care Board's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Health and Social Care Board; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on Regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Health and Social Care Board's affairs as at 31 March 2013 and of the net expenditure, cash flows and changes in taxpayers' equity for the year then ended; and
- the financial statements have been properly prepared in accordance with the Health and Social Care (Reform) Act (Northern Ireland) 2009 and Department of Health, Social Services and Public Safety directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Department of Health, Social Services and Public Safety directions made under the Health and Social Care (Reform) Act (Northern Ireland) 2009; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with Department of Finance and Personnel's guidance.

Report

I have no observations to make on these financial statements.

K J Donnelly

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

27 *June 2013*

HEALTH AND SOCIAL CARE BOARD

GOVERNANCE STATEMENT

FOR THE YEAR ENDED 31 MARCH 2013

HEALTH & SOCIAL CARE BOARD

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

Processes in place by which the HSCB works with partner organisations

- Public Health Agency (PHA)

Under Section 8 of the Reform Act, the HSCB is required to produce an annual Commissioning Plan in full consultation and agreement with the PHA. In practice the employees of the HSCB and PHA work in fully integrated/multi-disciplinary teams to support the commissioning process at both local and regional levels.

- Business Services Organisation (BSO)

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

- Health and Social Care (HSC) Trusts

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

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

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

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

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

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

2. Compliance with Corporate Governance Best Practice

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

Standing Orders
The Standing Orders, reserved and delegated powers and Standing Financial Instructions provide a comprehensive business framework for the HSCB and enable the organisation to discharge its functions. They reflect the following: Framework Document (September 2011); Management Statement/Financial Memorandum; Code of Conduct and Code of Accountability (2012) 7 Nolan Principles; Public Service Values; Code of Practice on Openness; Corporate Plan

The HSCB Standing Orders and Standing Financial Instructions are reviewed on an annual basis, considered by the HSCB Audit Committee and approved at the subsequent public Board Meeting. Section 5 of Standing Orders relates to the Conduct of Board Business and includes, amongst others, potential conflicts of interest. This section also applies to the conduct of public meetings of the Local Commissioning Groups (LCGs).

During the period there were no conflicts of interest noted at Board meetings, however there were abstentions or dissentions from voting on a number of occasions and these are recorded in the Board public minutes.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

Register of Interests

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

- Directors: These are reviewed annually and where relevant throughout the year. They are noted at public Board meetings and published on HSCB website.
- Committee Members: There is a Register of Interests for each of the 5 LCGs which are also subject to annual review and if relevant throughout the year. These are noted at public LCG meetings and also published on HSCB website.
- There is a Register of Interests for those involved in Board Committees who are not HSCB Officers. This was established in 2012 and relates solely to those who participate in the Pharmacy Practices Committee. This Register is also reviewed annually.
- Staff: A Register of Staff Interests, for those who are included in the Scheme of Delegated Authority, is reviewed annually. From 1 April 2013, the staff interest register will be rolled out to every member of staff.

Gifts and Hospitality Policy

The HSCB Gifts and Hospitality Policy was published in April 2012 and is based on DAO (DFP) 19/09. A nominated Officer in each HSCB Directorate's maintains a log and a six monthly report is reviewed by the Governance Committee. The first report was considered at the Governance Committee meeting on 29 November 2012.

Performance Appraisal System

During 2012/13 a Staff Appraisal Scheme was implemented for all staff. In addition, the DHSSPS carried out its annual appraisal with the HSCB Chair who in turn carried out an annual assessment of each Non Executive Directors and LCG Chairpersons.

Training

"Essential Skills" training was provided on 24 September 2012 to new appointments, including public appointments. In light of the re-appointments of HSCB Chair and Non Executives, arrangements will be undertaken to provide "Essential Skills" refresher training.

Self Assessment

- The Audit Committee completes a National Audit Office self-assessment checklist each year (March 12) which is submitted to DHSSPS.
- A Board Governance Self-Assessment Tool will be completed for submission to DHSSPS by 30 April 2013.

This exercise is a significant first step in putting arrangements in place for the regular evaluation of Arm's Length Bodies (ALB) Boards effectiveness. The completion of the self assessment evaluation in 2013/14 is primarily intended to facilitate the Board in establishing a baseline position and to identify its development/support needs

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through a system of corporate governance, which includes:

- A schedule of matters reserved for Board decisions, some of which may have been delegated to Committees;
- A scheme of delegation, which devolved decision making authority within set parameters to the Chief Executive and other officers;
- Standing Orders and Standing Financial Instructions, which set out the HSCB's governance regulations; (referred to above).
- The operation of a Governance Committee and an Audit Committee (comprised of Non Executive Directors) to assure adherence to those regulations (as above).
- The adoption of a Governance Framework which consists of a suite of documents that provides the Board with the necessary assurances that the organisation is discharging its functions in a way which ensures that risks are managed as effectively and efficiently as possible to acceptable standards of quality. The objective being to protect the organisation against loss, the threat of loss and the consequent of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

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

The Board

The Board of Directors is comprised of a Non Executive Chair, seven Non Executive Directors, the Chief Executive and four Executive Directors. There is currently one Non Executive vacancy.

The five Executive Directors: Chief Executive, Director of Finance, Director of Commissioning, Director of Social Care and Children's and Director of Performance Management and Service Improvement are employees of the HSCB.

During May 2013 the DHSSPS requested and authorised the HSCB to create a new post of Regional Director of eHealth and External Collaboration, which was filled with effect from 13 May 2013.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

The HSCB has three main functions:

- to commission a comprehensive range of modern and effective health and social care for the 1.8 million people who live in Northern Ireland;

- to performance manage the delivery by HSC Trusts of care services to ensure that these achieve optimal quality and value for money, in line with relevant government targets;

- to effectively deploy and manage its annual funding from the Northern Ireland Executive to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.

In the 2012/13 year, the Board met on 14 occasions and in accordance with the Board's Standing Orders were quorate for each meeting. During this period there was 100% attendance at 5 meetings; 92% attendance at 6 meetings and; 84% at 3 meetings, 2 of which were unscheduled Special Board Meetings (11 June and 25 September 2012).

During the reporting period the following changes occurred with regard to Executive Board membership:

- The Minister approved the re-appointment of the Chair and six Non Executive Members for a second term. The new terms of appointment have been staggered between 2-4 years to ensure a range of skills, knowledge and expertise.

- A Non Executive Director was removed from post by the Minister on 17 July 2012. The DHSSPS Public Appointments Unit advertised a Non Executive Financial Member vacancy which closed on 29 November 2012. This vacancy was filled on 15 April 2013.

- The Director of Performance Management and Service Improvement, an Executive Director, has been seconded as Programme Director in a major initiative on the development of Clinical Leadership within HSCNI. The secondment commenced on 1 November 2012 for an 18 month period.

- In a letter dated 16 November 2012, the HSCB Chief Executive advised that, following discussion with members of Senior Management Team (SMT), he had asked Head of Corporate Services to take on the role of Acting Director of Performance Management and Service Improvement with effect from 19 November 2012. The HSCB Chair advised the Board at its meeting on 13 December 2012.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

The HSC Board completed a Governance Self-Assessment Tool in respect of 2012/13 financial year which is a first step in putting in place arrangements for the regular evaluation of Board effectiveness. The Self-Assessment covered 4 areas: Board composition and commitment; Board evaluation, development and learning; Board insight and foresight and; Board engagement and involvement. A Board workshop, attended by all Non Executive and Executive Board Directors, was held on 23 April 2013 with the completed template approved by the Board at its public meeting on 9 May 2013. The exercise indicated that the Board complied with 13 (green) of the 17 points of good practice (76.5%); 2 Amber/Green ratings (11.76%); 1 Amber/Red (5.8%) and; 1 red rating (5.8%). The Governance Self-Assessment tool was completed taking account of the performance of Board Committees as indicated below.

Role of the Audit Committee

The Audit Committee comprises four Non Executive Directors. The Director of Finance has a standing invitation to attend, with the exception of the annual meeting with the External Auditor, and the Committee is also attended by other relevant Finance and Internal Audit staff. The External Auditor is invited to attend any meeting of the Committee. A DHSSPS representative is invited to attend one Audit Committee meeting per year.

The Terms of Reference of the Audit Committee are in accordance with the Good Practice Principles contained within HM Treasury Audit Committee Handbook (March 2007) and are kept under review in light of any emerging or changing accountability arrangements for the HSCB . The Code of Conduct and Code of Accountability for Board Members of HSC Bodies (July 12) clarifies the composition and roles of the Audit Committee and this has been reflected in the 2012/13 annual review of HSCB Standing Orders.

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

During the 2012/13 financial year five meetings of the Audit Committee were held and the average attendance by members was 87.5%. Since July 2012 there has been a Non-Executive Director vacancy which the DHSSPS is in the final stages of recruitment. Meetings since July have been quorate with 100% attendance from the remaining members.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

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

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

The Board's Audit Committee has completed their annual self-assessment using the National Audit Office's Checklist to assess performance. An action plan has been devised to address any gaps in compliance with the application of best practice, as required by the HM Treasury's Audit Committee Handbook.

Role of the Governance Committee

The Governance Committee comprises of four Non Executive Directors, two of which are from a nursing and medical background. The HSCB's SMT are in attendance at all meetings.

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

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

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

During the reporting period the Governance Committee met on a quarterly basis and considered the following:

- Management of corporate risk;
- Quality, safety and standards in health and social care;
- Social Care Delegated Statutory Functions;
- Controls assurance and internal control;
- Serious adverse incident management;
- Complaints management;
- Litigation management;
- Maintenance of the reputation, image and integrity of the HSCB ;
- Professional regulation;
- Information governance;
- Other matters, excluding finance that pertains to good corporate governance.

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

- The operation of a ***Governance Officer Group***. This is a multi-disciplinary team who are accountable to the HSCB Senior Management Team for the operational implementation of governance activities across the HSCB. One of the functions of this group is to consider and agree any issues that require to be brought to the attention of the Governance Committee
- The operation of five ***(LCGs)*** to exercise the Board's function under Section 9 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. In accordance with HSCB Standing Orders, LCGs have met at least nine times during 2012/13 and all meetings were quorate.
- The operation of a ***Reference Committee*** to exercise the HSCB's function under the Disciplinary Procedures Regulations (NI) 1996 with respect to the referral of disciplinary matters relating to Family Practitioner Services. During 2012/13, the Reference Committee held two meetings and were quorate on both occasions.
- The operation of a ***Pharmacy Practices Committee*** to exercise the functions of the Board under Regulation 6 (9) the Pharmaceutical Services Regulations (NI) 1997, on behalf of the Board and in accordance with Schedule 4 of the same Regulations. The Pharmacy Practices Committee has held 4 meetings during 2012/13 and has been quorate on each occasion.
- The operation of a ***Remuneration and Terms of Service Committee*** (also comprised of Non Executive Directors) to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives and Consultants within Departmental policy. In accordance with HSCB Standing Orders, the Remuneration and Terms of Service Committee met on one occasion.

- The operation of a ***Review Panel***, to hear representations from a doctor where the Board is proposing conditional inclusion in the Performers' List, contingent removal, suspension and also removal under Regulation 10 (4) from the Primary Medical Performers List to hear the case put forward by the Board's Investigating Officer: and make a determination. The Review Panel has not been required to meet during the reporting period.
- The operation of four ***Disciplinary Committees*** embracing Dental, Optometry and Pharmacy plus a Joint Committee. Each Committee is comprised of members of the geographical area covered by each of the four local offices. Three laypersons are appointed by the Board for each local office as well as a representative from each of the three professions. During the period the Disciplinary Committees were note required to meet. Think this should be Board – that sentence was direct lift from last year's
- The operation of a ***Review Panel*** convened to conduct oral hearings in relation to conditional inclusion, contingent removal, removal from the Primary Medical Performers List other than in circumstances where the HSCB is obliged to remove a performers name or in relation to suspension of a performer. The Review Panel has not been required to meet in 2012/13.

4. Business Planning and Risk Management

Business Planning

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

Commissioning Plan

In line with the above statute, the Board is required to prepare and publish an Annual Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery. The preparation of the Commissioning Plan is done in partnership with the PHA and is implemented through a series of integrated service teams. It takes full account of the financial parameters set by the Executive and DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Plan Direction. It encompasses all of relevant Transforming Your Care (TYC) recommendations and provides the means through which those elements of TYC is planned and delivered.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

Corporate Plan

Many of the Board's objectives and responsibilities for the period to 2015/16 are reflected in the Commissioning Plan. The Corporate Plan does not seek to duplicate the detailed objectives and activities set out in the Commissioning Plan, but rather to outline the key objectives for the organisation in addition to those associated with the Commissioning Plan, and those that will support its delivery. As such, the Corporate Plan includes objectives that primarily relate to how the HSCB will seek to commission the delivery of high quality health and social care services for the population of Northern Ireland, and how it conducts its business and ensures that its organisational arrangements are fit for purpose. Taken together with the Commissioning Plan and policies for the effective and efficient management of resources, the Corporate Plan will provide an overarching planning framework for the work of the HSCB.

The key objectives for the focal year 2012/13 are subject to bi-annual review. The first of these reviews was carried out as at 30 September 2012 and was approved by the Governance Committee at its meeting on 29 November 2012. The second of these reviews is scheduled as at 31 March 2012 and will be considered by SMT prior to being referred to the Governance Committee for approval at its meeting on 6 June 2013.

In taking forward key business planning objectives for 2013/14, the HSCB held a corporate planning workshop in February 2012, which was attended by SMT, Assistant Directors and senior staff from the HSCB and PHA. The purpose of the workshop was to agree the key business planning priorities for 2013/14 and beyond. Following the workshop, an exercise was undertaken to ensure the plan reflected a range of business requirements specified by DHSSPS.

Where these requirements are already included in other key documents, for example the HSCB's Governance and Assurance Frameworks, they are not replicated in the Corporate Plan, but together they form a suite of planning documents that describe the key strategic and service priorities and the associated governance arrangements that are intended to ensure the delivery of a wide range of high quality health and social care services.

In order to successfully meet the business planning priorities for 2013/14 the HSCB will continue to ensure effective user engagement by implementing its Personal and Public Involvement (PPI) strategy, promote equality, human rights and diversity in all its functions, and fully contribute to the implementation of regional policies and initiatives including the Quality 2020 strategy.

Business Continuity Plan

The Board has in place a corporate Business Continuity Plan, which meets BS25999 Standard. The plan identifies the HSCB functions that are 'critical' and that must continue to be delivered during an interruption to normal business. A risk assessment was carried out by each directorate as part of the development of the strategies to continue to deliver the critical functions.

Business continuity has been integrated into the HSCB's day to day management and the business continuity arrangements are agreed and supported by the SMT.

The corporate Business Continuity Plan was validated through a test in April 2012, and was reviewed and revised following this exercise. The plan was further reviewed and revised following an evacuation of Headquarters in June 2012 due to a flooding incident.

Risk Management

The HSCB recognise risk management is a key component of the Governance Framework and it is therefore essential that systems and processes are in place to identify and manage all risks as far as reasonably possible.

The purpose of risk management is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The HSCB has recognised the need to adopt such an approach and has put in place an independently assured risk management system that conforms to the principles contained in the Australian/New Zealand AS/NZS 4360:2004, standard (adopted by DHSSPS) and which ensures there is a systematic and unified process for the management of risks across all areas of the Board's activity. The process for the management of Board wide risks is part of the HSCB's overarching Governance Framework.

It includes a step by step process from the initial identification of a risk, risk grading, how the risk should be managed and escalation/de-escalation of grading to and from directorate to corporate registers. The implementation of this process has led to a fully functioning risk register at both directorate and corporate levels.

Risk Appetite

- Categorisation of Risk

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

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

The HSCB has adopted a 'five by five' risk quantification matrix (annex 1, appendix 1); that is consistent with DHSSPS mandatory guidance *An Assurance Framework: A Practical Guide for Boards of DHSSPS Arm's Length Bodies.* The matrix, is used to categorise potential risks, and incidents, and facilitates the prioritisation of risk in terms of likelihood and consequence. In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.

As part of a DHSSPS led initiative, the HSCB has been working collaboratively with other HSCB organisations in establishing a new regional risk matrix which is scheduled for implementation in 2013/14.

- Acceptable Risk

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

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

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

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

Risk Activity

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

Quarterly reviews for the first, second and third quarters of 2012-13 have now been completed for both directorate and corporate registers with the fourth quarter review scheduled as at 31 March 2013. Each review reflects additions/amendments in respect of:

- Identification/removal of risk
- De-escalation/escalation of risk
- Existing controls
- Internal and external assurances
- Gaps in controls and assurances
- Action being taken forward

The corporate register underwent a thorough review in September 2012 involving meetings with directors and their senior staff, co-ordinated by senior Governance staff.
This resulted in substantive changes to the corporate register thus providing the assurance mechanism to the Board of Directors that risks to meeting corporate objectives are being effectively managed.

Stakeholder Risk

- Serious Adverse Incidents (SAIs)

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010.

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

- Regional reporting system to the HSCB for all SAIs.
- The nomination of an HSCB/PHA Designated Review Officer to review and scrutinise reports.
- Regional SAI Review Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- The HSCB SMT receives and considers all SAI's on a weekly basis and the Governance Committee receive a SAI report at each of its meetings.

The purpose of any adverse incident reporting system is to improve patient safety. A key aim of the SAI reporting and learning process is to reduce the risk of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is core to achieving this and to ensure these lessons are embedded in practice and the quality of care provided.

The Regional SAI Review Group has a role in meaningful analysis, identifying learning across organisations, making recommendations for change and informing the development of solutions.

Last year, the HSCB in collaboration with the PHA issued the first bi-annual SAI Learning Report across the wider HSC. During 2012/13 a further two SAI Learning Reports have been issued covering the periods 1 October 2011 – 31 March 2012 and 1 April 2012 – 30 September 2012. In addition to learning from specific SAIs, work has also been undertaken with regard to SAI thematic reviews namely: Mental Health, Care and Treatment of Older People, and Physiological Early Warning Systems (PEWS).

As part of the review of 2010 Procedure for Reporting and Follow up of SAIs a series of events and meetings have been held. These have included meetings with HSC Trusts, in order to identify and resolve issues which have proved problematic in relation to the current procedure.

A group of HSCB/PHA staff involved in the SAI process are currently taking forward the outcome of these events and meetings. This has resulted in a number of sub groups being established to review particular aspects of the procedure e.g. guidance on review team composition, criteria for SAIs, guidance on joint investigations etc. Prior to implementation, a draft procedure will be circulated to the HSC for consultation; with formal issue anticipated in September 2013.

- Safety and Quality Alerts Team

During the reporting period, the HSCB/PHA has established a Safety and Quality Alerts Team who are responsible for the implementation and assurance of Regional Safety and Quality Alerts/Letters/Guidance issued by DHSSPS and HSCB/PHA.

The work of this group is closely aligned to the Regional SAI Review Group and Regional Complaints Group to ensure there is a fully integrated approach in relation to dissemination of learning.

- Complaints

Complaints in Health and Social Care' advises that the HSCB has a role in having oversight of all HSC complaints; is responsible for the monitoring of complaints and processes and for the identification and dissemination of learning from complaints. A Regional Complaints Group, which is attended by professionals from the HSCB and the PHA, meets on a quarterly basis to review information received from HSC Trusts and Family Practitioner Services (FPS) Practices.

The HSCB has a role in providing support and advice regarding complaints to FPS Practices and also in providing an 'honest broker' role in relation to FPS complaints, which is an intermediary role undertaken by complaints staff and involves liaison with Practices, and with the complainant, in an attempt to achieve a satisfactory outcome and resolution of the complaint.

In 2011, the HSCB reported on a 'process evaluation' of 'Complaints in HSC' which it had undertaken at the request of the DHSSPS. The evaluation process was informed by direct engagement with key stakeholders involved in complaints handling, i.e. HSC Trusts, FPS Practices, the Patient Client Council (PCC), RQIA, service users, and some voluntary organisations. This included a stakeholder workshop event. The report made 14 recommendations which aim to further improve 'Complaints in HSC', and which the HSCB has responsibility to ensure implementation of. An overarching Evaluation Implementation Group has been established by the HSCB with key stakeholders in membership.

Three specific subgroups have been established to address recommendations relating to developing a regional mechanism for service user feedback; developing a regional mechanism for dissemination of learning from complaints; and promoting positive attitudes and communications in the HSC. All three subgroups have key stakeholders in membership. The regional mechanism for service user feedback involves service users in the development of this mechanism.

- Medical Negligence Cases

The HSCB is responsible for the management of outstanding medical negligence cases which pre date Trust status (pre-1996). A Preliminary Advisory Group (PAG) attended by Public Health Consultants, PHA, the Assistant Director of Legal Services, BSO, HSC Trusts, and the Claims Manager and Claims Officer in the HSCB meets on a monthly basis to review activity on the cases, in particular those listed for hearing and requiring specific authorities

- Emergency Preparedness

A Joint PHA/HSCB/BSO Emergency Response Plan has been developed under the leadership of the PHA. This has been reviewed and updated in 2012/13 as a result of an activation of the Joint response arrangements in October 2012, due to an outbreak of e-coli, the response to which was led by the PHA. The revised Joint response plan was re-issued in December 2012.

Taking cognisance of the risks associated with annual seasonal flu, potential adverse weather; and preparedness for major events, in particular during 2013, the HSCB and PHA established a Flu, Weather and Major Events Group to have oversight of these arrangements. In addition a Project Team was established, chaired by the PHA to take forward the HSC preparedness for the major events scheduled for 2013.

The Joint Emergency Response Plan was activated on 24 March, to support the multiagency response to the severe weather situation experienced by some parts of Northern Ireland. The joint response was led by the HSCB, supported by the PHA and the BSO. The HSCB and the PHA received daily SitReps from the Trusts and Primary Care during the period which indicated that while challenges existed in some areas, these were effectively managed and there were no major service implications. A number of the Trusts had to deal with power outages during this period. The joint response was stood down on 3 April 2013. A de-brief is currently being organised.

<u>Risk Management Leadership</u>
As stated in section 3.0, the Board exercises strategic control through a system of corporate governance; by which the organisation is directed and controlled, at its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

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

During 2011/12 the HSCB delivered Operational Protocol Training to staff, providing an overview of corporate processes in place across the organisation. To build on this training and further strengthen risk management arrangements an e-learning risk management awareness programme has been developed and was implemented during 2012/13. This training is mandatory for all HSCB staff and includes a short multiple choice assessment with an agreed pass mark. Training in this programme will continue into early 2013/14 and will subsequently form part of the HSCB's overarching corporate induction programme.

5. Information Risk

The HSCB has structures and processes in place to facilitate the identification, management, monitoring and where necessary the escalation of information risks.

Structures include the roles of Senior Information Risk Owner, Personal Data Guardian and Information Asset Owners which are supported by an Information Governance Team. Escalation is facilitated via a range of forums across all levels of the organisation examples include the Records Management Working Group, Information Governance Steering Group, SMT and the Board's Governance Committee.

Processes in place to identify and manage information risks include the development and maintenance of an Information Asset Register, the mapping of data flows and the completion of risk assessments to identify and rate information risks. The development of treatment plans to address identified risks which are subsequently agreed with Information Asset Owners who in turn provide regular assurance to the Senior Information Risk Owner on progress. Where necessary, identified information risks are added to the relevant HSCB Directorate/Corporate Risk Registers.

The Accounting Officer and Board receive assurances on information risk via formal reporting mechanisms. The Information Governance Steering Group, chaired by the Senior Information Risk Owner, meets bi-monthly and receives updates at each meeting. Quarterly reports to SMT and six monthly reports to the HSCB Governance Committee are provided from the Senior Information Risk Owner who sits on both groups. Further assurances are sought via the self assessment of relevant Controls Assurance Standards and by inclusion of Information Governance as part of the rolling Audit Programme.

6. Public Stakeholder Involvement (PPI)

The HSCB, working collaboratively with the PHA, is committed to embedding PPI into its culture and practice and to enacting Departmental and Ministerial intentions and instructions in respect of this important issue. To this end, all commissioning service teams and LCGs actively consider PPI in all aspects of their work, from ensuring that feedback from service users and carers underpins the identification of their commissioning priorities, to involving patients in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements. There are many examples of good practice:-

- Involvement of service users to discuss public consultation documents on the Strategic Direction of GP Out of Hours services;
- Patient engagement undertaken in relation to the provision of general medical services to patients of a rural practice;
- Engagement with patients/carers/service users in respect of the Regional Acquired Brain Injury project work;
- Engagement with service users and carers regarding the modernisation of Glaucoma Services;
- Type 2 Diabetes pathfinder – gaining users' perspectives of diabetic services from 'at risk' communities

To further develop this work, the PHA and HSCB are currently implementing a joint PPI Strategy (produced in 2012). Complementary action plans have been developed and are being finalised and put into practice, with opportunities for joint working between the two organisations being identified and taken forward

The planned development of guidance for staff on service user involvement and participation will further strengthen the ability of staff to effectively and meaningfully engage with service users, carers and key stakeholders.

The PHA and HSCB are working collaboratively in respect of monitoring and evaluation in respect of PPI and, mechanisms are being developed to capture outcomes from PPI, including what difference has been made by engaging directly with service users, carers and key stakeholders, and to learn from these experiences and examples.

During 2013/14, the HSCB will continue to work collectively across related areas such as patient experience, safety, advocacy, complaints and community development and in partnership with other HSC organisations including the PCC, to share learning and insights, to improve processes and systems including monitoring, evaluation and most importantly to improve outcomes for service users and carers.

7. Assurance

Assurance Framework

As part of its overarching Governance Framework, the HSCB has established a two year Assurance Framework (Framework). The Framework, which operates to maintain and help provide reasonable assurance of the effectiveness of controls, was approved by SMT and the Governance Committee in December 2011 and will be in place for the period 2011/12 – 2012/13 with bi-annual progress reports to SMT and the Governance Committee on the 2nd and 4th quarters.

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

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

As part of its bi-annual review, the Framework was reviewed and updated by each directorate at 30 September 2012. At this time there were a total of 77 Assurance relating to the following domains:

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

The review indicated the following:

- 68% of all assurance functions have been achieved;
- 29% of all assurances functions are either partially achieved or are work in progress towards achievement in the preceding reporting period;
- 1% have not been achieved with action plans in place towards full or partial achievement in the preceding reporting period;
- 2% of the total assurance functions are no longer relevant and will be removed from the framework.

It should be noted; some of the assurance functions within the Framework are annual assurances and could therefore only gain either partial achievement or 'work in progress' during this mid-year review.

The review was considered by the Governance Committee at its meeting on 29 November 2012. A further review of the Framework is scheduled for 31 March 2013. Further development of the Framework will be progressed during the 1st and 2nd quarters of 2013/14 which is in line with the HSCB Corporate Plan and as per DHSSPS business planning requirements.

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

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

Delegated Statutory Functions

HSC Trusts submit an annual monitoring report on the delivery of statutory functions with a midyear return on Corporate Parenting. This is analysed by HSCB and an overview report on findings was considered by the Board at its meeting in September and submitted to DHSSPS. HSC Trusts have developed action plans where remedial action was required. The quality of supporting data has continued to improve and together with regular monitoring meetings, ensure that this area is kept under constant review.

Controls Assurance Standards

The HSCB assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in 2012/13.

The HSCB achieved the following levels of compliance for 2012/13.

Standard	DHSS&PS Expected Level of Compliance	HSCB Level of Compliance	Verified by Internal Audit
Buildings, land, plant & non-medical equipment	75% - 99% (Substantive)	82% (Substantive)	-
Decontamination of medical devices	75% - 99% (Substantive)	*Not Applicable*	-
Emergency Planning	75% - 99% (Substantive)	88% (Substantive)	-
Environmental Cleanliness	75% - 99% (Substantive)	*Not Applicable*	-
Environment Management	75% - 99% (Substantive)	83% (Substantive)	-
Financial Management *(Core)*	75% - 99% (Substantive)	83% (Substantive)	BSO IA
Fire safety	75% - 99% (Substantive)	92% (Substantive)	-
Fleet and Transport Management	75% - 99% (Substantive)	Not Applicable	-
Food Hygiene	75% - 99% (Substantive)	Not Applicable	-
Governance *(Core Standard)*	75% - 99% (Substantive)	89% (Substantive)	BSO IA
Health & Safety	75% - 99% (Substantive)	86% (Substantive)	BSO IA
Human Resources	75% - 99% (Substantive)	84% (Substantive)	-
Infection Control	75% - 99% (Substantive)	N/A (Substantive)	-
Information Communication Tech	75% - 99% (Substantive)	85% (Substantive)	-
M'ment of Purchasing & Supply	75% - 99% (Substantive)	81% (Substantive)	BSO IA
Medical Devices & Equipment Management	75% - 99% (Substantive)	*Not Applicable*	-
Medicines Management	75% - 99% (Substantive)	*Not Applicable*	-
Records Management *(Info Management in2013/14)*	75% - 99% (Substantive)	82% (Substantive)	-
Research Governance	75%- 99% (Substantive)	*Not Applicable*	-
Risk Management *(Core Standard)*	75% - 99% (Substantive)	87% (Substantive)	BSO IA
Security Management	75% - 99% (Substantive)	86% (Substantive)	-
Waste Management	75% - 99% (Substantive)	83% (Substantive)	BSO IA

8. Sources of Independent Assurance

The HSCB obtains Independent Assurance from the following sources:

Internal Audit

The HSCB has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

In 2012/13 Internal Audit reviewed the following systems:

- Financial Review (including General Ledger (GL) and new financial systems);
- Budgetary Control;
- Claims Management;
- Performance Management – Trusts;
- Fire Safety;
- Information and Communications Technology (ICT) Business Continuity and Disaster Recovery;
- Serious Adverse Incidents and Alert Letters;
- Management of Contracts with Voluntary and Community Organisations ;
- Voluntary Organisations Expenditure - Visits;
- Commissioning – Local Commissioning Groups;
- Management of Co-operation and Working Together (CAWT);
- TYC Governance arrangements;
- Family Practitioner Services – Pharmaceutical and Ophthalmic;
- Risk Management.

All received a satisfactory level of assurance with the exception of:

- Claims Management – substantial
- Financial Review (including GL and new financial systems) – limited
- CAWT - limited

In her annual report the Internal Auditor reported that there is a satisfactory system of internal control designed to meet the HSCB's objectives**.**

However, weaknesses in control (due to priority one recommendations) were identified in the Financial Review and Co-Operation and Working Together audits, recommendations to address these control weaknesses are being implemented. Further information is provided within section 10 of this report and is summarised below:

Financial Review

- Knowledge and experience of the new Finance Procurement and Logistics System (FPL)
- Human Resources Payroll and Travel system (HRPTS) - Payroll controls relating to availability of key reports
- FPL - Regional corrective action plan currently in place
- FPL - Payment controls, Stock accounting, Reconciliations, Reporting and Coding post implementation

The Head of Internal Audit noted that 'It is appreciated that the majority of the findings identified are beyond the direct sole control of HSCB to resolve'. The HSCB Finance Directorate had previously identified the majority of these issues and had escalated to the Business Services Transformation Project leads and the Business Services Organisation management. Action plans are in place and continue to be monitored until they are completed to the HSCB's satisfaction. Interim measures have been introduced by the HSCB to mitigate the most serious risks to Financial Reporting and Control where possible.

CAWT

- Finalisation and formal approval of governance arrangements by the Management Board and Secretariat
- Information required from partner organisations in respect of framework agreements and original supporting documentation

Plans are in place to redress these issues in the first half of 2013/14, please refer to section 10 (b) for further information.

In addition a verification exercise on six Controls Assurance Standards has been completed by the Internal Auditor giving a substantive level of compliance and details of these can be found within section 7 of this document.

In 2011/12 the Internal Auditor gave a satisfactory opinion on the system of internal control designed by the HSCB. There was one priority 1 recommendation made which related to an Information Governance cataloguing exercise which delayed the development of Information Governance Risk Assessments, a central register of Data Access Agreements finalised and an Information Asset Register. Action in relation to this priority one recommendation has been substantially progressed during 2012/13 year.

At her end of year review the Head of Internal Audit assessed that 82% of recommendations made in 2011/12 were fully implemented and a further 16% partially implemented.

External Audit

In the Report to Those Charged with Governance (RTTCWG) for the year ended 31 March 2012, the NI Comptroller and Auditor General gave an unqualified audit opinion on the financial statements and the regularity opinion of the HSCB's accounts, with no priority 1 issues being raised.

The two priority 2 recommendations related to:

- Reliance on third party organisations;
- Management of Co-Operation and Working Together (CAWT) a cross border initiative hosted by the HSCB.

Both were actively progressed, monitored by the Director of Finance and progress towards implementation reported to each meeting of the Audit Committee.

The majority, including minor recommendations, have been fully implemented although a number will require on-going monitoring, eg Reliance on Third Party Organisations.

Regulation Quality Improvement Authority

RQIA published two reports in this reporting year:

- Promoting Quality Care: the recommendation in this report will be taken forward through the Bamford Taskforce sub groups as appropriate
- Review of Safeguarding children and adults in mental health and learning disability hospitals.

The HSCB is preparing an implementation plan taking account of existing structural arrangements for dealing with safeguarding issues. This issue is included in the Risk Register for the Directorate of Social Care and Children.

9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the HSCB who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit and Governance Committees, and a plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

(a) Update on prior year control issues which have now been resolved and are no longer considered to be control issues

Community Pharmacy – Judicial Review

During 2011/12 Community Pharmacy Northern Ireland (CPNI) applied to the High Court of Justice in Northern Ireland for Judicial Review against the DHSSPS and the HSCB. The Court found in favour of the Applicant and its Order dated 7 February 2012 declared that:

i) The Respondents failed to carry out sufficient consultation and investigation to enable them to compile and publish a Drug Tariff which complies with the statutory objectives, including the objective of ensuring fair and reasonable remuneration for pharmacists, in particular, by failing to carry out any costs survey or any margins survey, and by failing to use available alternative powers to establish key information about the costs and profits of pharmacy businesses in NI;

ii) The Respondents failed to carry out sufficient consultation and investigation to enable them to identify the need for (and arrange for the implantation of) necessary adjustments to the English tariff model in light of conditions in NI, with the objective of ensuring fair and reasonable remuneration for pharmacists in NI;

iii) In the breach of the Applicant's legitimate expectation that a Regulatory Impact Assessment (RIA) would be conducted, the Department has erred in failing to carry out a RIA, and in disregarding paragraphs 1.6 and 1.7 of the RIA Guidance.

A notice of appeal was lodged and served on CPNI on 15 March 2012. A hearing in the Court of Appeal had been scheduled for 10 and 11 December 2012. Subsequently agreement was reached between DHSSPSNI/HSCB and the CPNI on 7 December 2012 and the Judicial Review and Cross Appeal were withdrawn. The agreement specifies that all parties now work collaboratively in the development of arrangements with respect to the community pharmacy contract and maintains the Drug Tariff. This collaborative working has commenced.

School of Dentistry, Belfast

In the second half of 2012/13 the HSCB has continued to work with the Action Planning Group of the Dental Hospital Inquiry. The HSCB has made sustained progress in the elements of the action plan for which it is responsible:

- Carry out a demand capacity analysis for Oral Medicine (OM): this analysis is complete and has identified a potential need for an additional NHS Consultant in OM from 2014 onwards. A funding bid for this post is currently in development.

- Examine referral pathways and criteria for OM: The HSCB has shared its proposals with all HSC Trust providers of OM care. It is hoped that OM referral criteria will be issued to all Northern Ireland General Dental Practitioners before the end of 2012/13.Review all OM patients seen in 2010 in the Belfast Trust: All 1850 patients who fell into this category have now been contacted and offered an appointment and all those who wished to be seen have been reviewed. Given the unpredictable nature of some OM conditions, a proportion of these patients will require to be reviewed for a prolonged period.

The SAI arising out of the additional case of late diagnosis of oral cancer referred to in the 30 September 2012 Assurance Statement has now been closed. A number of points for additional learning were noted from this SAI and the HSCB is working with the Belfast Trust to ensure these are implemented.

The HSCB continues to meet regularly with the Trust at the OM Clinical Governance Work Stream meetings. These meetings provide a forum for discussion on SAIs, OM service staffing issues and referral arrangements.

Modernisation of the Belfast Trust's OM service has formed one element of the Review Of Consultant-Led Hospital Dental Services undertaken by the DHSSPS. The HSCB has been closely involved the Review and has assisted DHSSPS with the provision of background information. It is expected that the Review will be published in the near future.

Endoscopy

Regionally at the end of January 2013, 511 patients were waiting longer than the 13 week maximum waiting time for endoscopy. This is a significant improvement on the position at the same time last year when 2,251 patients were waiting for more than 13 weeks. The improvement reflects the approach taken by the HSCB and HSC Trusts to ensure agreed levels of core activity are delivered, and where necessary for additional activity to be undertaken both within HSC Trust's and in the Independent Sector throughout 2012/13.

The position is expected to improve further by the end of March 2013 and has improved sufficiently to be no longer considered to be a control issue.

Child and Adolescent Mental Health (CAMH) services

Last year's SIC and the 2012/13 Mid-Year Assurance (MYAS) statement identified control issues in relation to CAMH services. In addition to this item the 2012/13 MYAS also included a new issue relating to Mental Health Access. For the reasons set out in the Mental Health Access item, the CAMHs element is no longer required to be a separate control issue and is now addressed within the overall mental health item which is set out below in section (c).

Pseudomonas

Following the RQIA–led independent review reports into the Pseudomonas outbreak in December 2011 and January 2012, the HSCB, working with PHA, established arrangements to take forward the implementation of relevant review recommendations. Almost all recommendations have now been implemented and one is in the final stages of completion. HSC Trusts are highlighting significant cost pressures as a result of the new requirements; these are being considered within financial and commissioning processes.

Information Security

The 2011/12 Statement of Internal Control advised that the HSCB had received an investigation report following an information security incident concerning the unauthorised removal of documents containing personal information about individuals and staff. The report detailed measures to strengthen information governance arrangements and minimise the potential for any recurrence of the information security incident. Following consideration of the report a number of actions were identified and included in the HSCB's Information Governance Action Plan for 2012/13. Progress on the action plan has been monitored via normal reporting mechanisms which include the Information Governance Steering Group, SMT and the HSCB Governance Committee and in that respect it is no longer considered a control issue.

Southern Cross Care Homes

A multi agency planning group was established, chaired by HSCB, to manage the transfer of homes from Southern Cross to alternative providers due to a solvent wind down of their operations. The homes were successfully transferred within the required timescale and there were no detrimental effects to the residents or staff.

The potential of failure by another provider is now included on the HSCB's Corporate Risk Register. There are action plans in place and these are due for review in June 2013.

Breach of Social Care Statutory Functions

New monitoring arrangements have been agreed with HSC Trusts in respect of previous breaches of Social Care Statutory Functions. These new arrangements were reviewed by Internal Audit in July 2012 and the new systems are operating satisfactorily. There are no remaining control issues.

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

Quality, Quantity and Financial Controls

This issue reflects the continued difficulties faced by the HSCB in fully commissioning and supporting the level of services provided for in the SBA's with providers.

In 2012/13 the financial constraints in the HSC sector continued to be rigorously monitored by the HSCB. The financial controls which were implemented in 2011/12 impacted on the commissioning and performance agendas within the HSC sector. These were subject of close working with all affected organisations to address any difficulties which arose and this has continued during 2012/13.

Looking forward, the model of health and social care which will drive the future shape of the service is now available through TYC. However, for 2013/14 there will continue to be a significant challenge for the HSC in delivering financial balance, whilst at the same time maintaining the integrity of services and driving forward the transition necessary to effect the long term reforms required.

The actions taken in 2012/13, with respect to financial planning and associated efficiency plans, will contribute towards mitigating the qualitative risks associated with managing services within a constrained budget.

Elective care

Regionally the 50% (60% by March 2013) standards for outpatient and for inpatient/daycase services have been maintained during 2012/13. At the end of January 2013, 9,209 patients were waiting longer than the maximum waiting time of 18 weeks for outpatient services and 4,833 patients were waiting longer than the inpatient/daycase maximum waiting time of 30 weeks.

This reflects a considerable improvement compared to the same period in 2011/12, and notably the approaches taken by the HSCB during 2012/13 have prevented the levels of increase seen during the first three quarters of 2011/12.

Based on the detailed examination of demand and capacity in all elective specialties, the HSCB provided additional funding to HSC Trusts during 2012/13 to undertake additional activity – both in-house and in the independent sector – to meet any gaps in capacity and/or reduce the backlog of patients waiting. The HSCB has monitored closely the delivery by HSC Trusts of agreed levels of core capacity and additional activity to ensure the improvement in waiting times. In parallel, the HSCB is making targeted recurrent investments to expand health service capacity to meet demand.

The overall trend remains an improving one and further improvements in waiting times are expected by the end of March 2013 as HSC Trusts undertake the volumes of core and additional activity agreed with the HSCB. There will however, be a small number of specialties at end of March where the waiting times will be longer than the Ministerial maximum waiting time targets and these have been escalated with HSC Trusts to ensure all actions are taken to achieve the best possible position at the end of March.

The HSCB will continue to monitor the position closely through the fortnightly elective performance management meetings.

A&E (4 and 12 hour performance standards)

Regionally, performance against the 4-hour and 12-hour A&E standards continues to be well below the level required. There has been a significant improvement in performance against the 12-hour standard during the past year, however it is unacceptable for any patients to wait longer than 12 hours and addressing this has been, and will continue to be a top priority for the HSCB working with colleagues in the PHA.

The majority of breaches of the 12-hour standard during this time have been in Northern (48%) and South Eastern (41%) Trusts. There has been a significant improvement in the position of Belfast Trust during 2012/13.

Cumulatively across the region to the end of January 2013, 80% of patients were treated and discharged, or admitted within four hours of their arrival in A&E. While the focus during 2012/13 has been on eliminating 12 hour breaches, the Emergency Care Improvement Action Group (IAG) established by the HSCB and PHA to address the excessive waiting times experienced by patients in a number of Emergency Departments is supporting HSC Trusts to develop sustainable approaches to managing patient flow including actions taken to improve key performance and quality measures including:

- 4-hour performance
- 12-hour performance
- ambulance turnaround times
- delivery of key process improvements including effective discharge
- arrangements
- patient experience.

The HSCB and IAG have carried out an analysis of changes in demand within the South Eastern Trust's Ulster Hospital and has made further investment to meet the changes in demand. Work has commenced to undertake a similar demand capacity analysis in the Northern Trust. The IAG is supporting the Trust in the redesign of its unscheduled care admission pathway and the community services response to unscheduled care demand.

Cancer services

HSC Trusts should ensure that at least 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

Performance has been below the 95% standard in all HSC Trusts during 2012/13 to the end of January 2013. However following a renewed focus on this important issue during 2012/13 performance has improved in recent months. Regionally, in the year to end of January 2012, 81% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days.

The HSCB has put new arrangements in place to monitor HSC Trusts' performance in relation to cancer access waiting times. It meets with HSC Trusts on a fortnightly basis with a specific focus on ensuring that the longest waiting patients are treated and good progress is being made on this milestone.

The HSCB has also made investment into specific areas of service pressure including thoracic surgery in Belfast Trust and chemotherapy services in South Eastern Trust.

HSC Trusts have cited increased levels of 'red flag' urgent referrals from GPs as a factor impacting on performance. Revised guidance on approaches to 'red flag' referrals has been developed by the HSCB in collaboration with the Northern Ireland Cancer Network (NICaN) and issued to GPs and HSC Trusts.

Further improving performance in this important area in line with the Minister's standard will continue to be a priority in 2013/14.

Children's Services Unallocated Cases

The number of unallocated cases continues to be an area of concern.

The HSCB worked with HSC Trust's through the Children's Service Improvement Programme (involving the five Trust Directors of Social Care and Children, and the HSCB's Directors of Social Care and Children, Performance management and Service Improvement and Finance) to address this issue.

The HSCB, through the Children's Services Improvement Programme Board, agreed profiled reduction plans for unallocated cases with all HSC Trust's which proposed that unallocated cases would be substantially reduced during the first two quarters of 2012/13. Performance against this plan was monitored on a monthly basis. The HSCB continued to monitor to ensure that this progress was maintained in 1012/13. Despite the progress noted and a reduction in the number of unallocated cases progress has slowed and the number remains too high.

Work on establishing consistent thresholds continues and there has been additional investment into Family Support Hubs. As this work develops there should be an increase for early support and signposting which should have an impact on referrals and consequently the number of unallocated cases. The issue remains on the HSCB Corporate Risk Register.

Northern HSC Trust performance

The 2011/12 Statement on Internal Control (SIC) highlighted issues in relation to operational performance and finance issues within Northern Trust. The key performance areas where there continues to be control issues are in relation to A&E, cancer and children's services. These are being addressed as part of the actions for these specific control items above.

The Minister has appointed a turnaround team to complete a strategic overview of the Trust in order to establish what changes and support may be required to accelerate progress.

In May 2013 the Minister announced new management arrangements in the Northern Trust to take forward the next stage of the turnaround process and secure improvements in key performance issues. This resulted in the secondment of the HSCB Director of Finance to the Trust for a period of up to 12 months and an Acting Director of Finance has been appointed.

Interruption of ICT services

The 2011/12 SIC included issues arising from an interruption to ICT services in January 2012. The Mid-Year Assurance Statement set out the actions taken in response to this, including that Gartner (one of the world's leading information technology research and advisory companies) had carried out an overarching review of the operational processes for the Data Centres and the recommendations from major suppliers. Gartner's recommendations fell into three main areas;

- Improve the overall Disaster Recover processes and technologies. This includes implementing the recommendations made by IBM and HP, and improving the detailed documentation covering all facets of the technical infrastructure environment, including architectural diagrams;
- Restructure the BSO ITS organisational design, removing management layers and separating the planning and design roles from the operational management and delivery roles;
- Develop clear governance documentation describing the agreed roles and responsibilities of HSCB and BSO ITS.

A number of work streams have been identified from these recommendations. The technical aspects of the Gartner Review are in the process of implementation and work has commenced on the organisational review of BSO ITS.

Overall, the robustness of the ICT services provided to HSCB by BSO ITS have improved over the past nine months, although with occasional estates issues which are under the control of the Estates Dept in BHSCT. BSO ITS is in the final stages of agreeing a Service Level Agreement with BHSCT Estates Department that is expected to reduce the number of outages.

Paediatric Congenital Cardiac Services (PCCS)

Following an external review in 2012, the HSCB and PHA undertook a public consultation to inform the Minister's decision on the future provision of paediatric cardiac surgery and interventional cardiology for the population of Northern Ireland.

At a special meeting of the HSCB Board in April 2013, a preferred option for the future commissioning arrangements was approved. The preferred option is one in which paediatric cardiac surgery will primarily be commissioned from Dublin. A preferred option paper has been submitted to the DHSSPS and a Ministerial decision is awaited.

Risk minimisation, namely adjustment to the complexity of surgery undertaken within the Belfast Trust, has been put in place as an interim measure. Monitoring arrangements have been established and will continue pending a decision on the way forward and, subject to that decision, subsequent implementation of new commissioning arrangements.

Co-operation and Working Together (CAWT)

In May 2012, the CAWT Management Board received the findings of an external governance review undertaken the Institute of Public Administration (IPA). The governance review sought to address issues raised in the earlier BSO Internal Audit and recognising the considerable reorganisation of health service organisations on both sides of the Border.

The IPA recommendations were largely accepted by the CAWT Management Board and an action plan was developed whereby the partnership's policies and practices would be incorporated in an Operational Governance Manual (OGM).

Internal Audit reviewed the governance arrangements in 2012/13 and noted that the formal governance arrangements had not yet been finalised and approved at the CAWT Management Board, resulting in a limited assurance.

Post 31 March 2013, the HSCB continued to work closely with members of the CAWT Management Board and Secretariat to strengthen existing governance structures and processes consistent with the control environment in which the HSCB operates, and a revised OGM addressing the outstanding issues was approved by the CAWT Management Board on 30 May 2013.

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

Mental Health Access-child and adolescent/adult (9 and 13 weeks)
HSC Trusts are required to ensure that from April 2012 no patient waits longer than nine weeks to access child and adolescent (CAMH) or adult mental health services and that no patient waits longer than 13 weeks for psychological therapies.

Regionally at the end of January 2013, 380 patients were waiting longer than nine weeks to access treatment. The majority of these patients were waiting for adult mental health services with a small number (49) waiting for CAMH services.

The 49 patients waiting more than nine weeks for CAMH services compares to 153 patients at the same point in 2011/12.

Investment has been made to support the development of CAMHS across the region by targeting development of Crisis Resolution and Home Treatment Teams and Primary Mental Health Workers in all HSC Trusts. The improvement also reflects a number of service improvement actions agreed with HSC Trusts together with the use of providers from community and voluntary sectors to enhance capacity.

The majority of patients waiting for adult mental health services were within the Southern Trust. The HSCB has allocated recurrent funding to allow Southern Trust to appoint additional staff to the service team and it is expected that this will deliver further improvements in the waiting time position by March 2013.

In relation to psychological therapies, regionally at the end of January 2013, 535 patients were waiting longer than 13 weeks from referral to assessment and commencement of treatment. The majority of breaches of the 13-week maximum waiting time standard at the end of January were in Belfast (213) and Southern (211) Trusts.

Of the 213 breaches in Belfast Trust, 129 were in adult health psychology services. The HSCB has been working with the Trust to remodel the psychological service particularly with regard to pain, HIV and cancer services. Further recurrent investment has been provided for health psychology services and the Trust is currently recruiting additional staff. Non-recurrent funding has also been provided to enable the Trust to undertake additional in-house activity and it is expected that this will result in an improved waiting time position by end of March 2013.

In relation to the position in the Southern Trust, the majority of the breaches (201) of the 13-week standard have been in adult health psychology services. The HSCB has allocated recurrent funding to enhance primary mental health services and psychologist input to pain management services.

The HSCB is also providing additional non recurrent funding to provide psychological therapy trauma counselling. Recruitment is currently underway for the pain management service and an improved position is expected by the end of March 2013.

Resettlement

While there had been limited progress against the resettlement targets in the first half of this year, there has been an increased number of resettlements completed since November 2012 – regionally at the end of January 2013, 21 long stay mental health patients and 28 long-stay learning disability patients have been resettled from hospital to appropriate places in the community.

HSC Trusts have submitted action plans setting out the number of resettlements to be completed by March 2013 and in each of the next two years to ensure achievement of the target that all long stay mental health and learning disability patients are resettled by 31 March 2015. Achievement of these plans is expected to deliver a significantly improved position by end of March 2013.

The HSCB has established a new Steering Group, co-chaired by the HSCB's Director of Social Care and Children and the Northern Ireland Housing Executive, to oversee this process and enhanced performance management arrangements have been put in place to monitor progress.

Healthcare Acquired Infection (HCAI) -C.Difficile

Regionally the 2012/13 target to have no more than 313 C. difficile infections has not been achieved. At the end of January 2013, there have been 354 C. difficile infections. All HSC Trusts, with the exception of South Eastern Trust, have exceeded their target levels for 2012/13. The HSCB supports the PHA on HCAI matters. The PHA is continuing to work closely with all HSC Trusts to take forward work to reduce the number of HCAIs. The emphasis is on ensuring that all required processes are being followed, that root cause analysis is carried out and that assurance systems are robust.

Securing of TYC Transitional Funding

A delay in the provision of transitional funding could negatively affect the timescale for implementing TYC proposals. The Executive awarded Invest to Save monies of £19m in respect of transitional funding for TYC (£13m) and other HSC savings initiatives (£6m) in 2012/13. There are four elements to the TYC funding: ICPs, Service change, VR/VER and Implementation costs. A significant element of this funding invested in 2012/13 has a recurrent requirement into 2013/14 and 2014/15. We continue to engage with the DHSSPS and DFP to seek to secure the most appropriate source of funding for the next two years. A strategic Business Case for the "Implementation of a system-wide transformation programme following the Review of Health and Social Care in Northern Ireland 2011" with a detailed analysis of full transitional funding requirements was submitted to DHSSPS and DFP for review in November 2012. This was approved by DFP on 10 April 2013 subject to a number of conditions being complied with.

Implementation of Transforming Your Care (TYC)

A lack of consensus on the implementation of TYC may impede delivery of the reforms which are necessary to both assure the quality and safety of health and social care services and to achieve financial break even in the longer term. This has been mitigated through regular dialogue and collaboration across a range of stakeholders within and out with HSC organisations. This has included a 14 week period of consultation on key service changes which demonstrated strong endorsement of the need for change and the proposed service changes. The Minister for Health updated the Northern Ireland Assembly on 19 March on the outcome of the consultation and provided a political mandate for the implementation of TYC. Arrangements are in place for ongoing communications and engagement planning and execution, working closely with the DHSSPS and across the HSC organisations, to further mitigate this issue as we move forward with implementation and local consultation for the service changes.

Business Services Transformation Project

During 2012/13 two new computer systems, were to be introduced by the Business Services Organisation (BSO) across all Health and Social Care (HSC) organisations as part of the Business Services Transformation Program (BSTP). These were Finance, Procurement and Logistics (FPL) and Human Resources, Payroll and Travel (HRPTS). The HSCB was selected to be included in the first phase of the roll out of these systems.

Since roll out, significant difficulties have been encountered over a range of areas. Particular areas of concern include:

- Knowledge and experience of the new system
- Payroll controls
- Payment controls and performance (including Prompt Payment)
- Stock accounting
- Coding and reporting
- Account reconciliations

The issues highlighted, which are not solely within the Board's control, have resulted in Internal Audit providing limited assurance in relation to the associated financial processes. Detailed corrective action plans have been developed locally in conjunction with BSO and regionally by the BSTP regional team in order to resolve the issues identified.

In order to manage and mitigate the most serious risks to financial control, a series of interim additional processes and controls have been introduced by HSCB financial management until the issues are resolved to the HSCB's satisfaction.

Statutory Residential Homes

The Minister has asked HSCB to lead the co-ordination of proposals in respect of the future of statutory residential homes. This work will be undertaken in partnership with HSC Trusts to ensure that the needs of residents are prioritised and managed with sensitivity. A regional group has been established and project plans are being developed.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

The Mid-Year Assurance Statement identified three new issues which, for the reasons set out below, are no longer considered to be control issues

Radiology-Plain film reporting

The 2011/12 SIC explained that the plain film x-ray issue in Belfast Trust should no longer be considered a control issue. However the Mid-Year Assurance Statement advised that in June 2012 the HSCB became aware through SAI reported by the Belfast Trust that the Trust had identified that up to 17,500 plain films dating back to 2007 had been read but not formally reported on.

The Trust has confirmed that all of these reports have now been reported on and that there have been no critical or unexpected significant findings within this group of patients. The SAI was overseen by the PHA who has advised that it has now been closed as it is content with the Trust's review and actions taken. The matter is therefore no longer considered to be a control issue.

Independent Health and Care Providers NI (IHCP NI) – Judicial Review

In July 2012 solicitors acting for IHCP NI made application for leave to apply for a judicial review. The application concerns the procedure adopted, and decision taken, by the HSCB in agreeing uplift on the tariff for residential and nursing homes in 2012/13. IHCP was granted leave and a hearing was listed for 28 January 2013.

The grounds of challenge were summarised as follows:

- Failure to comply with, justify departure from or properly take account of, the terms of Departmental Circular ECCU 1/2010 (the Guidance argument);
- Failure to take account of the potential effect of the decision on Article 8 rights (the Convention argument); and
- Failure to adequately consult the Applicant (the consultation argument).

After consideration the conclusion reached by Mr Justice Treacy was to reject all the grounds of challenge and dismiss the judicial review on 23 January 2013.

ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013
GOVERNANCE STATEMENT

Belfast Trust Performance

Following the decision by the Minister in April 2012 to introduce enhanced oversight arrangements for the Belfast Trust, the Board has worked closely with both the Department and the Trust to ensure that progress in the specific areas highlighted by the Department.

Following progress made by the Trust in addressing specific areas of concern, the Minister relaxed these arrangements in November 2012. The Board continues to closely monitor the Trust's performance as part of normal arrangements.

11. Conclusion

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

Further to considering the accountability framework within the Body and in conjunction with assurances given to me by the Head of Internal audit, I am content that the HSCB has operated a sound system of internal governance during the period 2012/13.

Mr John Compton
Accounting Officer and Chief Executive

Date 

HEALTH AND SOCIAL CARE BOARD

STATEMENT OF COMPREHENSIVE NET EXPENDITURE for the year ended 31st March 2013

	NOTE	2013 £000s	2012 £000s
Expenditure			
Staff costs	3.1	(23,572)	(21,411)
Depreciation	4.3	(2,388)	(2,738)
Other Expenditure	4.0	(937,477)	(944,782)
		(963,437)	(968,931)
Income			
Income from activities	5.1	46,861	45,076
Other Income	5.2	1,223	1,363
Deferred Income	5.3	0	0
		48,084	46,439
Net Expenditure		**(915,353)**	**(922,492)**
Revenue Resource Limit (RRL) Issued (to)			
Belfast HSC Trust		(1,079,274)	(1,041,743)
South Eastern HSC Trust		(474,470)	(466,913)
Southern HSC Trust		(488,506)	(464,946)
Northern HSC Trust		(547,898)	(536,190)
Western HSC Trust		(473,531)	(454,481)
NIAS HSC Trust		(57,449)	(57,445)
NIMDTA		(1,160)	(1,135)
RQIA		0	(22)
Total RRL issued		(3,122,288)	(3,022,875)
Total Commissioner resources utilised		(4,037,641)	(3,945,367)
Revenue Resource Limit (RRL) received from DHSSPS	25.1	4,037,873	3,945,475
Surplus / (Deficit) against RRL		**232**	**108**

OTHER COMPREHENSIVE EXPENDITURE

	NOTE	2013 £000s	2012 £000s
Net (loss) on revaluation of Property, Plant and Equipment	6.1/6.2/10	(982)	(3,637)
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March 2013		**(916,335)**	**(926,129)**

The notes on pages 100 to 141 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

STATEMENT of FINANCIAL POSITION as at 31 March 2013

	NOTE	2013 £000s	2013 £000s	2012 £000s	2012 £000s
Non Current Assets					
Property, Plant and Equipment	6.1/6.2	15,730		17,409	
Intangible assets	7.1/7.2	903		1,369	
Financial Assets	8	0		0	
Trade and other Receivables	12	0		0	
Other Current Assets	12	0		0	
Total Non Current Assets			16,633		18,778
Current Assets					
Assets classified as held for sale	9	0		0	
Inventories	11	1		7	
Trade and other Receivables	12	10,437		5,519	
Other current assets	12	31		2,232	
Financial Assets	8	0		0	
Cash and cash equivalents	13	3,859		3,302	
Total Current Assets			14,328		11,060
Total Assets			30,961		29,838
Current Liabilities					
Trade and other Payables	14	(189,885)		(217,146)	
Other Liabilities	8	0		0	
Provisions	16	(14,546)		(20,294)	
Total Current Liabilities			(204,431)		(237,440)
Non Current Assets plus/less Net Current Assets/Liabilities			**(173,470)**		**(207,602)**
Non Current Liabilities					
Provisions	16	(40,305)		(27,369)	
Other Payables > 1 yr	14	0		0	
Financial Liabilities	8	0		0	
Total Non Current Liabilities			(40,305)		(27,369)
Assets Less Liabilities			**(213,775)**		**(234,971)**
Taxpayers' Equity					
Revaluation Reserve		6,857		7,839	
SoCNE Reserve		(220,632)		(242,810)	
			(213,775)		**(234,971)**

The notes on pages 100 to 141 form part of these accounts.

Signed Ian Clements (Chairman) Date 18.6.13

Signed John Compton (Chief Executive) Date 18.6.13

HEALTH AND SOCIAL CARE BOARD

STATEMENT OF CASH FLOWS for the year ended 31 March 2013

	Note	2013 £000s	2012 £000s
Cash flows from operating activities			
Net expenditure after cost of capital and interest		(915,353)	(922,492)
Adjustments for non-cash costs	4	18,420	12,537
(Increase) in trade & other receivables	12	(2,716)	(2,356)
Decrease in inventories	11	6	1
Increase/(Decrease) in trade payables	14	(27,260)	15,509
Movement in payables relating to property, plant and equipment	14	359	(1,245)
Use of provisions	16	(8,130)	(7,476)
Net cash outflow from operating activities		(934,674)	(905,522)
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(2,226)	(1,162)
Purchase of Intangible Assets	7	(17)	(320)
Net Cash (Outflow) from investing activities		(2,243)	(1,482)
Cash flows from financing activities			
Grant in aid		937,474	910,204
Net financing		937,474	910,204
Net increase in cash and cash equivalents in the period		557	3,200
Cash and cash equivalents at the beginning of the period	13	3,302	102
Cash and cash equivalents at the end of the period	13	**3,859**	**3,302**

The notes on pages 100 to 141 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

STATEMENT OF CHANGES IN TAXPAYERS EQUITY for the year ended 31 March 2013

	Note	SoCNE Reserve £000s	Revaluation Reserve £000s	Total £000s
Balance at 31 March 2011		(230,583)	11,476	(219,107)
Balance at 1 April 2011		**(230,583)**	**11,476**	**(219,107)**
Changes in Taxpayers' Equity 2011/12				
Grant from DHSSPS		910,204	0	910,204
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(922,492)	(3,637)	(926,129)
Transfer of Asset Ownership	6.2	4	0	4
Non-cash charges-auditors remuneration	4	57	0	57
Balance at 31 March 2012		**(242,810)**	**7,839**	**(234,971)**
Changes in Taxpayers Equity 2012/13				
Grant from DHSSPS		937,474	0	937,474
Transfers between reserves		0	0	0
(Comprehensive expenditure for the year)		(915,353)	(982)	(916,335)
Transfer of Asset Ownership	6.1	0	0	0
Non-cash charges-auditors remuneration	4	57	0	57
Balance at 31 March 2013		**(220,632)**	**6857**	**(213,775)**

The notes on pages 100 to 141 form part of these accounts.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

STATEMENT OF ACCOUNTING POLICIES

1.0 Authority

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

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

1.1 Accounting convention

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

1.2 Currency and Rounding

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

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise Land, Buildings, Dwellings, Transport Equipment, Plant & Machinery, Information Technology, Furniture & Fittings, and Assets under construction.

Recognition

Property, plant and equipment must be capitalised if:

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

- it is probable that future economic benefits will flow to, or service potential will be supplied to, the HSCB;

- it is expected to be used for more than one financial year;

● the cost of the item can be measured reliably; and

● the item has cost of at least £5,000; or

● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

● Items form part of the initial equipping and setting-up cost of a new unit, irrespective of their individual or collective cost.

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

Valuation of Land and Buildings

The last valuation was carried out as at 31 March 2012 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance and Personnel. The valuers are qualified to meet the 'Member of Royal Institution of Chartered Surveyors' (MRICS) standard.

Land and buildings used for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

● Land and non-specialised buildings – open market value for existing use;

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

Modern Equivalent Asset

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

Assets Under Construction

The HSCB had no Assets Under Construction in 2012/13 or 2011/12.

Short Life Assets

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

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

Revaluation Reserve

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

1.4 Depreciation

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

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

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

1.5 Impairment loss

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

1.6 Subsequent Expenditure

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

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

1.7 Intangible assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, Patents, Goodwill and Intangible Assets under Construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the HSCB's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the HSCB; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised, while intangible assets which fall within the grouped asset definition must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

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

1.8 Donated Assets

The HSCB had no donated assets in either 2012/13 or 2011/12.

1.9 Non-current assets held for sale

The HSCB has no non-current assets held for sale in either 2012/13 or 2011/12.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.11 Income

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

Grant in aid

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

1.12 Investments

The HSCB did not have any investments in either 2012/13 or 2011/12.

1.13 Other expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The HSCB as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the HSCB's surplus or deficit.

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

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

The HSCB as lessor

The HSCB did not have any lessor agreements in either 2012/13 or 2011/12.

1.16 Private Finance Initiative (PFI) transactions

The HSCB had no PFI transactions in either 2012/13 or 2011/12.

1.17 Financial instruments

Financial assets

Financial assets are recognised on the Statement of Financial Position when the HSCB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial liabilities

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

Financial risk management

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

Currency risk

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

Interest rate risk

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

Credit and Liquidity risk

Since the HSCB receives the majority of its funding from the Department of Health Social Services and Public Safety, it has low exposure to credit risk and is not exposed to significant liquidity risks.

1.18 Provisions

In accordance with IAS 37, Provisions are recognised when the HSCB has a present legal or constructive obligation as a result of a past event, it is probable that the HSCB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using Department of Finance and Personnel's discount rates of -1.8% (1-5 years), -1.0% (>5-10 years), 2.2%(>10 years) or 2.8% in the case of pensions provisions, in real terms.

The HSCB has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the effect of any change in the discount rate.

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

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

A restructuring provision is recognised when the HSCB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Contingencies

Under IAS 37**,** the HSCB discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the HSCB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.20 Employee benefits

Short-term employee benefits

Under the requirements of IAS 19: Employee Benefits, staff costs must be recorded as an expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave that has been earned at the year end. This cost has been estimated using average staff numbers and costs applied to the average untaken leave balance determined from the results of a survey to ascertain leave balances as at 31 March 2008, and reviewed by way of a sample survey on an annual basis thereafter. It is not anticipated that the level of untaken leave will vary significantly from year to year. Untaken flexi leave is estimated to be immaterial to the HSCB and has not been included.

Retirement benefit costs

The HSCB participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Board and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Board is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

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

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the statement of financial position date and updates it to reflect current conditions. The 31 March 2008 valuation will be used in the 2012/13 accounts.

1.21 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments.

1.22 Value Added Tax (VAT)

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of Property Plant and Equipment.

1.23 Third Party Assets

The Board had no third party assets in 2012/13 or 2011/12.

1.24 Government Grants

The Board had no Government grants in either 2012/13 or 2011/12.

1.25 Losses and Special Payments

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

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

1.26 Accounting Standards that have been issued but have not yet been adopted

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

Management has reviewed the new accounting policies that have been issued but are not yet effective, nor adopted early for these accounts. Management consider that these are unlikely to have a significant impact on the accounts in the period of the initial application.

1.27 Changes in Accounting Policy/Prior Year Restatement

There were no changes in Accounting Policy during 2012/13.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 2. ANALYSIS of NET EXPENDITURE by SEGMENT

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

Summary

	Note	2013	2012
Net Expenditure		**£'000s**	**£'000s**
Commissioning	2.1	3,155,218	3,058,203
FHS	2.2	804,756	818,723
Board Administration	2.3	77,667	68,441
Total Commissioner Resources utilised		**4,037,641**	**3,945,367**

2.1 Commissioning

Expenditure			
Belfast HSC Trust	SoCNE	1,079,274	1,041,743
South Eastern HSC Trust	SoCNE	474,470	466,913
Southern HSC Trust	SoCNE	488,506	464,946
Northern HSC Trust	SoCNE	547,898	536,190
Western HSC Trust	SoCNE	473,531	454,481
NIAS HSC Trust	SoCNE	57,449	57,445
NIMDTA	SoCNE	1,160	1,135
RQIA	SoCNE	0	22
Other providers	4.1	59,273	61,372
		3,181,561	**3,084,247**
Income			
Income from activities	5.1	26,343	26,044
		26,343	**26,044**
Commissioning Net Expenditure		**3,155,218**	**3,058,203**

2.2 FHS

Expenditure			
General Medical Services	4.1	221,750	221,502
General Dental Services	4.1	120,277	113,613
General Pharmaceutical Services	4.1	461,427	482,025
General Ophthalmic Services	4.1	21,820	20,615
		825,274	837,755
Income			
FHS Receipts & Recovery of Charges	5.1	20,518	19,032
FHS Net Expenditure		**804,756**	**818,723**

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

2.3 Board administration

	Note	2013 £'000s	2012 £'000s
Expenditure			
Salaries and Wages	3.1	23,572	21,411
Operating Expenditure	4.2	36,898	35,856
Non Cash Costs	4.3	15,548	9,289
Depreciation	4.3	2,872	3,248
		78,890	69,804
Income			
Staff Secondment Recoveries	3.1	367	285
Operating Income	5.2	856	1,078
		1,223	1,363
Board Administration Net Expenditure		**77,667**	**68,441**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.1 Staff Costs

Staff costs comprise:

	2013			2012
	Permanently employed staff	Others	Total	Total
	£000s	£000s	£000s	£000s
Wages and salaries	17,716	1,727	19,443	17,871
Social security costs	1,518	174	1,692	1,412
Other pension costs	2,215	222	2,437	2,128
Sub-Total	21,449	2,123	23,572	21,411
Capitalised staff costs	0	0	0	0
Total staff costs reported in Statement of Comprehensive Expenditure	21,449	2,123	23,572	21,411
Less recoveries in respect of outward secondments			367	285
Total net costs			**23,205**	**21,126**

Staff Costs exclude £Nil charged to capital projects during the year (2012 £Nil)

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

3.2 Average number of persons employed

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

	2013			2012
	Permanently employed staff	Others	Total	Total
	No.	No.	No.	No.
Commissioning of Health and Social Care	443	46	489	463
Less average staff number in respect of outward secondments	6	0	6	5
Total net average number of persons employed	**437**	**46**	**483**	**458**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.3a Senior Employees' Remuneration

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

	2012/13			2011/12			2012/13				
Name	Salary £000s	Bonus / Performance pay £000	Benefits in Kind (Rounded to nearest £100)	Salary £000s	Bonus / Performance pay £000	Benefits in Kind (Rounded to nearest £100)	Real increase in pension and related lump sum at age 60 £000s	Total accrued pension at age 60 and related lump sum £000s	CETV at 31/03/11 £000s	CETV at 31/03/12 £000s	Real increase in CETV £000s
Non-Executive Members											
I Clements	30-35	0	200	30-35	0	200	0	0	0	0	0
S J Leach	5-10	0	100	5-10	0	100	0	0	0	0	0
M McCullough	5-10	0	100	5-10	0	100	0	0	0	0	0
R Gilmore	5-10	0	200	5-10	0	200	0	0	0	0	0
B McKeever	5-10	0	100	5-10	0	100	0	0	0	0	0
J Mone	5-10	0	300	5-10	0	300	0	0	0	0	0
W R Thompson	5-10	0	0	5-10	0	0	0	0	0	0	0
E Kerr (01/04/12 - 19/07/12)	0-5	0	0	5-10	0	100	0	0	0	0	0
Executive Members											
J Compton	145-150	0	0	140-145	0	1,800	0	70 - 75 pension 200 - 205 lump sum	0	0	0
P Cummings	105-110	0	1,100	105 - 110	0	1,600	0 - 2.5 pension 2.5 - 5 lump sum	35 - 40 pension 115 - 120 lump sum	656	708	15
F E McAndrew	80-85	0	0	80 - 85	0	300	0 - 2.5 pension 0 - 2.5 lump sum	15 - 20 pension 50 - 55 lump sum	357	391	13
S Harper	115-120	0	900	115 - 120	0	700	0 - 2.5 pension 0 - 2.5 lump sum	40 - 45 pension 125 - 130 lump sum	770	815	5
D Sullivan	100-105	0	800	100 - 105	0	800	0 - 2.5 pension	0 - 5 pension	34	54	18
M Bloomfield (Head of Corporate Services & acting Director of PMSI since 19/11/12)	80-85	0	0	75 - 80	0	300	0 - 2.5 pension 2.5 - 5 lump sum	20 - 25 pension 70 - 75 lump sum	355	390	15
P McCreedy* (appointed 01/05/12)	65-70	0	0	0	0	0	0	0	0	0	0
L McMahon (01/04/12 - 31/10/12 - seconded to the Leadership Centre from 01/11/12)	60-65	0	100	105 - 110	0	300	0 - 2.5 pension 0 - 2.5 lump sum	10 - 15 pension 25 - 30 lump sum	165	204	24

* No real increase figures available as appointment within this financial year.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.3a Senior Employees Remuneration continued

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines prescribed by the institute and Faculty of Actuaries.

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

3.3b Median Salary

	2013 **£**	**2012** **£**
Band of Highest paid Director Total Remuneration	147,500	142,500
Median Salary	31,206	31,787
Median Total Remuneration Ratio	**4.7**	**4.5**

There has been no significant change to the ratio mainly due to the continuing public sector pay freeze.

NOTE 3. STAFF NUMBERS AND RELATED COSTS

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

Exit package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2013	2012	2013	2012	2013	2012
<£10,000	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	1	0	1
£25,000 - £50,000	0	0	1	6	1	6
£50,000 - £100,000	0	0	0	5	0	5
£100,000- £150,000	0	0	0	5	0	5
£150,000- £200,000	0	0	0	1	0	1
> £200,000	0	0	0	1	0	1
Total number of exit packages by type	**0**	**0**	**1**	**19**	**1**	**19**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total resource cost	**0**	**0**	**25**	**1,648**	**25**	**1,648**

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation Act 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at note 4. Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 3. STAFF NUMBERS AND RELATED COSTS

3.5 Staff Benefits

The HSCB had no staff benefits in 2012/13 or 2011/12.

3.6 HSCB Management Costs

	2013 £000s	2012 £000s
HSCB Management Costs	29,489	28,635
Income:		
RRL	4,037,873	3,945,475
Less non cash RRL excluding element to cover clinical negligence provision	(18,420)	(12,537)
Income per Note 5	48,084	46,439
Total Income	4,067,537	3,979,377
% of total income	**0.72%**	**0.72%**

The Management Costs have been prepared on consistent basis from previous years and have been based on the appropriate HSCB elements contained in the circular HSS (THR) 2/99.

3.7 Retirements due to ill-health

During 2012/13 there were 3 early retirements from the HSCB, agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £25K pa. These costs are borne by the HSC Pension Scheme.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 4. OPERATING EXPENSES

4.1 Commissioning	**2013 £000s**	**2012 £000s**
General Medical Services	221,750	221,502
General Dental Services	120,277	113,613
General Pharmaceutical Services	461,427	482,025
General Ophthalmic Services	21,820	20,615
NHS Trusts	20,487	20,097
Other providers of healthcare and personal social services	38,786	41,275
Total Commissioning	**884,547**	**899,127**
4.2 Operating Expenses are as follows:		
Supplies and services - General	610	651
Establishment	33,904	32,869
Transport	10	7
Premises	2,316	2,270
Bad debts	3	3
Rentals under operating leases	55	55
Interest charges	0	1
Total Operating Expenses	**36,898**	**35,856**
4.3 Non cash items		
Depreciation	2,388	2,738
Amortisation	484	510
Impairments	0	0
Loss on disposal of property, plant & equipment (including land)	173	53
Provisions provided for in year	14,137	8,170
Cost of borrowing of provisions (unwinding of discount on provisions)	1,181	1,009
Auditors remuneration	57	57
Total non cash items	**18,420**	**12,537**
Total	**939,865**	**947,520**

During the year the HSCB purchased the following non audit services from its auditor (NIAO).
The fee for this National Fraud Initiative (NFI) work was £1,119 and is included within operating costs above.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 5. INCOME

5.1 Income from Activities

	2013	2012
	£000s	£000s
Income from Department of Education	22,499	21,739
CAWT	3,060	3,862
Family Health Services Receipts	20,518	19,032
Other Income	784	443
Total	**46,861**	**45,076**

5.2 Other Operating Income

	2013	2012
	£000s	£000s
Accommodation	670	788
Canteen	186	174
Seconded staff	367	285
Charitable and other contributions to expenditure	0	116
Total	**1,223**	**1,363**

5.3 Deferred income

Income released from conditional grants	0	0
Total	**0**	**0**

TOTAL INCOME	**48,084**	**46,439**

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 6. PROPERTY, PLANT AND EQUIPMENT

NOTE 6.1 Property, plant & equipment - year ended 31 March 2013

	Land £000s	Buildings (excluding dwellings) £000s	Plant and Machinery (Equipment) £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation						
At 1 April 2012	3,026	7,639	6	17,609	164	28,444
Indexation	0	0	0	0	0	0
Additions	0	66	0	1,800	0	1,866
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairments charged to the SoCNE	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(304)	(724)	0	0	0	(1,028)
Reversal of impairments (indexation)	0	0	0	0	0	0
(Disposals)	0	0	0	(2,559)	0	(2,559)
At 31 March 2013	**2,722**	**6,981**	**6**	**16,850**	**164**	**26,723**
Depreciation						
At 1 April 2012	0	511	6	10,360	158	11,035
Indexation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairments charged to the SoCNE	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	(45)	0	0	0	(45)
Reversal of impairments (indexation)	0	0	0	0	0	0
(Disposals)	0	0	0	(2,385)	0	(2,385)
Provided during the year	0	222	0	2,163	3	2,388
At 31 March 2013	**0**	**688**	**6**	**10,138**	**161**	**10,993**
Carrying Amount						
At 31 March 2013	**2,722**	**6,293**	**0**	**6,712**	**3**	**15,730**
At 31 March 2012	**3,026**	**7,128**	**0**	**7,249**	**6**	**17,409**
At 31 March 2013	**2,722**	**6,293**	**0**	**6,712**	**3**	**15,730**

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in res assets held under finance leases and hire purchase contracts is £Nil (2012 £Nil).

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 6.2 Property, plant & equipment - year ended 31 March 2012

	Land £000s	Buildings (excluding dwellings) £000s	Plant and Machinery (Equipment) £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation						
At 1 April 2011	3,358	10,631	6	17,863	164	32,022
Indexation	0	388	0	0	0	388
Additions	0	305	0	2,102	0	2,407
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	8	0	8
Revaluation	171	0	0	0	0	171
Impairments charged to the SoCNE	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(503)	(3,685)	0	(7)	0	(4,195)
Reversal of impairments (indexation)	0	0	0	0	0	0
(Disposals)	0	0	0	(2,357)	0	(2,357)
At 31 March 2012	**3,026**	**7,639**	**6**	**17,609**	**164**	**28,444**
Depreciation						
At 1 April 2011	0	243	6	10,203	145	10,597
Indexation	0	8	0	0	0	8
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	4	0	4
Revaluation	0	0	0	0	0	0
Impairments charged to the SoCNE	0	0	0	(7)	0	(7)
Impairments charged to the revaluation reserve	0	0	0	0	0	0
Reversal of impairments (indexation)	0	0	0	0	0	0
(Disposals)	0	0	0	(2,304)	0	(2,304)
Provided during the year	0	260	0	2,464	13	2,737
At 31 March 2012	**0**	**511**	**6**	**10,360**	**158**	**11,035**
Carrying Amount						
At 31st March 2012	**3,026**	**7,128**	**0**	**7,249**	**6**	**17,409**
At 31st March 2011	**3,358**	**10,388**	**0**	**7,660**	**19**	**21,425**
Asset financing						
Owned	3,358	10,388	0	7,660	19	21,425
Carrying Amount						
At 31st March 2011	**3,358**	**10,388**	**0**	**7,660**	**19**	**21,425**
Asset financing						
Owned	3,026	7,128	0	7,249	6	17,409
Carrying Amount						
At 31st March 2012	**3,026**	**7,128**	**0**	**7,249**	**6**	**17,409**

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 7. INTANGIBLE ASSETS

NOTE 7.1 Intangible assets - year ended 31 March 2013

Cost or Valuation	**Software Licenses £000s**	**Information Technology £000s**	**Total £000s**
At 1 April 2012	1,201	3,625	4,826
Indexation	0	0	0
Additions	7	10	17
Donations / Government grant / Lottery funding	0	0	0
Reclassifications		0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairments charged to the SoCNE	0	0	0
Impairments charged to the revaluation reserve	0	0	0
(Disposals)	0	(365)	(365)
At 31 March 2013	**1,208**	**3,270**	**4,478**
Amortisation			
At 1 April 2012	528	2,929	3,457
Indexation	0	0	0
Reclassifications	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairments charged to the SoCNE	0	0	0
Impairments charged to the revaluation reserve	0	0	0
(Disposals)	0	(365)	(365)
Provided during the year	160	323	483
At 31 March 2013	**688**	**2,887**	**3,575**
Carrying Amount			
At 31 March 2013	**520**	**383**	**903**
At 31 March 2012	**673**	**696**	**1,369**
Asset financing			
Owned	520	383	903
Carrying Amount			
At 31 March 2013	**520**	**383**	**903**

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

HEALTH AND SOCIAL CARE BOARD

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 7.2 Intangible assets - year ended 31 March 2012

	Software Licenses	Information Technology	Total
Cost or Valuation	**£000s**	**£000s**	**£000s**
At 1 April 2011	897	3,641	4,538
Indexation	0	0	0
Additions	304	16	320
Reclassifications	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairments charged to the SoCNE	0	0	0
Impairments charged to the revaluation reserve	0	0	0
(Disposals)	0	(32)	(32)
At 31 March 2012	**1,201**	**3,625**	**4,826**
Amortisation			
At 1 April 2011	416	2,562	2,978
Indexation	0	0	0
Reclassifications	0	0	0
Transfers	0	0	0
Revaluation	0	0	0
Impairments charged to the SoCNE	0	0	0
Impairments charged to the revaluation reserve	0	0	0
(Disposals)	0	(32)	(32)
Provided during the year	112	399	511
At 31 March 2012	**528**	**2,929**	**3,457**
Carrying Amount			
At 31 March 2012	**673**	**696**	**1,369**
At 31 March 2011	**481**	**1,079**	**1,560**
Asset financing			
Owned	673	696	1,369
Carrying Amount			
At 31 March 2012	**673**	**696**	**1,369**
Asset financing			
Owned	481	1,079	1,560
Carrying Amount			
At 1 April 2011	**481**	**1,079**	**1,560**

The fair value of assets funded from Donations, Government Grants or Lottery was £Nil.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 8. FINANCIAL INSTRUMENTS

Due to the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within the HSCB in creating risk than would apply to a non public sector body of a similar size, therefore the HSCB is not exposed to the degree of financial risk faced by business entities. The HSCB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the HSCB in undertaking activities. Therefore the HSCB is exposed to little credit, liquidity or market risk.

NOTE 9. ASSETS CLASSIFIED AS HELD FOR SALE

Non current assets held for sale comprise of non current assets which are held for resale, rather than for continuing use within the business.

The HSCB did not hold any assets classified as held for sale in 2012/13 or 2011/12 .

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 10. IMPAIRMENTS

	2013		
	Property, plant & equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	982	0	982
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	982	0	982
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**0**	**0**	**0**

	2012		
	Property, plant & equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	4,188	0	4,188
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	4,188	0	4,188
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**0**	**0**	**0**

	2011		
	Property, plant & equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	815	0	815
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	815	0	815
Impairments charged / (credited) to Statement of Comprehensive Net Expenditure	**0**	**0**	**0**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 11. INVENTORIES

	2013 £000s	2012 £000s
List by classification		
Stationery	0	0
Oil	1	7
Total	**1**	**7**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 12. TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.1 Trade receivables and other current assets

	2013 £000s	2012 £000s
Amounts falling due within one year		
Trade receivables	7,995	4,600
Deposits and advances		0
VAT receivable	566	919
Other receivables - not relating to fixed assets	1,876	0
Trade and other receivables	10,437	5,519
Prepayments and accrued income	31	2,232
Other current assets	31	2,232
Intangible current assets	0	0
Amounts falling due after more than one year		
Trade and other receivables	0	0
Other current assets falling due after more than one year	0	0
TOTAL TRADE AND OTHER RECEIVABLES	10,437	5,519
TOTAL OTHER CURRENT ASSETS	31	2,232
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**10,468**	**7,751**

The balances are net of a provision for bad debts of £Nil (2012 £Nil).

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 12. TRADE RECEIVABLES AND OTHER CURRENT ASSETS

12.2 Trade receivables and other current assets: Intra-Government balances

	Amounts falling due within 1 year 2012/13 £000s	Amounts falling due within 1 year 2011/12 £000s	Amounts falling due after more than 1 year 2012/13 £000s	Amounts falling due after more than 1 year 2011/12 £000s
Balances with other central government bodies	2,018	3,091	0	0
Balances with local authorities	2,329	4	0	0
Balances with NHS /HSC Trusts	466	228	0	0
Balances with public corporations and trading funds	0	0	0	0
Intra-Government Balances	**4,813**	**3,323**	**0**	**0**
Balances with bodies external to government	5,655	4,428	0	0
Total Receivables and other Current Assets at 31 March	**10,468**	**7,751**	**0**	**0**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 13. CASH AND CASH EQUIVALENTS

	2013 £000s	2012 £000s
Balance at 1st April	3,302	102
Net change in cash and cash equivalents	557	3,200
Balance at 31st March	**3,859**	**3,302**

The following balances at 31 March were held at	2013 £000s	2012 £000s
Commercial banks and cash in hand	3,859	3,302
Balance at 31st March	**3,859**	**3,302**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 14. TRADE PAYABLES AND OTHER CURRENT LIABILITIES

	2013 £000s	2012 £000s
Amounts falling due within one year		
Other taxation and social security	507	667
VAT payable	0	0
Trade capital payables - property, plant and equipment	762	1,121
Trade capital payables - intangibles	0	0
Trade revenue payables	51,567	81,276
Payroll payables	1,099	3,254
Clinical negligence payables	0	220
RPA payables	0	0
BSO payables	9,654	3,967
Other payables	1,814	3,724
Accruals and deferred income	124,482	122,917
Trade and other payables	189,885	217,146
Other current liabilities	0	0
Intangible current assets	0	0
Total payables falling due within one year	189,885	217,146
Amounts falling due after more than one year		
Total non current other payables	0	0
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**189,885**	**217,146**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 14. TRADE PAYABLES AND OTHER CURRENT LIABILITIES

14.1 Trade payables and other current liabilities - Intra-government balances

	Amounts falling due within 1 year 2012/13 £000s	Amounts falling due within 1 year 2011/12 £000s	Amounts falling due after more than 1 year 2012/13 £000s	Amounts falling due after more than 1 year 2011/12 £000s
Balances with other central government bodies	6,553	1,788	0	0
Balances with local authorities	10	495	0	0
Balances with NHS /HSC Trusts	9,826	22,610	0	0
Balances with public corporations and trading funds	69	0	0	0
Intra-Government Balances	**16,458**	**24,893**	**0**	**0**
Balances with bodies external to government	173,427	192,253	0	0
Total Payables and other liabilities at 31 March	**189,885**	**217,146**	**0**	**0**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 15. PROMPT PAYMENT POLICY

15.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that the HSCB pay their non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The HSCB's payment policy is consistent with the Better Payments Practice Code and Government Accounting rules and its measure of compliance is:

	2013 Number	2013 Value £000s	2012 Number	2012 Value £000s
Total bills paid	15,018	46,155	16,896	42,065
Total bills paid within 30 day target or under agreed payment terms	12,794	40,736	15,486	37,411
% of bills paid within 30 day target or under agreed payment terms	**85.2%**	**88.3%**	**91.7%**	**88.9%**

Total bills paid within 10 day target or under agreed payment terms (since 01/11/12)	2,427	10,161
% of bills paid within 10 day target under agreed payment terms (since 01/11/12)	**52.34%**	**58.24%**

10 day information available from 01/11/12 and therefore prior year comparatives not available

From 16 March 2013 EU Directive 2011/7/EU on Combating Late Payment in Commercial Transactions was implemented through the Late Payment of Commercial Debts Regulations 2013. These regulations apply to all contracts made from 16 March 2013. They require all public bodies to pay suppliers for goods/services received within 30 days of receiving an undisputed invoice. The impact of this directive will take effect 30 days from 16 March 2013 (which is payment to be received by 14 April 2013) and the performance against the EU directive will be shown in the 2013-14 financial year accounts.

15.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of Compensation paid for payment(s) being late	40
Amount of Interest paid for payment(s) being late	41
Total	**81**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 16. PROVISIONS FOR LIABILITIES AND CHARGES - 2013

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2013 £000s
Balance at 1 April 2012	15,340	25,359	6,964	47,663
Provided in year	3,283	10,135	2,250	15,668
(Provisions not required written back)	(312)	(1,122)	(97)	(1,531)
(Provisions utilised in the year)	(1,156)	(6,439)	(535)	(8,130)
Cost of borrowing (unwinding of discount)	429	558	194	1,181
At 31 March 2013	**17,584**	**28,491**	**8,776**	**54,851**

Comprehensive Net Expenditure Account charges	2013 £000s	2012 £'000
Arising during the year	15,668	14,386
Reversed unused	(1,531)	(6,216)
Cost of borrowing (unwinding of discount)	1,181	1,009
Total charge within Operating expenses	**15,318**	**9,179**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	Total 2013 £000s
Not later than one year	1,121	12,865	560	14,546
Later than one year and not later than five years	4,806	10,978	2,278	18,062
Later than five years	11,657	4,648	5,938	22,243
At 31 March 2012	**17,584**	**28,491**	**8,776**	**54,851**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 16. PROVISIONS FOR LIABILITIES AND CHARGES - 2012

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2012 £000s
Balance at 1 April 2011	11,064	28,916	5,980	45,960
Provided in year	5,352	7,720	1,314	14,386
(Provisions not required written back)	(229)	(5,896)	(91)	(6,216)
(Provisions utilised in the year)	(1,090)	(6,017)	(369)	(7,476)
Cost of borrowing (unwinding of discount)	243	636	130	1,009
At 31 March 2012	**15,340**	**25,359**	**6,964**	**47,663**

Analysis of expected timing of discounted flows

	Pensions relating to other staff £000s	Clinical negligence £000s	Other £000s	2012 £000s
Not later than one year	1,121	18,766	407	20,294
Later than one year and not later than five years	4,806	6,593	1,575	12,974
Later than five years	9,413	0	4,982	14,395
At 31 March 2012	**15,340**	**25,359**	**6,964**	**47,663**

Provisions have been made for 5 types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Early Retirement and Injury Benefit. The provision for Early Retirement and Injury Benefit relates to the future liabilities for the HSCB based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims and Employment Law the HSCB has estimated an appropriate level of provision based on professional legal advice.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 17. CAPITAL COMMITMENTS

The HSCB did not have any capital commitments at 31 March 2013 or 31 March 2012.

NOTE 18. COMMITMENTS UNDER LEASES

18.1 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise	2013 £000s	2012 £000s	2011 £000s
Buildings			
Not later than 1 year	55	55	142
Later than 1 year and not later than 5 years	14	28	50
Later than 5 years	0	0	0
	69	**83**	**192**

18.2 Finance Leases

The HSCB had no finance leases in 2012/13 or 2011/12.

18.3 Operating Leases

The HSCB had no lessor obligations in either 2012/13 or 2011/12.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 19. COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

The HSCB had no commitments under PFI or other service concession arrangement contracts in 2012/13 or 2011/12.

NOTE 20. OTHER FINANCIAL COMMITMENTS

The HSCB did not have any other financial commitments at either 31 March 2013 or 31 March 2012.

NOTE 21. FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

Because of the relationships with HSC Commissioners, and the manner in which the HSCB is funded, financial instruments play a more limited role within the HSCB in creating risk than would apply to a non public sector body of a similar size, therefore the HSCB is not exposed to the degree of financial risk faced by business entities. The HSCB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the HSCB in undertaking activities. Therefore the HSCB is exposed to little credit, liquidity or market risk.

The HSCB did not have any financial instruments at either 31 March 2013 or 31 March 2012.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 22. CONTINGENT LIABILITIES

Clinical negligence
The HSCB has contingent liabilities of £1.452m

	2013 £000s	2012 £000s
Total estimate of contingent clinical negligence liabilities	1,449	1,773
Amount recoverable through non cash RRL	(1,449)	(1,773)
Net Contingent Liability	**0**	**0**

In addition to the above contingent liability, provision for clinical negligence is given in Note 16. Other clinical litigation claims could arise in the future due to incidents which have already occurred. The expenditure which may arise from such claims cannot be determined as yet.

Contingencies not relating to clinical negligence are as follows:

	2013 £000s	2012 £000s
Employers' liability	3	3
Total	**3**	**3**

NOTE 23. RELATED PARTY TRANSACTIONS

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

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

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

NOTE 24. THIRD PARTY ASSETS

The HSCB held £Nil cash at bank and in hand at 31 March 2013, or 31 March 2012, relating to third parties.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 25. FINANCIAL PERFORMANCE TARGETS

25.1 Revenue Resource Limit

The HSCB is given a Revenue Resource Limit which it is not permitted to overspend.

	2013 Total £000s	2012 Total £000s
DHSSPS (excludes non cash)	4,019,453	3,932,938
Non cash RRL (from DHSSPS)	18,420	12,537
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**4,037,873**	**3,945,475**

25.2 Capital Resource Limit

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

	2013 Total £000s	2012 Total £000s
Gross capital expenditure	1,884	2,727
Capital Resource Limit	1,884	2,727
Underspend against CRL	**0**	**0**

NOTE 25.3 Financial Performance Targets

The HSCB is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25% of RRL limits.

	2012/13 £000s	2011/12 £000s
Net Expenditure	(4,037,641)	(3,945,367)
RRL	4,037,873	3,945,475
Surplus against RRL	232	108
Break Even cumulative position(opening)	331	223
Break Even cumulative position (closing)	**563**	**331**

Materiality Test:	**2012/13**	**2011/12**
Break Even in year position as % of RRL	0.01%	0.00%
Break Even cumulative position as % of RRL	0.01%	0.01%

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

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2013

NOTE 26. LOSSES & SPECIAL PAYMENTS

26.1 Part A: Losses

Type of loss and special payment		2012/13		2011/12
		Number of Cases	£	£
Cash losses	Cash Losses - Theft, fraud etc	2	30	0
Claims abandoned	Waived or abandoned claims	**2**	**30**	**0**
		1	15,875	1,950
		1	**15,875**	**1,950**
Administrative write-offs	Bad debts	3	3,000	0
		3	**3,000**	**0**
Fruitless payments	Late Payment of Commercial Debt	2	81	782
	Other fruitless payments and constructive losses	2	52	0
		4	**133**	**782**
Stores losses		0	0	449
		0	**0**	**449**
Special Payments	Compensation payments			
	- Clinical Negligence	19	5,958,444	4,198,556
	- Public Liability	0	0	0
	- Employers Liability	0	0	0
		19	**5,958,444**	**4,198,556**
	Ex-gratia payments	**0**	**0**	**250**
	TOTAL	**29**	**5,977,482**	**4,201,987**

26.1 Special Payments
There were no other special payments or gifts made during the year.

26.2 Other Payments and Estimates
There were no other payments made during the year.

Estimate of patient exemption fraud.
The calculation was carried out by the Business Services Organisation (BSO) Information and Registration Unit on the following basis:

1. The BSO on behalf of the HSCB, handles payments to contractors providing family practitioner services. The Counter Fraud and Probity Service within the BSO is responsible for checking patient exemption entitlement and for taking follow-up action where a patient's claim to exemption from statutory charges has not been confirmed.

2. Given the volume of Dental and Ophthalmic claims each year, sampling is used to establish an estimate of the total annual potential loss due to fraud. Patients aged 80 and over are excluded from the population from which the sample is drawn. The sample data is passed to the Department for Works and Pensions and the Business Services Authority to provide independent verification of entitlement across a number of exemption categories. Where entitlement to exemptions claimed is not confirmed for individual patients as part of this process, such instances are referred as cases to EPES case management system for further investigation.

3. To estimate the total annual loss in the population the BSO applies the estimate rate of loss for each exemption category in the sample to the volumetric and average liability for that category in the population.

The total loss for the NI region for 2012/13 has been estimated as £3.1m (£2.4m Dental, £0.7m Ophthalmic). Comparative figures for 2011/12 when uplifted to 2012/13 activity levels, are: Dental £2.3m and Ophthalmic £0.5m.

26.3 Losses and Special Payments over £250,000

Losses and Special Payments over £250,000	Number of Cases	2012/13 £	2011/12 £
Special Payments			
Clinical Negligence settlement: - delay in diagnosis and treatment iro heart condition	1	375,480	
- relating to birth complications	1	1,007,284	
- relating to birth complications	1	4,079,823	
Prior year total for comparison (2 cases)			3,462,371
TOTAL	**3**	**5,462,587**	**3,462,371**

NOTE 27. POST BALANCE SHEET EVENTS

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

NOTE 28. DATE AUTHORISED FOR ISSUE

The Accounting Officer authorised these financial statements for issue on 27 June 2013.

ISBN: 9780337098857