HSS (PPM) 10/2002

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Chief Executives, HSS Boards
Chief Executives, HSS Trusts and Special Agencies;
Chairs, Local Health and Social Care Groups
Chief Officers, HSS Councils

13 January 2003

Dear Colleague

GOVERNANCE IN THE HPSS –
Clinical and Social Care Governance: Guidelines for Implementation

Summary

1. This guidance is intended to enable you to formally begin the process of developing and implementing clinical and social care governance arrangements within your organisation or area of responsibility with effect from the date of receipt of this circular. It should be read in conjunction with guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

Background

2. The consultation document "Best Practice – Best Care" set out proposals for a framework to improve the quality of services delivered by the Health and Personal Social Services (HPSS). Decisions on the way forward with implementing these proposals were announced in July 2002 focusing on three main areas:

   (i) arrangements for setting clear standards for services;

   (ii) mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) effective systems for regulating services and monitoring the delivery of services.

3. In July 2002 the Department wrote to Chief Executives of HSS Boards, Trusts, Special Agencies and Chairs of Local Health and Social Care Groups setting out these new arrangements in more detail and enclosing a draft circular on clinical and social care governance for comment. The attached circular has been revised to take account, as far as is possible, of comments received from the HPSS.

4. The requirements set out in this circular have been kept to a minimum for this stage. The detailed requirements arising from clinical and social care governance will be developed in conjunction with the HPSS starting with a series of workshops across Board areas in January/February 2003. Further guidance will be issued as necessary.

Action Needed

5 While it is recognised that there has been some progress in developing clinical and social care governance arrangements, what has been lacking is a consistent approach throughout the region. This guidance builds on the work of the past and maps out the way ahead, providing a management framework for clinical and social care governance. The following is the minimum list of actions, covered in greater detail in the circular, which need to be taken by each organisation.

- The appointment of a senior professional at board level to provide leadership in relation to clinical and social care governance arrangements and processes.

- The designation of a committee to be responsible for the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

- An evaluation of the current clinical and social care governance arrangements in the organisation to establish the baseline from which developments must begin.

- The formulation of a plan for the development and maintenance of clinical and social care governance arrangements.

- A system to deliver routine progress reports to the board and a formal progress report within the organisation's Annual Report.

6. The structure of this circular is as follows:

- Introduction
- Key Policy Objectives
- The Challenge
- Tailoring Guidance to Individual Organisations
- Monitoring Performance
- Next Steps
- Resources
- Further Guidance

For ease of reference the following paragraphs summarise what is covered by each section.

INTRODUCTION

1. The purpose of this circular is to provide guidance specific to clinical and social care governance. The Department recognises that many HPSS organisations have already begun to develop their own systems for clinical and social care governance based on guidance issued in England Scotland and Wales. While there are many parallels in approach, our arrangements for clinical and social care governance must take account of the organisational structures and manner of delivery of services currently in place here. This guidance must be read in the context of guidance already issued on the implementation of a common system of risk management across the HPSS and the development of controls assurance standards for financial and organisational aspects of governance.

2. It is important, therefore, that while much good work has already been done in relation to the development of clinical and social care governance, from now on all organisations must apply the principles set out in this guidance.

3. It is not intended to be prescriptive on an exact model to be used. It is for your organisation or group, together with your co-workers, staff, users and local communities to determine how best to implement arrangements which take account of the services delivered by you and your organisation at every level. This circular does, however, set a framework for action which highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care.

KEY POLICY OBJECTIVES

4 The key elements of the strategy for improving quality in the HPSS are:

(i) arrangements for setting clear standards for services;

(ii) mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements, reinforced with a statutory duty of quality. These arrangements will be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation; and

(iii) effective systems for regulating services and monitoring the delivery of services.

Statutory Duty of Quality

5. Clinical and social care governance arrangements within organisations which provide or commission services will be underpinned by a statutory duty of quality. The introduction of this duty will mean that accountability for the quality of services provided, including commissioning, is comparable with the statutory duty that exists on HPSS bodies in relation to the financial management of their organisations.

6. The statutory duty of quality will apply to Health and Social Services Boards (HSS Boards), Health and Social Services Trusts (HSS Trusts), and some Special Agencies

(the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the NI Guardian ad Litem Agency) for the services they commission and provide to the public. While the statutory duty of quality will not, for now, directly apply to the management boards of Local Health and Social Care Groups (LHSCGs), the Central Services Agency (CSA) and the remaining Special Agencies, they too must put in place effective clinical and social care governance arrangements which will also be subject to monitoring.

7. Everyone employed in the organisation, individuals, teams and corporate board members, have a role to play in ensuring effective clinical and social care governance arrangements work throughout their organisation and must be aware of their role and responsibilities.

What is clinical and social care governance?

8. "Best Practice – Best Care" defines clinical and social care governance as a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. Clinical and social care governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

9. The clinical and social care governance framework is intended to build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes activity on:

- audit;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance.
- risk assessment and risk management;
- adverse incident management;
- quality standards;
- complaints management;
- clinical and social care effectiveness;
- evidence-based practice;
- research and education;
- effective leadership and management;
- a clear policy aimed at improving communication between management, users, staff and local communities;
- policies aimed at securing effective user involvement, and which enable local communities to engage in all aspects of clinical and social care governance;
- effective recruitment and selection procedures;
- continuing professional and personal development; and
- professional regulation.

10. The framework is designed to bring all of these components together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice. This will ensure that high quality, effective treatment and care is delivered and that where things do go

wrong, they are quickly addressed and lessons are learnt to help prevent re-occurrence.

11. Clinical and social care governance is central to achieving improvements in the quality of services provided in the HPSS. Its successful development and delivery is crucial to the overall success of the framework for quality improvement.

12. The integration of health and social services means that governance arrangements must include social care in addition to clinical care, where operationally appropriate, within HSS Boards, LHSCGs, HSS Trusts, the CSA and Special Agencies. In addition, local arrangements for clinical and social care governance must complement the existing roles and management and executive professional responsibilities in place within HSS Boards and HSS Trusts.

Changing Culture

13. The introduction of clinical and social care governance arrangements will bring about a fundamental change in the culture of HPSS organisations. Clinical and social care governance is about developing a culture that safeguards high standards, promotes and supports improvements in practice and in the treatment and care delivered. This culture needs to be one of openness, transparency, listening to the views of users, staff and local communities, learning, sharing information and developing partnerships.

14. A culture that encourages open discussion and reflection on practice allows staff to learn from their experiences. This includes both celebrating what is done well and learning from what is done less well. If an organisation is to encourage staff to report incidents and learn from mistakes, it must develop an open and honest culture, rather than one of blame and shame and a reliance solely on disciplinary procedures. Developing the right culture is perhaps one of the biggest challenges in establishing clinical and social care governance processes. It will take dynamic leadership, time and commitment from all levels of the organisation.

Effective User and Community Involvement

15. Effective user and community involvement is crucial to the delivery of high quality treatment and care. Clinical and social care governance arrangements must involve users in ways that are meaningful, appropriate and acceptable to them. Each organisation needs to have a clear policy about and strategy for securing user and local community involvement. Involving users will provide a means whereby organisations can show that they are accountable to the population they serve. It can also help to improve staff/user communication and understanding as well as make use of the specific expertise that users have to offer. Similarly, HPSS organisations need to have regard to the relationship they have with their local communities and to consider how best these communities can be empowered to participate in the arrangements for clinical and social care governance.

16. "Token involvement syndrome" must be avoided. Users and local communities can and should play a much more meaningful role in the planning and delivery of services. They could for example identify issues that may inform the way in which information is gathered or through a partnership approach with professionals, they

could help determine the scope, focus and outcome of a service initiative. Organisations will wish to take account of the work and expertise developed by Health and Social Services Councils

17. Ultimately the effective involvement of users and local communities within clinical and social care governance arrangements will be determined by the approach taken by individual organisations

Development of Clinical and Social Care Governance

18. While those HPSS organisations which have already begun developing arrangements are to be commended for the work they have already done, clinical and social care governance is a dynamic and continuous process and full implementation will be an evolving process. There are however some practical steps that all HPSS organisations should address.

19. These involve setting up local structures to ensure clinical and social care governance arrangements are in place. Whilst the range of local structures will be dependent on the size and complexity of each organisation, there are some core arrangements which should always be put in place. These are establishing and maintaining:

- clear lines of responsibility and accountability for the overall quality of treatment and care;
- effective systems to identify, value, promote and share good practice within the organisation and where appropriate outwith the organisation particularly in circumstances where services are commissioned from an external provider;
- a comprehensive programme of quality improvement activities, including arrangements for ensuring users and local communities will be fully involved in securing high quality services;
- clear policies aimed at assessing and managing risk; and
- an open, honest and proactive system where people can report poor performance, near-misses and adverse events to allow them to be appropriately dealt with, lessons learnt and shared within and where appropriate outwith the organisation.

THE CHALLENGE

20. Clinical and social care governance has significant implications for the way in which HPSS organisations will conduct their business. Issues relating to the quality of clinical and social care provision will feature highly on their agenda and will form an equal and complementary strand with financial and organisational governance issues in their accountability.

21. The leadership provided within HPSS organisations will be the key to creating a culture and environment where the delivery of the best possible standards of care and treatment is seen to be the responsibility of everyone in the organisation.

Where are we now and what do we need to do?

22. Whilst it is recognised that HPSS organisations may already have made varying degrees of progress in developing governance arrangements, there are key steps which all HPSS organisations will need to take in the first year. These are:

Step 1: establishing leadership, accountability and working arrangements;

Step 2: depending on how advanced clinical and social care governance arrangements are within an organisation either:

(a) review their current arrangements and progress towards complying with the principles set out in this guidance;

or

(b) carry out an initial baseline assessment of capacity and capability;

Step 3: formulate a development plan, in the light of this review or assessment securing agreement and support for this plan across the organisation; and

Step 4: clarify reporting arrangements for clinical and social care governance as part of the management of the organisation and arrange for the preparation of an annual report on what has been achieved and what is planned for subsequent years.

Taking these steps is the key requirement arising from this circular. The following paragraphs set out guidance in relation to each of the four steps.

Step 1: Establish leadership, accountability and working arrangements

23. The Chief Executive of each organisation will be accountable to his/her board for the delivery of quality, treatment and care by the organisation in the same way as he/she is already responsible for financial and organisational matters.

24. The following paragraphs set out the suggested leadership arrangements within HPSS organisations that commission or provide services directly to the public. It is important to remember, however, that whatever leadership arrangements are decided upon it is essential that all organisations demonstrate:

- **inclusivity:** ensuring that all staff in the organisation are involved and kept fully informed about the purpose and progress of the clinical and social care governance programme;

- **commitment from the top:** reporting and having access to the Chief Executive and the board, particularly when problems need to be resolved or barriers to progress have been identified;

- **good external relationships:** forging strong open working partnerships with users, local communities, health and social care organisations and other agencies in the locality;

- **good internal relationships:** forging ownership of clinical and social care governance by the employees of an organisation;

- **continuing focus:** keeping the arrangements on course and not being deflected from the goals that the organisation has set itself;

- **accounting for progress:** being able, on request, to provide a comprehensive overview of progress with the clinical and social care governance arrangements programme throughout the organisation; and

- **communication:** with all staff in the organisation and with external partners, users and local communities on a regular basis.

Leadership arrangements within all organisations

25. The Chief Executive of each organisation (or in the case of LHSCGs the management board) will designate a senior professional at board level to support him or her in the discharge of his or her role as accountable officer for the delivery of quality care and treatment within the organisation. The leadership arrangements will differ according to local circumstances but it is likely that the senior professional will wish to assemble a multi-disciplinary team, with each member having responsibility for different aspects of the arrangements. It may well be that such a multi-disciplinary team has already been established as part of the organisation's overall approach to risk management.

26. It is proposed that this senior professional will provide leadership in relation to clinical and social care governance arrangements and processes. He/she will support and encourage good practice, while ensuring that where problems are identified, appropriate remedial action is taken.

27. The senior professional will also develop local systems for engaging the views of users and staff and mechanisms that will support the dissemination of clinical and social care standards, best practice and innovation. In addition the senior professional will be expected to put in place mechanisms for ensuring the production of clinical and social care governance reports. The senior professional will look to other key professional and staff groups to provide support. They will need to meet as often as necessary to promote and maintain a culture of quality and will be monitored on behalf of the organisation by the committee with responsibility for clinical and social care governance.

Leadership arrangements – Committee of the board with responsibility for clinical and social care governance

28. HPSS organisations to which the statutory duty of quality applies, must designate a Committee to be responsible for the oversight of the clinical and social care governance of the organisation. This may be an entirely new committee or the function could be taken on by an existing committee e.g. the Risk Management Committee.

29. The Committee with responsibility for clinical and social care governance should represent an appropriate balance of skills and interests and organisations should give consideration to how they can best ensure user and local community input into discussions about the development and maintenance of clinical and social care governance at the various levels of the organisation.

30. The Committee will be responsible for assuring the organisation's board that effective and regularly reviewed structures are in place to support the implementation and development of clinical and social care governance. The Committee must ensure:

- that where problems are identified, appropriate remedial action is taken;
- local community and user input into the development and maintenance of clinical and social care governance arrangements;
- effective mechanisms for engaging the views of users and staff are developed; and
- the provision of a report, to the board, which includes recommendations and any remedial action taken or proposed if there is an internal failing in systems or services.

31. The Committee should appoint a chair. In most organisations this should be a Non-Executive Director. The organisation's Chief Executive and other Executive Directors may be invited to attend meetings. The Committee should meet as often as required to discharge its role effectively and efficiently but not less than three times a year.

Step 2(a): Review current arrangements or progress towards complying with the principles set out in this guidance

32. For those organisations, which have begun to develop their own systems for clinical and social care governance, a review of current clinical and social care governance arrangements should be undertaken in light of this guidance. The review should include a report on the progress made towards complying with the components and features set out in paragraph 9 above as well as an assessment of the extent to which the criteria in Step 1 have been applied in relation to leadership and management.

or

Step 2(b): Carry out a baseline assessment of capacity and capability

33. For those organisations, which have not begun to develop a system of clinical and social care governance, implementation should start with a baseline assessment of the organisation's position. The baseline assessment should include:

- an analysis of the organisation's strengths and weaknesses in relation to current performance on quality;
- identification of any particularly problematic services;
- assessment of the extent to which data is in place for quality surveillance;
- establishing whether there are deficiencies in existing key mechanisms;
- ensuring integration of quality activities and systems;
- making clear the links with health and wellbeing investment programmes, delivery plans and local priorities; and
- designing ways in which underpinning strategies such as information management and technology, human resources, continuing professional development and research and development will support clinical and social care governance.

34. The review/baseline assessment (whichever is appropriate) should let the whole organisation see what it is good at, what it is less good at, and the areas needing to be developed. It should provide the basis for a development plan that includes clear milestones. When a quality initiative has significant resource consequences, discussions should take place within the context of the health and wellbeing investment plans, taking account of planned service development frameworks (when in place) and the available resources. Decisions will have to be made about which improvements are feasible and at what pace.

Step 3: Formulate a development plan and secure agreement across the organisation in the light of this review/assessment

35. On the basis of the review/baseline assessment, organisations can then establish a plan for developing and maintaining clinical and social care governance arrangements. This should address issues such as reducing any gaps in current performance, developing infrastructure (ie reporting structures, information management and technology, human resources etc), identifying and responding to staff development and organisational developmental needs and resource implications. The aim should be to build on existing best practice.

Step 4: Clarifying reporting arrangements

36. Organisations will be expected to include an up-date on progress in the development of clinical and social care governance arrangements in their Annual Reports for 2002-2003. Thereafter they will be expected to devote a specific section in subsequent

Annual Reports, giving a full account of their activities related to clinical and social care governance, what has been achieved and what is planned for subsequent years. In addition, organisations should ensure that they have appropriate mechanisms in place to deliver routine reports to the board on progress made in implementation, building on current best practice arrangements.

37. Clinical and social care governance reports for all organisations should attempt to answer three broad sets of questions about implementation

- *Where did we start?* – the review/baseline position;
- *What progress have we made?* - the development plan for the year and the monitoring and evaluation undertaken; and
- *Where are we going?* – the development plan for the coming year.

38. It is important to remember that each organisation will have to develop systems in accordance with its structure and responsibilities.

TAILORING GUIDANCE TO SUIT INDIVIDUAL ORGANISATION'S NEEDS

Health and Social Services Boards (HSS Boards)

39. HSS Boards will be expected to adopt the principles of clinical and social care governance in relation to all services they provide or commission. The principles will guide the planning of services and the development of Health and Wellbeing Investment Plans.

40. HSS Boards will be responsible for developing a culture that encourages high quality treatment and care. They will also be responsible for ensuring a high quality public health function and that the local health and social care infrastructure encourages open, confident, and responsive quality treatment and care provision.

41. As outlined at paragraph 23, the Chief Executive of each HSS Board will be responsible and accountable to his/her organisation's board for ensuring the HSS Board's responsibilities with regard to clinical and social care governance are discharged. The Chief Executive will be expected to look to his/her Professional Directors to provide support.

42. In addition to the steps outlined at paragraph 22, the HSS Boards should:

- identify the priorities for quality improvement in the HSS Board area through mechanisms such as needs assessment processes and as identified in local and regional action plans and other sources of information;
- base decisions on investment and action on the basis of these priorities;
- recognise and promote good practice within their own organisation and those organisations from which they commission services;

- ensure good clinical and social care governance of the HSS Board's own internal processes and functions such as public health, communicable disease control, and clinical and social care advice on commissioning;

- support, facilitate and ensure the development of clinical and social care governance amongst all local HPSS organisations, including LHSCGs.

Health and Social Services Trusts (HSS Trusts)

43. HSS Trusts will be expected to adopt the principles of clinical and social care governance in relation to all services they provide directly or commissioned by the Trust. The principles will guide the provision of services and the development of Trust Delivery Plans. Chief Executives in line with the statutory duty of quality must make sure that their organisations have in place effective clinical and social care governance arrangements.

44. In addition to the steps outlined in paragraph 22, HSS Trusts should:

- recognise and promote good practice within their own organisation and those organisations from which they commission services;

- reflect the pursuit of quality in Trust Delivery Plans; and

- have regard to/support the clinical and social care governance arrangements within other organisations locally.

Central Services Agency and the Special Agencies

45. Central Services Agency and the four Special Agencies, the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency, the Health Promotion Agency and the Guardian ad Litem Agency will be expected to adopt the principles of this guidance in relation to the services they provide and commission. In addition the Chief Executives of the Regional Medical Physics Agency, the Northern Ireland Blood Transfusion Agency and the Guardian ad Litem Agency will be responsible and accountable to their respective boards for the quality of care (as they will have a statutory duty of quality for the services provided directly to the public) provided by that agency in the same way as they are already responsible for financial matters. It will be for each Agency's board to develop the framework appropriate to discharge their relevant responsibilities, in line with general principles set out in this guidance.

Local Health and Social Care Groups (LHSCGs)

46. The establishment of LHSCGs provides an organisational platform around which a system of clinical and social care governance can be developed. The principles of clinical and social care governance apply to all LHSCGs including independent contractors. (Further guidance will be issued on this). Therefore the steps outlined in paragraph 22 and subsequent paragraphs, apply equally to LHSCGs. The leadership structure may differ according to the size and complexity of the LHSCG. The following paragraphs are intended to give an example of a structure for clinical and social care governance within LHSCGs.

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47. Each LHSCG should appoint a professional at management board level (a clinical and social care governance lead) to co-ordinate clinical and social care governance activities. This professional, who will need to be supported by a local sub-group or task group will:

- review current arrangements, carry out a baseline assessment and formulate a development plan;
- ensure that clinical and social care governance activity takes place across the whole of the LHSCG in a planned way;
- provide leadership in relation to clinical and social care governance arrangements within the LHSCG;
- co-ordinate the efforts of the LHSCG in the pursuit of the provision of high quality services;
- support and encourage good practice, while ensuring that where problems are identified appropriate remedial action is taken;
- develop mechanisms for engaging the views of users, local communities and staff;
- identify a development programme to meet the individual and organisational needs of all staff who work within the LHSCG, and work collaboratively with other organisations to meet these needs;
- have regard to the clinical and social care governance arrangements within other organisations; and
- ensure that there is an agreed mechanism in place for reporting progress on clinical and social care governance.

48 The clinical and social care governance lead will account to the management board of the LHSCG, which in turn will account to the HSS Board for the implementation of clinical and social care governance activities at LHSCG level.

MONITORING PERFORMANCE

Monitoring of Clinical and Social Care Governance Arrangements

49. Monitoring of clinical and social care governance will take several forms. The Department through its accountability arrangements will monitor implementation in HSS Boards, HSS Trusts, the Central Service Agency and Special Agencies. HSS Boards will provide the first line of external monitoring for its development within LHSCGs.

50. In addition, the new Health and Social Services Regulation and Improvement Authority (HSSRIA) will provide the independent monitoring of clinical and social care governance. The HSSRIA will have the following core functions:

- regulate services;
- inspect services;
- provide advice;
- conduct reviews of clinical and social care governance arrangements;
- carry out systematic service reviews; and
- undertake investigations.

51. It is intended that the powers of HSSRIA will be wide ranging. In addition to the regulatory function, it will take the lead in conducting reviews of clinical and social care governance arrangements. It will, through a rolling programme of local reviews of HPSS organisations, independently scrutinise the arrangements developed to support, promote and deliver high quality services. It will also help organisations identify and tackle serious or persistent shortcomings in clinical or social care service delivery. The ultimate aim of HSSRIA will be to support HPSS organisations in the delivery of high quality, safe services for the user.

52. As well as the HSSRIA, the Department, subject to the Minister's approval, can call on the Commission for Health Improvement (CHI) to undertake specific service reviews and in exceptional cases, where it is considered that expertise in clinical issues from elsewhere is required, to assist in other investigations.

53. Over time the HSSRIA will have a key role in providing users, the public and the Minister with the assurance that systems are in place to ensure that the best possible standards are being adhered to and the risk of something going wrong is greatly reduced.

54. HSSRIA will have to work collaboratively with other organisations involved in review or inspection such as the Northern Ireland Audit Office, the Health and Safety Inspectorate, the Social Services Inspectorate and the Pharmacy Inspectorate.

NEXT STEPS
Action by all HPSS organisations

55. The following actions must be taken by all organisations:

From the date of receipt of this circular

- formally begin the process of developing and implementing arrangements for effective clinical and social care governance;

By 28 February 2003

- identify the senior professional at board level to provide leadership in relation to clinical and social care governance;

By 31 March 2003

- designate a Committee with responsibility for clinical and social care governance (or in the case of LHSCGs, a sub-group or team), and appropriate supporting structures; and

- complete a review/baseline assessment or arrangements within the organisation that identifies current systems that support clinical and social care governance and identifies systems that require further development;

By 1 May 2003

- formulate and agree the organisation's plan for developing and maintaining effective clinical and social care governance arrangements;

By 1 June 2003

- incorporate a requirement to comply with the principles of clinical and social care governance into service agreements with provider organisations to take effect from 1 April 2004;

By 30 November 2003

- provide update on progress in the development of clinical and social care governance arrangements in Annual Report for 2002/03.

RESOURCES

56. The Department wishes to engage with HPSS organisations on the development of clinical and social care governance and to that end a series of workshops has been arranged for January and February 2003, across the four HSS Board areas, to discuss the way forward including the establishment of a Clinical and Social Care Governance Support Team (CSCGST). It is envisaged that the CSCGST will be multi-disciplinary and will consist of staff experienced in management, clinical and social care practice and family health services. It could provide support and training for HPSS organisations and develop further implementation guidance. In November 2002 an additional £0.25m (rising to £0.4m from 1 April 2003) was allocated to the HPSS to support governance and in recognition of the additional costs of implementing risk management arrangements, including clinical and social care governance arrangements.

FURTHER GUIDANCE

57. This circular will be supplemented by further guidance as necessary.

Yours sincerely

JOHN McGRATH

Director

HSC	Controls Assurance Standard	Risk Management

RISK MANAGEMENT

Statement of Standard

An independently assured risk management system is in place that conforms to the principles contained in AS/NZS 4360:2004, and which meets HPSS/HSC and other requirements in respect of managing risks, hazards, incidents, complaints and claims.

Overview

This Standard is principally concerned with ensuring that all HPSS/HSC bodies have the basic building blocks in place for managing risk through development and implementation of a comprehensive risk management system.
This Standard, together with the Governance and Financial Management Standards, provides the basis for statutory reporting for the Statement on Internal Control as set out by the Department of Finance and Personnel in DAO(DFP) 05/01 and DAO(DFP) 25/03. Requirements for reporting on internal controls for HPSS bodies in 2003/04 was issued to the service in February 2004 under cover of Circular HSS(F) 02/04.

Risk management should be recognised within an organisation as an integral part of good practice and should be part of the organisation's culture. It should be integrated into its philosophy, practices and business plans, and not be viewed or practiced as a separate programme. When this is achieved, risk management becomes the business of everyone in the organisation.

Whilst this standard does address key issues, it does not purport to be exhaustive. The boards of HPSS/HSC bodies should satisfy themselves that all relevant internal control and risk management requirements incumbent upon them, including those associated with the duty of quality, are properly identified and suitably addressed. When addressing risks to the organisation, in particular those which the organisation deems high/extreme to the achievement of key objectives, the risk and actions identified across other organisational controls assurance standards need to be considered.

The design of a risk management system will be influenced by and tailored to the existing structure of the HPSS/HSC body, the services provided and the processes and specific practices followed. A specific risk management approach applicable to all organisations is, therefore, unlikely to be servicable. However, common principles can be identified and used to form the basis for the Standard. These in large part originate from the Australia/New Zealand Standard on risk management, which defines a set of generic principles for establishing a risk management system in any organisation. The Standard has been licensed for the HPSS/HSC and the full Standard has been made available to all HPSS/HSC bodies, which are encouraged to make good use of the information and guidance contained in AS/NZS 4360:2004.

KEY REFERENCES

Statutes

Statutory Instruments: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003/431 (NI 9)
http://www.northernireland-legislation.hmso.gov.uk/si/si2003/20030431.htm

Statutory Rules: Social Security (Claims and Payments) Regulations (Northern Ireland) 1977 No.351

Statutory Rules: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 No.455
http://www.northernireland-legislation.hmso.gov.uk/sr/sr1997/Nisr_19970455_en_1.htm

Guidance and Codes

HPSS Complaints Procedures Directions (Northern Ireland) Order 1996

Guidance on Implementation of the HPSS Complaints Procedure, March 1996 **[The revised HPSS Complaints Procedure, entitled Complaints in Health and Social Care – Standards and Guidelines, has been issued for implementation by April 2009]**

The Miscellaneous Complaints Procedures Directions (Northern Ireland) 1996

HPSS (Special Agencies) Complaints Procedures Directions (Northern Ireland) 1996

Standards Australia Risk Management AS/NZS 4360:2004

NHS Good Practice Guide for Convenors, October 1999
http://www.dh.gov.uk/assetRoot/04/01/21/34/04012134.pdf

Guidance on Handling HPSS Complaints: Hospital, Community Health and Social Services, April 2000 **[The revised HPSS Complaints Procedure, entitled Complaints in Health and Social Care – Standards and Guidelines, has been issued for implementation by April 2009]**

Internal Control – Guidance for Directors on the Combined Code of Practice on Good Corporate Governance (The 'Turnbull' report).
http://www.icaew.co.uk/viewer/index.cfm?AUB=TB216634&thtb5+1

Health Estates (various) Firecode (Northern Ireland)

Department of Health, Social Services and Public Safety (2004): Guidance Note – Implementing the Equality Good Practice Reviews

http://www.dhsspsni.gov.uk/econsultation/Good_practice/GPRs_circ_HSSPS_29Jan04.pdf

ALARM /UCL - Clinical incident investigation protocol

Establishing an Assurance Framework: A Practical Guide for management boards of HPSS organisations

Circulars

Circular HSS (PDD) 1/1994 - Management of Food Services and Food Hygiene in the HPSS

Circular HSS (F) 20/1998 – Clinical Negligence Claims: Claims Handling

Circular HSS (F) 21/1998 – Clinical Negligence Claims: Structured Settlements

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular DAO (DFP) 25/2003 – Statement of Internal Control
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp
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http://www.dhsspsni.gov.uk/hssppm05-05.asp

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http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

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http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

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http://www.dhsspsni.gov.uk/microsoft_word_-_hss_sqsd_18-07_patient_service_review_guidelines_-_final_Feb07.pdf

Circular HSS(SQSD) 19/2007 – Reporting and Follow-up on Serious Adverse Incidents: and Reporting on Breaches of Patients Waiting in Excess of 12 Hours in Emergency Care Department
http://www.dhsspsni.gov.uk/hss_sqsd_19-07.pdf

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Circular HSS(SQSD) 34/2007 – HSC Regional Template and Guidance for Incident Review Reports
http://dhsspsni.gov.uk/hsc_sqsd_34-07.pdf

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http://www.dhsspsni.gov.uk/gpi_quality_standards_for_health___social_care.pdf

Safety First: a framework for sustainable improvement in the HPSS
http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

Establishing an Assurance Framework: A Practical Guide for management boards of HPSS organisations: January 2006
http://www.dhsspsni.gov.uk/assurance_framework.pdf

INDEX OF RISK MANAGEMENT CRITERIA

Criterion 1 (*Board accountability*)

Board level responsibility for risk management is clearly defined and there are clear lines of individual accountability for managing risk throughout the organisation, leading to the board.

Criterion 2 (*Organisation-wide risk management processes*)

The organisation's senior management has defined and documented its strategy for managing risks, including objectives for, and its commitment to, risk management. The risk management strategy is relevant to the organisation's strategic context and its goals, objectives and the nature of its business. Management ensures that the strategy is understood, implemented and maintained at all levels of the organisation.

Criterion 3 (*Organisation-wide accountability*)

A committee structure is in place, which supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the board.

Criterion 4 (*Adverse incidents*)

An agreed process for reporting, managing, analysing and learning from adverse incidents is in place, in accordance with HPSS/HSC guidance.

Criterion 5 (*Complaints and claims*)

An agreed process for reporting, managing, analysing and learning from complaints and claims is in place, in accordance with HPSS/HSC guidance.

Criterion 6 (*Risk management process*)

A risk management process, based on the requirements of AS/NZS 4360:2004 and covering all risks, is embedded throughout the organisation at all levels, including the board, with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the board in order to learn and make improvements to the system.

Criterion 7 (*Capability*)

All employees, including members of the board, clinical and social care professionals, managers, bank, locum and agency staff, together with, where relevant, contractors and volunteers are provided with appropriate risk management training.

Criterion 8 (*Independent assurance*)

The board receives independent assurance(s) that a risk management system is in place that meets the requirements of this standard.

CRITERION 1

Board level responsibility for risk management is clearly defined and there are clear lines of individual accountability for managing risk throughout the organisation, leading to the board.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers. DHSSPS(2003): Code of Conduct for HPSS Managers

Guidance

Implementation of risk management programmes at all levels, especially at the corporate level, is a challenge for all managers. Its success will depend largely on the support of the Chief Executive and senior management team. Critical to this process is the involvement of clinical and social care professionals – nursing, medical, social services and allied health professionals.

The ultimate goal of any risk management programme is to make the effective management of risk an integral part of everyday practice. This can only be achieved if there is a comprehensive and cohesive risk management system in place, underpinned by clear accountability arrangements throughout the management organisational structure.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The Chief Executive has overall responsibility for risk management.
- An Executive Director, who may be the Chief Executive, has been designated accountable for the implementation of risk management and controls assurance
- A risk management strategy has been approved by and is owned by the board.
- Clear lines of accountability for risk management have been established throughout the organisation.
- One or more persons are charged with the responsibility for advising on and co-ordinating risk management activities. The designated Executive Director should be consulted on the strategic direction of all such activities.

Examples of Verification

- Risk management strategy has been approved by the board;
- Job descriptions for executive directors and senior managers;
- Job descriptions for specialist risk management advisors or governance managers;
- Risk management organisational chart;
- Assurance Framework in place;
- Terms of reference for the audit committee;
- Minutes of the audit committee;
- Terms of reference of the board sub-committee(s) responsible for overseeing risk management;
- Minutes of the board sub-committee(s) responsible for overseeing risk management;
- Minutes of the board;
- Copy correspondence or minutes of meetings of the executive directors with responsibility for risk management;
- Audits/checks of compliance with risk management objectives, financial, organisational and clinical and social care.

CRITERION 2

The organisation's senior management has defined and documented its strategy for managing risks, including objectives for, and its commitment to, risk management. The risk management strategy is relevant to the organisation's strategic context and its goals, objectives and the nature of its business. Management ensures that the strategy is understood, implemented and maintained at all levels of the organisation.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04;
- Assurance Framework in place.

Guidance

Management of risk should be integrated into the philosophy of an organisation. A risk management strategy should be developed, which provides the organisation with strategic direction.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a board-approved strategy for risk management, which is reviewed annually.
- The risk management strategy includes a list of key objectives for managing risk and is relevant to the organisation's strategic aims and objectives and the nature of its services.
- The strategy takes a holistic approach to the management of risk across the organisation and sets out the organisation's attitude to risk.
- The strategy clearly describes the process for reviewing the organisation's performance with regard to the management of risk.
- The strategy contains guidance on acceptable risk and for the management of situations in which control failure leads to material realisation of risk.
- The strategy includes reference to other risk management policies/procedures.
- Individual directorates/departments maintain local strategies that reflect their individual risk profile.
- The strategy specifies how new activities should be assessed for risk and incorporated into risk management structures.
- The strategy makes reference to and considers appropriatedly shared risks and those owned elsewhere (eg by independent contractors)

Examples of Verification

- Risk management strategy;
- Minutes of the board;
- Assurance Framework in place;
- List of internal and external stakeholders;
- Evidence of the risk management strategy being linked to the strategic/corporate plan;
- Specialist risk management policies and procedures;
- Risk management organisational chart;
- Evidence of strategy distribution to staff and its availability to other stakeholders;
- Local risk management strategies

CRITERION 3

A committee structure is in place, which supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and communicated to the board.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers. DHSSPS(2003): Code of Conduct for HPSS Managers
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04
- Audit Committee Handbook, March 2007 – HM Treasury

Guidance

The full benefit of risk management will only be achieved if there is a comprehensive and cohesive system in place, underpinned by an organisation-wide risk management structure.

To ensure that all significant risks are properly considered and communicated to the board, boards of HPSS/HSC bodies should ensure that they have a sub-committee for overseeing risk management within their organisations.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a board sub-committee(s) responsible for overseeing all aspects of risk management.
- The role and responsibilities of the committee(s) responsible for overseeing risk management activities are clearly defined to ensure that any separations of clinical and social care, financial and organisational risks are kept under review.
- The Executive Director designated with responsibility for specific aspects of risk management must be a member of the committee.
- There is at least one Non-Executive Director as a member of the committee.
- The Committee's responsibility includes organisation-wide co-ordination and prioritisation of risk management issues.
- The committee(s) responsible for risk management issues oversee the work of any specialist risk management groups, and these specialist groups report directly to it.
- The role of the Audit Committee in reviewing and providing verification on the systems in place for risk management is clearly defined.

Examples of Verification

- Risk management strategy;
- Terms of reference for committees;
- Risk management organisational chart;
- Minutes of meetings;
- Annual risk management reports;
- Schemes of delegation;
- Annual report;
- Committee objectives;
- Agendas and supporting documentation

CRITERION 4

An agreed process for reporting, managing, analysing and learning from adverse incidents is in place, in accordance with HPSS guidance.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004.
- Circular HSS (F) 20/2002 - Clinical Negligence: Prevention of Claims and Claims Handling.
- Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation.
- Safety Notice SN(NI) 2003/01: Health Estates, Northern Ireland Adverse Incident Centre (NIAIC), Reporting Adverse and Disseminating Warning Notices Relating to Medical Devices, Non-Medical Equipment, Buildings and Plant
- DHSSPS, 2001 – Guidance for reporting accidents with, and defects in, medicinal products
- Circular HSS(PPM) 6/2004 – Reporting and Follow-Up on Serious Adverse Incidents: Interim Guidance
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04
- NPSA (2003): The Patient Safety Journey: Seven Steps to Patient Safety. The National Patient Safety Agency, London
- Safety First: a framework for sustainable improvement in the HPSS
- Circular HSS(PPM) 05/2005 – Reporting of Serious Adverse Incidents within the HPSS
- Circular HSS(PPM) 02/2006 – Reporting and Follow-up on Serious Adverse Incidents
- Circular HSS(MD) 12/2006 – Guidance Document – “How to Classify Incidents and Risk”
- Circular HSS(SQSD) 18/2007 – Conducting Patient Safety Reviews/Lookback Exercise

- Circular HSS(SQSD) 18/2007 – Guidance Document – A Practical Guide to Conducting Patient Safety Reviews or Lookback Exercises

- Circular HSS(SQSD) 19/2007 – Reporting and Follow-up on Serious Adverse Incidents: and Reporting on Breaches of Patients Waiting in Excess of 12 Hours in Emergency Care Department

- Circular HSS(SQSD) 19/2007 – 3 Guidance Documents

- Circular HSS(SQSD) 34/2007 – HSC Regional Template and Guidance for Incident Review Reports

- Circular HSS(SQSD) 34/2007 – Guidance Document

Guidance

Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses and hazards, which help to facilitate wider organisational learning.

Incidents and their consequences, if not properly managed, may result in loss of public confidence in the organisation, loss of assets and unnecessary proliferation of loss.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a board-approved policy/procedure for recording, reporting, analysing and managing incidents and serious adverse incidents are treated in accordance with DHSSPS guidance.
- The policy/procedure is based upon a standard definition of incidents
- The policy/procedure promotes a positive and non-punitive approach towards incident reporting.
- The policy/procedure states that all incidents must be reported promptly and an incident form completed and submitted to the risk manager (or equivalent).
- The policy/procedure contains clear guidance to be followed on incident investigation and root cause analysis.
- The policy/procedure states that management actions and preventative measures taken must be recorded.
- For serious adverse incidents that could have an impact or ‘adverse effect’ upon staff, users or the public, the policy/procedure requires a mechanism to be in place to inform the board. Furthermore the senior manager at board level who has overall responsibility for the reporting and management of adverse incidents within the organisation should consider the incident against the criteria set out in paragraph 16 of HSS(PPM) 6/2004 and, if applicable, submit a report to the DHSSPS using the appropriate proforma.
- All incidents are reported on a standard form(s), which may be paper-based or electronic, and which captures a ‘minimum dataset’ of information in accordance, where relevant, with HPSS guidance.
- All reported incidents are graded according to severity of outcome and potential future risk to users and/or the organisation.
- Based on the grading, reported incidents are subject to an appropriate level of local investigation and causal analysis and, where relevant, an improvement strategy is prepared, implemented and monitored.
- All reported incidents and causal factors are classified and categorised in accordance with a standardised classification scheme.

- Aggregate reviews of local incident data/information are carried out on an ongoing basis and the significant results are communicated to local stakeholders.

Examples of Verification

- Incident reporting policy/procedure;
- Incident report form and guidelines for completion;
- Incident investigation reports;
- Trend analysis reports;
- Minutes of the committees responsible for overseeing risk management;
- Copies of relevant reports to the DHSSPS and to other external bodies and stakeholders;
- Induction training programmes;
- Completed incident report forms;
- Relevant correspondence;
- Action plans and follow up reports;
- Major incident policy.

CRITERION 5

An agreed process for reporting, managing, analysing and learning from complaints and claims is in place, in accordance with HPSS guidance.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004.
- HPSS (March 1996) Guidance on Implementation of the HPSS Complaints Procedure (revised April 2000) **[The revised HPSS Complaints Procedure, entitled Complaints in Health and Social Care – Standards and Guidelines, has been issued for implementation by April 2009]**
- Circular HSS (F) 20/2002 - Clinical Negligence: Prevention of Claims and Claims Handling
- Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation.
- NPSA (2003): The Patient Safety Journey: Seven Steps to Patient Safety. The National Patient Safety Agency, London
- DHSSPS (2004): Guidance Note – Implementing the Equality Good Practice Reviews
- Safety First: a framework for sustainable improvement in the HPSS
- Circular HSS(F) 67/2006 – Payments in Respect of Litigation and Legal Services – Implementation of Controls

Guidance

Competent handling of complaints can assist in improving the quality of care and minimising claims by listening to the voice of service users and using this as an opportunity for the organisation to learn from complainants. Complaints and claims when examined in conjunction with reported incidents, accidents and near misses allow trends to be identified at both a local and regional level. This leads to prevention of recurrence or of more serious incidents and complaints occurring.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- There is a documented complaints procedure, which meets HPSS requirements and is approved by the board.
- There is a designated complaints manager responsible for handling all complaints.
- The arrangements for making complaints are publicised to service users.
- Front line staff receive training and guidance on the complaints procedure to enable them to deal with complaints on the spot.

- The organisation has an effective system for the recording of formal and informal complaints.
- Independent review panels, when they are required, are established in full accordance with the HPSS complaints procedure(To be abolished from 1 April 2009).
- All reported complaints are graded according to severity as well as potential future risk to users and/or to the organisation.
- One or more persons are charged with the responsibility for the management and co-ordination of claims.
- There is a documented claims management procedure, which meets HPSS requirements and is approved by the Board.
- All reported claims are graded according to severity as well as potential future risk to users and/or to the organisation.
- Information on complaints is reported to and considered by a relevant sub-committee of the Board.

Examples of Verification

- Complaints policy/procedure;
- Claims handling policy/procedure;
- Evidence of dissemination within the organisation and use of the Equality Good Practice Review on the handling of complaints
- Job descriptions;
- Board reports;
- Reports of the committee responsible for overseeing risk management;
- Complaints committee reports
- Training needs analysis;
- Training programmes;
- Training evaluation forms;
- Induction programme;
- Complaints leaflets and posters;
- Complaints files;
- Independent review reports;
- Evidence of claims management training;
- Evidence of claim settlement negotiations.

CRITERION 6

A risk management process, based on the requirements of AS/NZS 4360:2004 and covering all risks, is embedded throughout the organisation at all levels, including the board, with key indicators being used to demonstrate performance. The whole system of risk management is continuously monitored and reviewed by management and the board in order to learn and make improvements to the system.

Source

- Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services.
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04;
- Assurance Framework in place;
- Standards Australia Risk Management AS/NZS 4360: 2004.

Guidance

The organisation must be aware of its risk profile across its entire range of activities. Specific risk assessments will have been undertaken but in order to prioritise action an organisation-wide review is necessary to ensure that all exposures are duly considered.

“Key risks”, sometimes termed “principal risks”, are those which have significant potential to impair or affect the operational or financial ability of the organisation to deliver services and meet objectives, and may be strategic or operational in nature.

A comprehensive assessment of risks should be carried out, creating a continuum of risk assessments across the length and breadth of the organisation, encompassing all risks.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- Risks are systematically identified, recorded, assessed and analysed on a continuous basis.
- A comprehensive risk register is maintained on an ongoing basis for all units, (eg directorates, departments, functions or sites) for significant projects and for the organisation as a whole. The corporate/organisation-wide risk register is ‘owned’ and regularly reviewed by the board.

- The risk register should identify risks in a consistent and structured way, show dependencies, and ensure linkage between principal and other key risks.
- There should be a reasonable mechanism for managing relationship risk, ie service partners/key suppliers taking into account the behaviour and risk priorities of those partners.
- Common terminology for risk activities, taking into account DHSSPS guidelines, is applied throughout the organisation.
- For all risks identified as requiring treatment, actions are determined, appropriately recorded and implemented in order of priority using, where relevant, appropriate decision-making tools (e.g. risk ranking or cost-benefit analysis)
- The board is informed of and, where necessary, consulted on all principal/significant risks and associated risk treatment plans on a continuous basis. Any risk exposure should be recorded and exposure justified. Adequate contingency plans should be in place.
- All relevant stakeholders are kept informed and, where appropriate, consulted on the management of risks faced by the organisation.
- All relevant staff are kept informed of the management of significant risks faced by the organisation.
- Key indicators capable of showing improvements in management of risk and/or providing early warning of risk are used at all levels of the organisation, including the board, and the efficacy and usefulness of the indicators are reviewed regularly.
- An annual report is produced for the board to demonstrate the risk management system's continuing suitability and effectiveness in satisfying the organisation's risk management policy and strategy.

Examples of Verification

- Risk management strategy;
- Risk identification tools;
- Hazard reporting policy and forms;
- Risk assessment tools and forms;
- Completed risk assessments;
- Risk treatment options;
- Evidence of risk treatment;
- Business plans;
- Annual report;
- Risk registers;
- Minutes of committees;
- Job descriptions;
- Training programmes;
- Action plans;
- Evidence of communication with stakeholders;
- Evidence of communication with staff;
- Assurance Framework in place;
- Monitoring and review procedure;

- Performance indicators;
- Evidence of monitoring and review;
- Board minutes;
- Patient surveys;
- Incident, complaints and claims analysis.

CRITERION 7

All employees, including members of the board, clinical and social care professionals managers, bank, locum and agency staff, together with, where relevant, contractors and volunteers are provided with appropriate risk management training.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04

Guidance

This contributes to the organisation's risk management culture, which needs to be embedded at all levels throughout the organisation.

An appropriate training programme is an important means of achieving competence and helps to ensure compliance with safe working practices. All job descriptions for employees within the organisation should contain reference to their risk management responsibilities.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The organisation has assessed and delivered the level of risk management training that is needed throughout.
- Training records are kept, monitored and reviewed and inadequate attendance rectified.
- Induction for all new starters includes risk management training.
- The organisation can demonstrate that risk management training is effective through monitoring and review.
- Employees with responsibility for co-ordinating and advising on aspects of risk management have adequate training and development to fulfil their role.

Examples of Verification

- Training needs assessment;
- Training prospectus;
- Local training needs assessment;
- Training records (risk management training in the *wider* sense such as training on fire safety, health & safety, first aid/CPR, management of needle stick injuries, management of aggression, records management, etc.);

- Reports on attendance levels;
- Induction programme;
- Local induction procedures;
- Training objectives;
- Evidence of review of training objectives;
- Training course evaluations.

CRITERION 8

The board receives independent assurance(s) that a risk management system is in place that meets the requirements of this standard.

Source

- Standards Australia Risk Management AS/NZS 4360: 2004;
- Assurance Framework in place;
- Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance
- Circular HSS (F) 2/2004 - Statement on Internal Control – Full Implementation for 2003/04

Guidance

Reviews by independent bodies will assist organisations in demonstrating performance, and also in highlighting areas that need to be addressed. This will give the organisation assurance that controls are working satisfactorily and that local and national targets are being met. In due course, RQIA will have direct access to controls assurance information and reports on performance produced by the Authority should be given due consideration.

The following sub-criteria will help in deciding whether the key requirements of the main criterion are being met:

- The role of the Audit Committee in reviewing and providing assurance on the risk management systems in place is clearly defined.
- The role of the internal audit function in reviewing and providing verification on the systems in place for risk management is clearly defined.
- The internal audit function, aided as necessary by relevant technical specialists, carries out periodic reviews to provide assurances to the organisation that a suitable risk management system is in place and working properly taking into consideration reviews by other review bodies**.**
- The organisation has a system in place to ensure that reviews carried out by external agencies are effectively co-ordinated and any recommendations implemented within the context of available resources.
- Reports are presented to the Audit Committee and copied to the overarching committee(s) responsible for risk and any other relevant committee/group.

Examples of Verification

- Assurance Framework in place;
- Internal Audit reports;
- Internal audit statement to Chief Executive;
- Audit Committee minutes;
- Minutes of the committee(s) responsible for overseeing risk management;
- Minutes of the committee(s) responsible for overseeing Clinical and Social Care Governance;
- Reports from RQIA and other review bodies;
- Reports from external audit (NIAO);
- Reports from multi-professional audit.

From: Brian Godfrey
Head of Safety Strategy Unit

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

To: SHSCSG members

Date: 25th February 2020

Dear colleagues

The Safety in Health and Social Care Steering Group (SHSCSG) is a long established group led by the Department of Health and made up of members from a wide range of organisations within the HSC and across the Department.

In recent years the focus of the group has been mainly associated with governance and assurance around operating systems and processes as opposed to patient safety or quality improvement. Quality 2020 (Q2020), the Department's 10 year regional quality improvement strategy is nearing its conclusion and we will be taking forward the consideration of a new quality improvement approach during 2020/2021, including potentially refocusing on patient safety as a driver for change.

This new work will require the adoption of a co-production and co-design approach together with colleagues from the Department, HSC organisations, service users and other stakeholders which is much wider than the current SHSCSG.

I am therefore standing down the SHSCSG with immediate effect and I would like to thank you all for your support over the years and to wish you all well for the future.

Yours sincerely

Brian Godfrey
Head of Safety Strategy Unit

MAHI - STM - 089 - 5884

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

ALB Chief Executives

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

[redacted]

Our ref: RP2484

Date: 1 June 2018

Dear Chief Executive

Risk Management

As you will be aware the AS/NZ risk management standard previously used by the Department and its ALBs has not been updated since 2009 and has been superseded by an ISO standard (ISO 31000:2018). From 30 June 2018 the Department will cease to pay a licence fee for the outdated AS/NZ standard.

From 1 July 2018 all new material on risk management must not contain references to the AS/NZ standard or the Department will be in breach of copyright. References may be retained in historical documents.

The Department has engaged with ALB Governance/Risk leads to identify an appropriate way forward. The Department recognises that all ALBs already have established risk management arrangements in place that have evolved over time to meet the unique needs of each organisation.

From 1 July 2018, as a minimum, ALBs will be required to ensure they have no references to the AS/NZ Standard in new documentation. In line with your MS/FM you should ensure that your organisation has an appropriate and proportionate risk management framework in place that complies with recognised best practice guidance e.g. HMT Orange Book, ISO 31000:2018.

Your approach to risk management should form part of an assurance framework that provides a body of evidence required to support the continuous assessment of the effectiveness of the management of risk and internal control.

I understand that some of the larger ALBs have decided to adopt the 'spirit' of ISO 31000:2018 i.e. they will follow the principles of the standard but will not be seeking

accreditation. This group is drafting a framework and will share this with all ALBs in due course.

A review of risk management across this Northern Ireland Civil Service is currently underway and this may further inform the approach to risk management across the HSC. I will keep you updated as the review progresses.

Assurance on risk management will continue to be provided to the Department through established sponsorship and accountability arrangements.

Yours sincerely

RICHARD PENGELLY

A practical guide to Policy Making in Northern Ireland

Northern Ireland Executive
www.northernireland.gov.uk

Contents

Welcome to the NICS Policy Making Guide

Guidance to help those developing or reviewing policy to identify the issues they need to take into account to produce effective policy which will make a difference to and improve the lives of people living in Northern Ireland.

CHAPTER 1:

Introduction

Policy Making for the 21st Century

Policy making is the process by which governments translate their political vision into programmes and actions to deliver 'outcomes' – desired change in the real world.

Policy can take a range of different forms, including non-intervention; regulation, for instance by licensing; or the encouragement of voluntary change, including by grant aid; as well as direct public service provision.

Policy development is the process by which decisions are taken about how resources of various types are allocated and used. These processes take a variety of forms. They can be wholly informal, or highly structured, but where they are effective, they draw on our best thinking about what works and include contributions and evidence from many partners.

The need for a policy making guide

The Northern Ireland Civil Service has a long history of supporting Ministers in the development of policy, whether under Direct Rule or devolution. Equally, there is considerable policy development experience and expertise in the wider public service. The advent of devolution and the institutions established by the Belfast/Good Friday Agreement has however considerably changed the context for policy making in Northern Ireland. In particular, there is more opportunity - and a desire by Ministers - to design policies specifically to meet the needs of the Northern Ireland population, rather than primarily adapting policies developed in Whitehall, as was often the approach in the past under Direct Rule.

This guide seeks to provide a starting point to help those working on developing or reviewing policy identify what issues they need to take into account to ensure that policy is evidence-based, focused on outcomes, forward looking, 'joined up' and meets Northern Ireland requirements.

It aims to provide you with tools, skills and advice that will help you to develop high quality and effective policy.

It sets out a number of common elements of policy development processes. These do not occur in a particular order, nor are they always clear-cut, independent pieces of work. They are interdependent and in some instances all may be developed at the same time. Decisions about how to address each of these elements will be informed by the circumstances in which you are developing policy.

Outcomes Based Accountability

This guide introduces you to the concept of Outcomes Based Accountability (OBA) - encouraging policy-makers to focus on the desired outcomes and to use the OBA process to help them achieve those outcomes.

Case studies have been included to show how OBA has been used to good effect by many different types of service providers worldwide.

However, this guide cannot be fully comprehensive and is not a substitute for consulting detailed guidance on aspects of the institutional framework, legislative and financial processes and statutory obligations. However, it seeks to cover the basic essentials and includes appropriate contact details and web links to make it easier to track down more specialised assistance.

CHAPTER 2:

Policy Making Process

What is good policy making?

The process of policy making is not a high science, but it is difficult to do well. As in any process, there are tools and techniques that can help in doing the job more effectively. Public policy operates in an extremely wide environment. Governments have obligations to, and are answerable to, every part of civic society. Policy making often requires a department or the administration as a whole to strike a balance among a wide range of competing interests without losing sight of the desired policy outcome.

The world for which policies have to be developed is becoming increasingly complex, uncertain and unpredictable. Citizens are better informed, have rising expectations and are making growing demands for services tailored to their individual needs. Key policy issues, such as social need, low educational achievement and poor health, are connected and cannot be tackled effectively by departments or agencies acting individually. In addition, devolution introduces a system of government which is designed to be more joined-up and responsive than in the past, and better able to judge Northern Ireland's needs because of the shorter lines of accountability to the public.

At the same time, the world is increasingly interconnected and interdependent. National and global events and trends can very quickly become major issues for a regional administration - for example, a pandemic or rapid adoption of new information and communications technology and a wide range of interests needs to be co-ordinated and harnessed.

In parallel with these external pressures, Ministers expect a focus on solutions that work across existing organisational boundaries and on bringing about real change. Civil servants must adapt to this new, fast-moving, challenging environment if public policy is to remain credible and effective.

The TEN features of good policy making

1. FORWARD LOOKING

The policy making process clearly defines outcomes that the policy is designed to achieve. Where appropriate, it takes a long-term view based on statistical trends and informed predictions of social, political, economic and cultural trends, for at least five years into the future of the likely effect and impact of the policy. The following points demonstrate a forward looking approach:

- a statement of intended outcomes is prepared at an early stage;
- contingency or scenario planning;
- taking into account the Executive's long-term strategy; and
- use of the Foresight programme (details at http://www.foresight.gov.uk/) and/or other forecasting work.

2. OUTWARD LOOKING

The policy making process takes account of influencing factors in the regional, national, European and international situation; and draws on experience in other regions and countries. The following points demonstrate an outward looking approach:

- makes use of OECD, EU mechanisms, etc;
- looks at how other countries have dealt with the issue; and
- recognises variation within Northern Ireland.

3. INNOVATIVE, FLEXIBLE AND CREATIVE

The policy making process is flexible and innovative, questioning established ways of dealing with things, encouraging new and creative ideas; and, where appropriate, making established ways work better. Wherever possible, the process is open to comments and suggestions of others. Risks are identified and actively managed. The following points demonstrate an innovative, flexible and creative approach:

- uses alternatives to the usual ways of working;
- defines success in terms of outcomes already identified;
- consciously assesses and manages risk;
- takes steps to create management structures which promote new ideas and effective team working; and
- brings in people from outside into the policy team.

4. EVIDENCE-BASED

The advice and decisions of policy-makers are based upon the best available evidence from a wide range of sources; all key stakeholders are involved at an early stage and through the policy's development. All relevant evidence, including that from specialists, is available in an accessible and meaningful form to policy-makers. Key points of an evidence- based approach to policy making include:

- reviews existing research;
- commissions new research;
- consults relevant experts and/or uses internal and external consultants; and
- considers a range of properly costed and appraised options.

5. INCLUSIVE

The policy making process takes account of the impact on and/or meets the needs of all people directly or indirectly affected by the policy; and involves key stakeholders directly. An inclusive approach may include the following aspects:

- consults those responsible for service delivery/implementation;
- consults those at the receiving end or otherwise affected by the policy;
- carries out any relevant impact assessments; and
- seeks feedback on policy from recipients and front line deliverers.

6. JOINED UP

The process takes a holistic view; looking beyond institutional boundaries to the administration's strategic objectives and seeks to establish the ethical, moral and legal base for policy. There is consideration of the appropriate management and organisational structures needed to deliver cross-cutting objectives. The following points demonstrate a collaborative approach to policy making:

- cross cutting objectives clearly defined at the outset;
- joint working arrangements with other departments clearly defined and well understood;
- barriers to effective joining up clearly identified with a strategy to overcome them; and
- implementation considered part of the policy making process.

7. LEARNS LESSONS

Learns from experience of what works and what does not. A learning approach to policy development includes the following aspects:

- information on lessons learned and good practice disseminated.
- account available of what was done by policy-makers as a result of lessons learned; and
- clear distinction drawn between failure of the policy to impact on the problem it was intended to resolve and managerial/ operational failures of implementation.

8. COMMUNICATION

The policy making process considers how policy will be communicated with the public. The following contribute to effective communication of policy:

- communications/presentation strategy prepared and implemented; and
- Executive Information Service involved from an early stage.

9. EVALUATION

Systematic evaluation of the effectiveness of policy is built into the policy making process. Approaches to policy making that demonstrate a commitment to evaluation include:

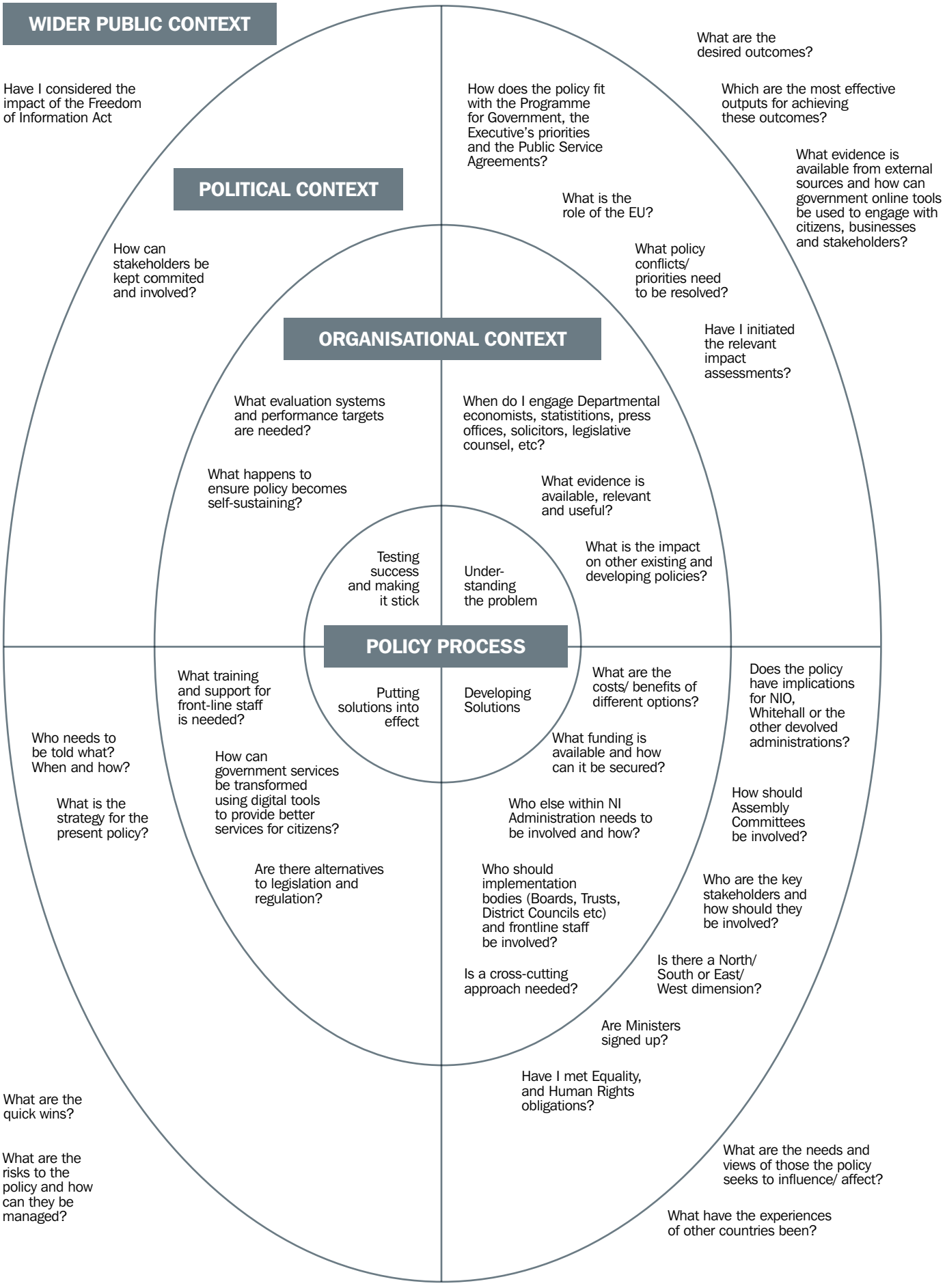
- clearly defined purpose for the evaluation set at outset;
- success criteria defined;
- means of evaluation built into the policy making process from the outset; and
- use of pilots to influence final outcomes.

10. REVIEW

Existing/established policy is constantly reviewed to ensure it is really dealing with problems it was designed to solve, taking account of associated effects elsewhere. Aspects of a reviewing approach to policy making include:

- ongoing review programme in place with a range of meaningful performance measures;
- mechanisms to allow service deliverers/customers to provide feedback direct to policy-makers set up; and
- redundant or failing policies scrapped.

The policy process in context



Before you start

Before embarking on any policy programme or project, it is important to give adequate consideration to how it will be managed and resourced. Some aspects of the policy making process are very time-consuming, and effective planning is essential. For example, it is important to take a realistic view of timescales for consideration of policy proposals by Ministers, especially where a policy needs to be considered by the Executive. The recommended period for a public consultation exercise, especially one involving an Equality Impact Assessment, is eight weeks. And when legislation is required to implement a policy, this can add considerably to the time taken from initial idea to implementation. It is very easy to underestimate the time and effort which will be required to introduce a new policy or review an existing one, and inadequate planning can lead to failure to deliver. Early engagement with key stakeholders is essential - this will help shape the policy and ensure buy-in from the stakeholder community. See the section on making lives better - digital transformation of services for citizens below which should also be considered at this stage.

This relates not only to the branch or team responsible for the programme but also to the potential involvement of professional advisors such as statisticians, economists or lawyers. Such specialists need to be alerted early so that their work programmes can take proper account of the department's needs.

It is important to ensure that implementation issues are integrated into policy development from the start.

It is also important to identify information requirements. Good policy making will be based on evidence setting out what the need is and potentially evidence surrounding how best to intervene to meet the need also. This is particularly important when policies come forward for consideration by the Executive, which must decide among a wide range of competing priorities for funding from a limited budget. The Executive has agreed that it should be provided with the appropriate supporting analysis, including economic analysis, before endorsing policy proposals and decisions. It is therefore important that all policy papers coming before the Executive address this issue explicitly, and that those working on policy development anticipate this need early on and arrange for the necessary information to be gathered.

Planning the Policy

To minimise the risk of a policy project failing to deliver on time and on budget, it is advisable to establish a project team to take it forward. In this way, those involved in the project have more control over their priorities and can focus clearly on delivering on time. It is also good practice to establish a Project Board at senior level to ensure that the project keeps on schedule and to help resolve issues outside the direct influence of the project team. Where legislation is required, it is essential that the necessary resources are also put in place to carry this work forward, usually by the establishment of a Bill team.

Below sets out some programme or project start-up questions which help in mapping out the various steps that need to be completed in a policy programme or project, taking as the starting point the vision which it is setting out to achieve. These questions should be of use to policy-makers embarking on a project of any scale.

Project or programme start-up questions

1. Why are we doing this?
2. What is the Minister's vision?
3. Who are the stakeholders?
4. What outcomes do the stakeholders want?
5. What mechanisms, systems, processes and changes does the vision suggest?
6. What's the scope of this initiative? What are we prepared to do?
7. What are the success criteria?
8. What are the pre-conditions of success?
9. What are we going to have to produce?
10. Who needs to participate in the project?
11. What do we need from others?
12. How big are these tasks?
13. What sequence do they need to be done in?
14. What resources do we have available eg staff, funding, research, statistics etc?
15. What assumptions are we making?
16. What are the constraints?
17. What are the barriers to success?

18. What are the likely consequences and side-effects of our success?
19. Who/what is likely to be disadvantaged by our success?
20. What are they likely to do that would cause problems?
21. What is the likely probability and impact of each risk?
22. What should we do to reduce the probability and/or impact?
23. What contingency arrangements do we need?
24. What's the plan?

In OBA terms the questions to ask at this stage are the 7 Population Level Questions

Joined-up government / cross-cutting issues

The need to achieve cross-cutting outcomes presents a major challenge to policy-makers. Actions of one Northern Ireland department can have a major impact on others. Policy-makers from related policy areas in different departments should keep each other informed and consulted, both formally and informally, about developments of common interest from an early stage, in order to help promote joined-up outcomes for the citizen. Policy making must be built around shared outcomes, not around organisational structures or existing functions.

A project approach to promoting joined up policy making and implementation, will include the following characteristics:

- collaboration between key departments;
- specific terms of reference linked to outcomes;
- responsible for the development of policy and implementation;
- rigorous implementation dates and a fixed shelf life;
- senior responsible owner;
- project planning, monitoring and control methods;
- ring fenced funding where possible;
- clearly identified responsibilities for all staff involved;
- only meeting as a group when absolutely necessary and using alternative communication methods; and
- regular review of performance.

But joining up is not just about shared approaches to cross-cutting issues. Horizontal joining up between organisations needs to be supplemented by better co-ordination among policy staff within departments and by better 'vertical' joining up with service deliverers and those who implement policy. It is not an end in itself but should be undertaken where it adds value.

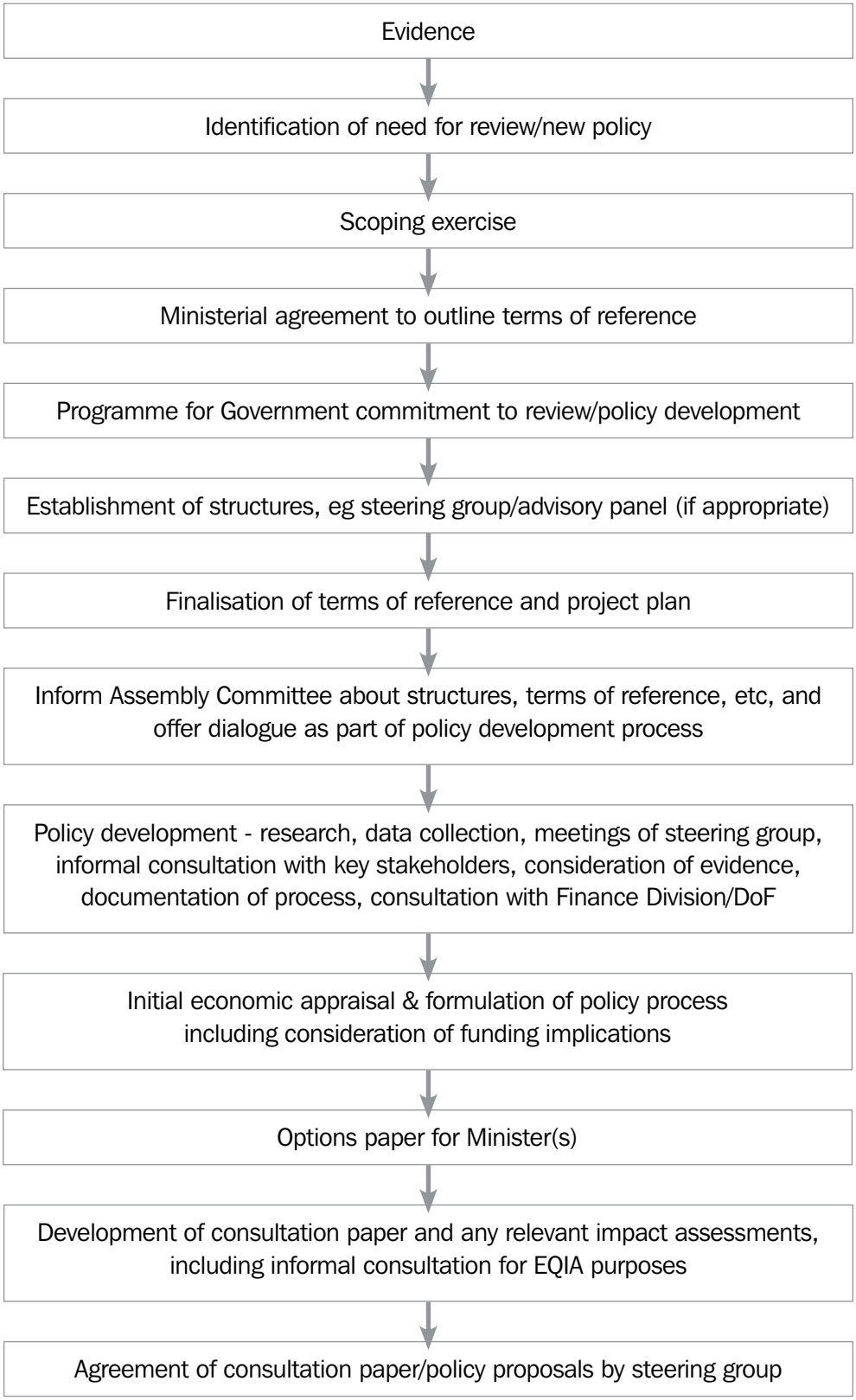
Common reasons for not joining up include incompatible IT systems, differences of culture and organisational structure and lack of time. All of these are real barriers to successful joining up that require sustained effort and collaborative approaches to overcome.

The timescale for policy making

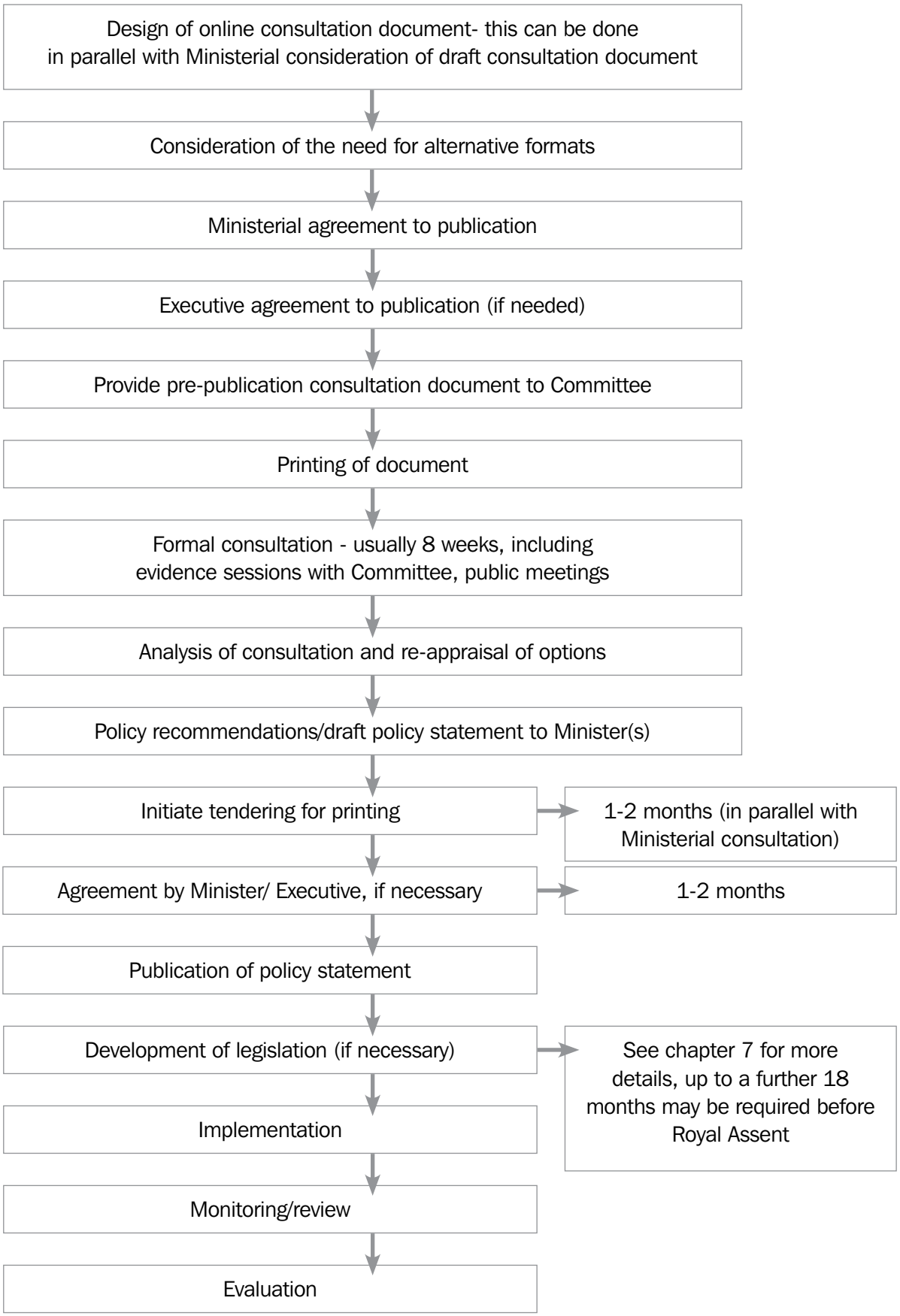
The overall timescale for development and implementation varies depending on a range of factors, including the urgency or political priority of the issue, whether legislation is required and the methodology adopted. The diagram below shows the key stages which need to be completed in a typical policy review and, where possible, gives an indication of required timescales. However, it is important to note that every policy development exercise is likely to have its own distinctive characteristics. For example, in some cases, policy development may have to be taken forward urgently and stages of the process which would normally take weeks have to be taken forward in days (usually involving redeployment of staff), or omitted. The timescales set out in the diagram below are intended to be typical of planned policy development.

It should be noted that the policy development process is considerably longer when legislation is required: the passage of legislation, particularly Primary legislation, can add up to a further 18 months to the overall process from when the policy is established, although with careful planning and consultation arrangements this can be substantially reduced.

Key stages in the Policy Making Process



Key stages in the Policy Making Process



CHAPTER 3:

Looking at the Evidence

This chapter looks at the various sources of evidence for the development of policy. These include professional advisors within the Civil Service, statistics and research published by the Northern Ireland administration and official sources elsewhere, and academic research. But one of the key messages of the guide in general is the importance of using evidence from the 'front line' of service delivery, both from potential customers and from those directly involved in service management and provision.

It is also helpful to bear in mind that looking at evidence has two primary purposes - to help identify and clarify the problem which is being addressed; and to help identify potential solutions. In order to achieve the latter, it is unlikely to be sufficient to look at evidence from Northern Ireland alone.

Evidence-based policy making - What evidence is available, relevant and useful?

It is crucial that policy decisions should be based on sound evidence. Good quality policy making depends on high quality information, derived from a variety of sources - expert knowledge; existing local, national and international research; existing statistics; stakeholder consultation; evaluation of previous policies; new research, if appropriate; or secondary sources, including the internet. To be as effective as possible, evidence needs to be provided by, and/or be interpreted by, experts in the field working closely with policy-makers. The first port of call is likely to be professional advisors within the NI Civil Service: for example, statisticians, economists, medical officers, inspectors, technical and professional officers, scientists, and social researchers. These professionals should know what relevant published statistics are available and be in touch with the latest research evidence and best practice internationally in the relevant policy areas. They can also advise on commissioning new research and generally point policy-makers in the right direction.

A list of likely sources of information and expertise on evidence to support policy making can be accessed here. The list covers internal Government sources, government-funded independent bodies and non-Governmental organisations. In addition to this general list, in each policy area there is likely to be a range of organisations with a particular interest in the policy field, some of which may commission or have access to information of particular importance or relevance.

Evidence from the 'front line'

However, evidence is not something that is only generated by external research. In any policy area there is a great deal of important evidence held by both front line managers and staff in departments, agencies, schools, hospitals, etc, and the citizen, customer or consumer to whom the policy is directed. Very often these groups will have a clearer idea than the policy-makers about what the problems are, why the situation is as it is and why previous initiatives did or did not work. They are also well placed to advise on how a new policy can be put into practice on the ground and what pitfalls need to be avoided. Gathering that evidence through interviews, surveys or focus groups can provide a very valuable input to the policy making process and can often be done much more quickly than more conventional research. It may well also help to avoid expensive mistakes later.

In addition, it is important to consider implementation of policy from the outset. It is often easier to implement change when those directly affected understand the reason for it and have some sense of engagement or ownership over the nature of the change or the way it is to be introduced. This provides another set of reasons for considering engaging with the staff and customers involved in the area affected by the policy initiative.

What have experiences of other countries and regions been?

It is helpful to use international comparisons as part of the wider evidence base. This can contribute very positively to the policy making process, in particular helping to guide policy-makers to new solutions to problems and new mechanisms for implementing policy and improving public service delivery. It can also provide useful evidence of what works in practice and what does not work. It is of course important to take account of social, economic and institutional differences which may require adjustment to policy solutions that work elsewhere to meet Northern Ireland circumstances.

When discussing policy in other regions, it is useful to consider whether there is an EU policy/legislation in place and if not, a check on the EU websites to see if there are any proposals for one. Even on areas where they don't legislate, there are at times useful research papers which have been produced by EU policy sections.

It is not always necessary to look very far afield for policy comparisons as, for example, other parts of the United Kingdom and Ireland can provide some good examples. The Policy Champions Network leads on policy exchange across the four nations of the UK. Other useful places to look for relevant policy comparisons include the Australian states, Canadian provinces and New Zealand, which are interesting from a Northern Ireland perspective because they have long experience of operating in a similar institutional framework. For example, the development of the Strategic Investment Board was influenced by the existence of a similar organisation in Ontario.

There is a range of factors which can be helpful in identifying possible countries or regions elsewhere from which to learn: for example, regions which have successfully addressed similar social or economic issues, or which have geographical similarities to Northern Ireland. Tables published by the Office for National Statistics, include key indicators across a range of policy areas comparing all the regions in the European Union, which may help in identifying appropriate comparator regions.

It is important in many areas of public service to understand the importance of factors such as settlement patterns and population density in determining what types of provision are appropriate and where we might learn lessons from elsewhere. For example, Northern Ireland is sparsely populated by comparison with England, but its population density is around the European average and approximately twice that in the Republic of Ireland or in Scotland. Parts of Europe with broadly similar population densities to Northern Ireland include Wales, Denmark, parts of France and Germany and North West Spain. Identifying appropriate comparators will, however, depend on your own policy area.

When looking at international comparators, it is important to do so objectively. Officially published material tells the story which the promoters of a policy or project wish to tell publicly. It is important to explore beyond that: to find out what criticisms are made as well as ways in which arrangements are successful; to find out the views of service users as well as providers; to find out the extent to which a policy has actually achieved its intended outcome and whether there have been any unintended or unforeseen drawbacks or benefits; and to explore potentially crucial differences in context which might mean that a policy which was successful elsewhere would not work in Northern Ireland. Face-to-face contact will reveal more than looking at a website alone, but given the costs associated with study visits, it is essential to do adequate research in advance to be sure that a comparator is really relevant.

Benchmarking

International and inter-regional comparisons are also important for benchmarking Northern Ireland's performance against that of other regions. Regional Trends provides statistical comparisons among the regions of the UK of a wide range of indicators across most policy areas. It also includes tables of key indicators comparing all the regions in the European Union.

However, caution must be used in making comparisons: for example, Northern Ireland's population is the youngest of any region in the EU, with 19.5% of the population aged under 15 in 2011, compared to an EU average of 15.4%. This is in itself an important factor for policy-makers to bear in mind, but it can also distort other comparisons: for example, it can make some health comparisons appear more favourable than they are.

Forward-looking policy making

Ensuring that policy making is forward-looking is important for a number of reasons. Firstly, it must be based on a long-term strategy, aimed at achieving defined intended outcomes. The Programme for Government sets out the outcomes to be achieved mainly within the next 5 years, but it is important in most areas of policy making to take a view at least 5 to 10 years into the future. Indeed, in many cases, policy decisions taken now will have implications well beyond even this time horizon. For example, the educational experience of school children now will have an impact on the skills of the workforce until the 2070s! Policy-makers in all areas should therefore have in mind the top-level strategic vision and goals to which they are contributing.

It is also important when developing policy to ensure that it is sufficiently robust to deal with change in the outside world, whether predicted or unpredictable. There are some specific techniques designed to assist policy-makers in thinking about future challenges. For example, contingency or scenario planning can be used to provide a structure for considering how policy-makers need to respond if the world develops in various possible ways in the future. The UK Government Foresight programme developed a range of scenarios, Foresight Futures 2020, which are available for organisations, whether in the public, private or voluntary sectors, to use in developing their future strategies. The point of such an exercise is not to predict the future but to help determine what should be priorities for the organisation under any of the possible scenarios. A synopsis of key drivers and underlying assumptions is given alongside the storyline for each scenario. In addition, Snapshot 2010, which can be found at the end of the report, provides key performance indicators for each of the scenarios. The indicators were chosen to cover a wide range of economic, social and environmental issues and relate to commonly-used statistics, such as the National Well-being Indicators or the OECD Better Life Index.

Forward-looking policy making also needs to take a long-term view based on statistical trends and informed predictions of social, political, economic and cultural trends, for at least five years into the future of the likely effect and impact of the policy. NISRA produces a range of statistics such as population projections which are helpful in this regard.

Conclusion

The figure below sets out a number of key questions to address in assessing evidence requirements to assist policy making. The questions are primarily relevant to consideration of external research evidence but can be adapted for other types of evidence.

Key questions in assessing evidence

Some key issues that you need to think through before deciding whether to use a piece of evidence are set out below. Policy-makers will need to consider drawing on specialist expertise and knowledge to help assess evidence (e.g. advice from researchers, statisticians and economists).

Is it relevant?

- Does the study address the key policy issues and questions?
- Is it appropriate to use evidence collected in a different context?
  i.e. How far can results of local or national studies inform a regional policy? Is the social, cultural and economic context for an overseas study similar to that in Northern Ireland?
- Was the study undertaken recently - have things changed since it was done? (NB This does not mean that research evidence can be ignored just because it is old - in some policy areas, research can remain relevant for a long time.)
- Does the study clearly identify implications for policy and/or practice?

Is it good quality?

- Are the research methods used appropriate to the key questions being asked?
- Does the study consider the issues from a range of perspectives e.g. involving service users/ other stakeholders?
- Has the study been conducted properly - is there information on how the methods were implemented e.g. response rates for surveys?
- Does the individual or organisation which undertook the study have previous experience of research on the issue and/ or the methods used?
- Has the study been undertaken, commissioned or funded by individuals or organisations with views or vested interests which may favour particular conclusions?

CHAPTER 4:

Sources of evidence to support policy making

This chapter provides a range of suggested sources of evidence and expertise to support policy making. It covers internal Government sources, government- funded independent bodies and non-Governmental organisations. It includes organisations based within Northern Ireland, at UK level, in the Republic of Ireland, and international organisations. In addition to this general list, in each policy area there is likely to be a range of organisations with a particular interest in the policy field, some of which may commission or have access to information of particular importance or relevance.

Sources within Northern Ireland

The website of the **Northern Ireland Statistics and Research Agency** includes a list of statistical and research publications produced by some NI departments in recent years and, in most cases, links to online versions of the documents. Other departments publish research only on their own websites, although in general more social research than economic research is undertaken directly or published by the administration.

The departments which display best practice in this area allocate their research budgets on a competitive basis. They decide on areas where they particularly need research to be undertaken and invite bids from the academic community accordingly. However, there is also scope for academics to bring forward proposals of their own, and the bids are prioritised on the basis of quality and policy relevance.

The Assembly has a considerable research capacity and, through the Committees, a role in policy making under the Agreement. Inquiries undertaken by the Committees usually consider evidence from a wide range of witnesses and will be very relevant to future policy making. The reports are available on the Assembly website.

UK and Irish sources

It is rarely sufficient to look only within Northern Ireland for evidence to support policy making, but in some more specialised policy areas, there has been little or no published research undertaken in Northern Ireland. Some NI departments are therefore likely to rely heavily on research evidence undertaken at UK level or in RoI. As well as relevant Whitehall departments, the **Cabinet Office** website provides a wide range of other useful resources on good practice in policy making. These include a set of guidance notes for social researchers on methods for evaluating policies, programmes and projects, entitled **The Magenta Book**.

The **Economic and Social Research Council** is the main UK research funding and training agency addressing economic and social concerns, including the effectiveness of public services and policy. The websites of the Economic and Social Research Institute and the National Economic and Social Council hold a range of research evidence from the RoI context. It may also be desirable to engage directly with relevant academics at the universities in Northern Ireland or elsewhere where there is particular expertise in your policy area.

The **What Works Network** uses evidence to make better decisions to improve public services. The network is made up of 7 independent What Works Centres and 2 affiliate members. Together these centres cover policy areas which receive public spending of more than £200 billion. What Works Centres are different from standard research centres. They enable policy-makers, commissioners and practitioners to make decisions based upon strong evidence of what works and to provide cost-efficient, useful services.

The centres help to ensure that thorough, high quality, independently assessed evidence shapes decision-making at every level, by:

- collating existing evidence on how effective policy programmes and practices are
- producing high quality synthesis reports and systematic reviews in areas where they do not currently exist
- assessing how effective policies and practices are against an agreed set of outcomes
- sharing findings in an accessible way
- encouraging practitioners, commissioners and policymakers to use these findings to inform their decisions

Nesta

Nesta (formerly NESTA, National Endowment for Science, Technology and the Arts) is an independent charity that works to increase the innovation capacity of the UK. The organisation acts through a combination of practical programmes, investment, policy and research, and the formation of partnerships to promote innovation across a broad range of sectors.

Nesta was originally funded by a £250 million endowment from the UK National Lottery. The endowment is now kept in trust, and Nesta uses the interest from the trust to meet its charitable objects and to fund and support its projects.

Carnegie UK Trust

The Carnegie United Kingdom Trust was founded in 1913 to address the changing needs of the people of the United Kingdom and Ireland. It is one of the oldest and most respected charitable trusts in the British Isles.

The 2016 – 2020 strategic plan outlines the role of the organisation as an operating Trust that makes proactive decisions about its projects and activities. The Trust no longer takes unsolicited grant applications, but seeks to build partnerships with other organisations for specific pieces of work.

The Carnegie UK Trust continues to work to improve the lives and wellbeing of people throughout the UK and Ireland by changing minds through influencing policy, and by changing lives through innovative practice and partnership work.

To change minds, the Policy Team seeks to develop objective, evidence-based policy to improve lives. The Trust's work over the next five-year period will be focused on a set of three themes which all have the potential to contribute in a positive way to the wellbeing of people in their communities, in the regions and in the nations of the UK and Ireland. The three themes are

1. Be a recognised leader in wellbeing and its links to public policy
2. Be a champion for sharing learning between all jurisdictions of the UK and Ireland
3. Make working across the public, private and voluntary sector more normal and valued.

The Institute for Government is an independent charity working to increase government effectiveness.

It works with all the main political parties at Westminster and with senior civil servants in Whitehall. It provides evidence based advice that draws on best practice from around the world.

It undertakes research, provides development opportunities for senior decision makers and organises events to invigorate and provide fresh thinking on the issues that are relevant to government.

The Policy Library is a website which aims to provide on-line access to a comprehensive range of policy and research papers, from universities, independent research institutes and government departments. Its coverage includes resources in the UK, the wider English- speaking world, and Europe.

CHAPTER 5:

From desired outcomes to possible solutions

This chapter looks at some of the key internal processes which need to be undertaken in developing policy.

Having weighed up the available evidence, it should be possible to start developing a broad outline of what policy interventions, if any, might be appropriate to address the issues you are dealing with. Where possible, you should develop a range of options, including costings. Management of risk is also a key consideration.

It continues to be important to keep professional advisors and others within your department involved in policy development as you move from initial consideration of the evidence towards formulating policy solutions. At the very least, all those disciplines within your department with an interest should be copied into key papers at a senior level to keep them informed and involved. However, it is likely that you will also need to keep them engaged in a more proactive way, for example through a Project Board.

Appraisal of options

Consideration of alternative options is an important part of the policy making process. It is about identifying the range of possible courses of action, and comparing their relative merits, including the costs, benefits and risks that are associated with them, in order to inform selection of the best policy implementation option. This often involves an option appraisal, also known as an 'economic appraisal'.

Substantial guidance is available on option appraisal in The Northern Ireland Guide to Expenditure, Appraisal and Evaluation (NIGEAE). This is consistent with the Green Book, the Treasury's authoritative guide to appraisal and evaluation, but is more detailed and tailored to Northern Ireland's circumstances.

Option appraisal is a flexible tool and needs to be tailored to the circumstances. However, a typical appraisal will cover the following steps:

- establish the policy need - Identify target populations, quantify problems/demands to be addressed, show how policy intervention will contribute to strategic aims;
- define the policy objectives - broadly enough that a range of policy options can be identified. Measurable targets should normally be developed, to provide for detailed appraisal and subsequent measurement of the policy's success;
- identify and describe the policy options - a "status quo" or "do minimum" baseline option and a suitably wide range of alternative policy options for consideration;
- detail the costs, benefits, risks and other relevant impacts - for each policy option. Consider screening and impact assessment requirements;

- spell out the funding implications, including the relative priorities for funding - particularly important when appraising a policy with several components, some of which could be taken forward in advance of others;
- summarise the findings and recommend the preferred policy option comparing the relative merits of each option in turn; and
- make recommendations for managing, monitoring and evaluating the policy.

Plans for option appraisal should be considered early in the policy making process. It may be appropriate to conduct an initial appraisal and then develop it or re-visit it at various stages, e.g. following consultation. Specialist advice may be required - departmental economists can advise on the design and conduct of option appraisals, and can assist with other forms of economic analysis such as relevant economic research.

Funding and how to secure it

Ensuring any necessary resources are available is key to making policy happen. When developing a policy you must always be aware of the cost implications of policy implementation and the need to achieve best value for money.

Where policies do not involve significant public expenditure, there may still be implementation costs for the administration and compliance costs for individuals and organisations, which need to be considered and justified.

The project planning process will help you to judge whether you have the necessary resources to support the development of policy. However, the cost of the policy implementation can often be many times more than the cost of the internal resources.

Departments' Finance Divisions are the first port of call for advice on financing policy solutions. They should be involved in policy development at the earliest possible stage and kept up to date throughout the process. Early engagement with Department of Finance (DOF) through the Departmental Finance Division is in turn important, given DOF's approval role in relation to new or contentious proposals. The key point, however, is that the business case for a policy must stand up on its own terms. Funding should follow policy, rather than policy being skewed, for example, by the availability of funding from external sources. If a policy is decided to be of sufficient priority by departmental Ministers and subsequently by the Executive on the basis of the evidence, the resources will be found. Conversely, as there will never be sufficient funding to do everything that is desirable, Ministers and in turn the Executive need to be in a position to take strategic decisions about policy priorities (involving both new and existing policies). That could mean ending existing activities which are no longer necessary in order to allow new priorities to be taken forward.

It is important for policy staff to be aware that there is no automatic read-across from additional funding allocations made in England to comparable programmes in Northern Ireland. While additional funds come to the Northern Ireland block under the 'Barnett formula', the Executive determines the allocation of the overall budget on the basis of the competing priorities from all the departments, in tandem with the development of the Programme for Government. Nonetheless, in many cases there will be a public expectation that the Northern Ireland administration will respond to funding increases or new programmes in England. It is therefore important to keep in touch with counterpart Whitehall Departments to monitor their policy developments and assess how to respond.

Legal advice

As your policy making process proceeds, it becomes important to start thinking about whether there is sufficient legislative basis for the policy solutions you are considering and you need to engage in dialogue with Departmental solicitors.

Departmental solicitors will also be able to advise on any human rights or EU aspects which you have identified. If you are considering establishing a new body as part of the implementation of your policy, solicitors can advise on the options for establishing the body and their involvement will be important throughout that process. If legislation is required, it is important to engage too with the Office of the Legislative Counsel.

Engaging Ministers

This guide has already noted that Ministers are likely to be engaged in initiating or agreeing the initiation of policy work. As the policy process develops, it is essential to give Ministers regular updates on progress, highlighting in particular the key issues for decision and retaining a focus on the overall progress of the policy project. In preparing papers, it is helpful to consult with Ministers' special advisors from the outset.

Involving the Executive

As the development of a policy initiative proceeds a department needs to help fulfil its Minister's duty under the Ministerial Code. In this regard and in relation to policy initiatives, the following are examples of matters that should be brought to the Executive for prioritisation, consideration and agreement:

- significant policy issues which cut across the responsibilities of two or more Ministers;
- issues on which it is desirable that the Executive should adopt a common position;
- matters involving conflict with, or not provided for within, the priorities and actions contained in the Programme for Government; and

- all primary legislation proposed to be presented to the Assembly.
- unlike primary legislation, subordinate legislation does not require prioritisation by the Executive. However, individual pieces of subordinate legislation should be brought to the attention of the Executive where this is required under paragraph 2.4 of the Ministerial Code (eg where the legislation cuts across the responsibilities of two or more Ministers).

This list is not exhaustive and Executive & Central Advisory Division in The Executive Office will advise on proposals to table issues in any other categories. Departments should refer to the Ministerial Code for fuller guidance on the matters which are to be brought to the Executive.

Any issue which has particular implications for the Minister's constituency should also be brought to the Executive for consideration as should any other significant policy issue or proposed decision which is novel or contentious, or is of particular importance or interest to the public.

The views of the Executive should be sought at an early stage and to ensure that sufficient time is allowed for an Executive paper to obtain timely approval and circulation to the Executive, departments should allow for a 4-week period in their planning timetable for this stage of the policy making process. It may facilitate the subsequent handling of such papers to share early drafts of Executive papers with other interested departments and the First Minister and deputy First Minister. It is also useful to include in any Executive paper details of consultations with other Ministers and how the outcomes of such consultations have been reflected in the paper.

The legislative process

Many new or revised policies require the passage of legislation in order to give departments and others a legal basis for action. The legislative process is complex and resource intensive: even after the policy has been agreed, it takes considerable time and effort to produce a Bill and get it onto the statute book. Because legislation is a time-consuming process (it can take 18 months or more from policy agreement to Royal Assent), it is important to get it right and in particular to consider all the implementation issues fully.

When considering any proposed changes of policy that may require legislation, the guidance requires departments to consult widely with interested groups both inside and outside government. Consultees will include, for example, Assembly Departmental Committees, the Human Rights and Equality Commissions and may also include consultation on an Equality Impact Assessment as provided for by departmental Equality Schemes. It is also crucial to consult the Office of the Legislative Counsel at an early stage, and to work closely with that office throughout the process.

When the policy proposals for primary legislation have been formulated the departmental Minister will present these to the Executive for endorsement. This is in line with the Ministerial Code (paragraph 2.4) which requires Ministers to bring matters to the attention of the Executive Committee.

Later in the process when a Bill has been drafted and cleared by the Executive it may be used for a public consultation exercise mentioned at end of paragraph. Departmental Committees will normally expect to be afforded the opportunity of pre-legislative scrutiny of a Bill before its introduction to the Assembly. In addition there are opportunities throughout the Assembly process for Members to examine and debate the policy that the Bill would implement, to question the responsible Minister on the policy, and to table amendments to the Bill.

For subordinate legislation, again the policy implications have to be carefully assessed from the outset and this can also lead to public consultation. Human rights and equality considerations also must be taken into account and, like primary legislation, the departmental Committee will have an opportunity to consider the policy at an early stage. The Executive only becomes involved in a small number of policy papers relating to subordinate rules. These are Rules that are subject to affirmative or confirmatory resolution which, because of their Assembly procedure, have a higher profile than the majority of rules.

Detailed guidance on the actions required from policy consideration through the various legislative stages in the Assembly can be obtained here and Guidance on the legislative process is also available from departmental Legislation Liaison Officers and from the Legislative Programme Secretariat in Executive and Central Advisory Division in the Executive Office.

The key stages of the legislative process and approximate associated timescales are set out in the following table:

Timescale for development of primary legislation

	Stage	Time required (in months)	Comment
A	Scoping		Identification of potential requirement, resourcing, planning
B	Policy development		Including impact assessments up to clearance by Minister
C	Policy consultation clearance	1	With Committee and Executive
D	Policy consultation	3	
E	Policy finalisation		Including impact assessments and clearance with Minister
F	Policy clearance	1	With Committee and Executive
G	Legislation drafting	6-12 (or more)	Including preparation of instructions to Office of the Legislative Counsel. Considerably longer required for large Bills
H	Legislation clearance	1	With Executive
I	Legislation consultation	3	Including pre-legislative scrutiny with Committee
J	Legislation finalisation		Including clearance with Minister
K	Bill: clearance	1	With Executive
L	Bill: introduction	1	Including clearance by the Speaker and (if appropriate) Secretary of State
M	Bill: second stage		
N	Bill: committee stage	3 (say)	Six weeks minimum but add time for extension, report print, etc. (Can be extended by a further 2-3 months if it coincides with the Assembly's summer recess)
O	Bill: consideration stage	1-2	
P	Bill: further consideration stage		
Q	Bill: final stage	2	
R	Bill: Royal Assent		Including clearance by the Attorney General (six weeks from Final Stage)
S	Act: operative date		
(Note: the following stages only apply if subordinate legislation is appropriate, in which case stages T to V can be carried out in advance of the operative date of the Act)			
T	Subordinate policy development		At least SL 1 (a letter advising of the proposal for a Statutory Regulation) to Committee, but public consultation if required
U	Subordinate policy clearance		With Executive if affirmative or confirmatory procedure
V	Subordinate drafting		
W	Subordinate (making) printing & laying		
X	Subordinate affirmation (if applicable)		Allow sufficient time between laying and debate
Y	Subordinate operative date		Allow 21 days from laying if negative procedure
Z	Subordinate confirmation (if applicable)		

CHAPTER 6:

Engagement

For more detailed information, click HERE to access the Policy Champions Network Effective Stakeholder Engagement Good Practice Guidelines.

In its simplest sense engagement and consultation is about talking to people, particularly those who are to be affected by the policy or intervention. Government has faced criticism in the past for treating consultation as a tick box exercise where a near final policy document is circulated to 'the usual suspects' for comment.

Engagement is at the heart of the Executive's commitment to openness and inclusivity. It is firmly embedded in the culture of the public service in Northern Ireland and is particularly important in the context of the statutory duties on equality and good relations under Section 75 of the Northern Ireland Act 1998.

Engagement is not an end in itself. The most fundamental reason for engaging in formulating policy is to help develop solutions which will work and gain acceptance in practice. Early informal engagement with key stakeholders and in particular those involved in front-line service delivery and service users is therefore of key importance. Proceeding with no or token engagement may appear to save time in the short term, especially in a context of limited resources, but it can result in problems later. For example, correspondence campaigns due to lack of buy-in to the policy from key opinion-formers; Assembly questions and debates where Ministers have to be very much on the defensive; or policies which simply do not work effectively and have to be put right, possibly at considerable expense.

The strongest forms of engagement are those which happen regularly throughout the entire policy cycle. Not only does this provide important feedback, leading to more effective policy development, it can help secure the buy in and a sense of ownership from key stakeholders that are crucial to the success of any policy or intervention. The emergence of social media has created new avenues for engagement. This has led to there being different expectations on how government should engage. People are now able to comment on issues in an instant and, as a consequence, expect a response to their views instantly too.

However, it is important to ensure that any engagement is tailored to the groups trying to be reached.

Guidance on Consultation

Machinery of Government guidance:

NI Direct guidance on public consultation:

Citizen Space:

National Archives guidance on consultation:

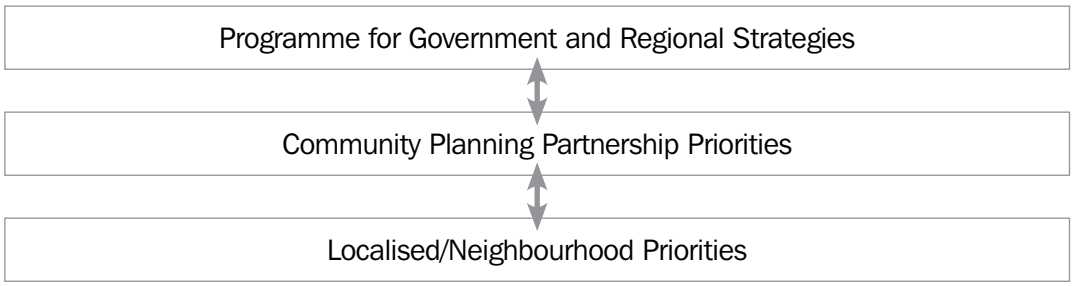
Community Planning

With the advent of Community Planning, it is essential that policy-makers fully engage with the relevant local councils. Community Planning came into operation on 1st April 2015 as part of the full implementation of local government reform.

The new duty of community planning requires councils as the lead partner to be responsible for making arrangements for community planning in their areas. They will work with statutory bodies and their communities to develop and implement a shared vision for promoting the well-being of an area, community cohesion and improving the quality of life of its citizens.

The Local Government Act (Northern Ireland) 2014 provides the high level framework for the operation of community planning. All organisations involved in community planning must have regard to their legal obligations and the potential impact on the community planning process.

As can be seen from the diagram below community planning is the key over-arching partnership framework helping to co-ordinate other initiatives and partnerships and where necessary acting to rationalise and simplify a cluttered landscape. It has the ability to improve the connection between national priorities and those at regional, local and neighbourhood levels.



For more information on Community Planning, go to the Guidance on Community Planning.

Making Lives Better - Digital Transformation of services for citizens - Government Digital Services E-government

Digital transformation of public services is about making lives better through delivering better outcomes for society and is a Programme for Government imperative. Government aspires to embrace 'digital' in everyday public services to deliver better outcomes, with citizens and businesses digitally enabled to better engage with government in their time and at a location of their choice. Under the NICS digital first mandate, public services are being transformed by applying a 'digital by design' principle. This means that core systems and processes are being transformed to enable efficient and effective delivery and the citizen and businesses get a better service.

Digital services are being offered online through NI Direct. NI Direct is the primary source of information for central Government in Northern Ireland and the primary place where citizens can transact services with central government. 'Digital' enhances sustainability, facilitates user friendly interactions, enables self service and drives citizen engagement /behaviour as well as maximising choice and convenience. 'Digital' is also connecting businesses so that government services are easier to use and red tape is reduced. As well as promoting a 'digital first' approach one of the key principles of the NICS Citizen Contact Strategy is that transactional services should be 'accessible and inclusive' . This means consideration should also be given to using alternative channels to communication with service users, such as SMS/text, webchat and social media. Digital inclusion initiatives should also be considered so that all citizens regardless of their skills, access or motivation have the appropriate support to access online public services. When considering digital platforms, policy-makers should take note of the Equality Commission Initiative, 'Every Customer Counts' which provides a free self-assessment tool to help assess how accessible the proposed service would be to people with limited access to technology. Also see the good practice in the public sector publication: Promoting Accessible Services - Good practice in the public sector.

Citizens should not need to know how government is organised in order to transact his or her business. Where more than one part of government is involved in completing a transaction consideration should be given at the outset to building service delivery through a collaborative working approach across Departments in a way that is invisible to the citizen and provides a better, 'joined-up' service as well as a better citizen experience. A collaborative approach to policy problem solving, for example through Innovation Labs, could provide opportunities not only for departments to be more joined up but also to be truly innovative.

All parts of government, including policy, delivery and IT, have an important role to play in the delivery of digital government in creating a digital environment for those who wish to engage with us digitally. Services need to be delivered in more innovative and collaborative ways with more emphasis placed on the delivery channels used to consult and engage with citizens and businesses in order to inform public policy development.

Online consultation and digital engagement as a means of facilitating pre-consultation feedback are tools that can be added to the wider policy development toolkit. Online consultation will help to engage wider audiences, including audiences that are harder to reach, as well as help increase Civic Participation across the board. Crucially online consultation ensures robust standards, compliance and security of any data captured. NI Direct 'Citizen Space' is the NICS online consultation and survey portal and is available for all departments to use. 'Citizen Space' supports an end to end online consultation process, for policy-makers and users, through an intuitive browser-based interface. 'Citizen Space' also adheres to UK government standards regarding cybersecurity and accessiblility and is compliant with the Data Protection Act (DPA).

Departments should increasingly be looking to improve choice in the way in which the citizen can access government services. Access might be via the NI Direct telephone contact centre, online via the internet or across a counter, but perhaps not one solely dedicated to a particular department. The potential for using digital approach technology should be a central key criterion in all policy reviews.

Co-design/co-production

Here are some definitions which will help to explain the difference.

Co-design: is an approach to design attempting to actively involve all stakeholders (e.g. employees, partners, customers, citizens and users) in the design process to help ensure the result meets their needs and is useable. A design is a plan or method for doing something. The person who discovered that rubbing sticks over tinder can make fire was a designer, and the process was the design. Equally, a person who produces architectural drawings for an office block is a designer, and the plans are the design. Co-design, therefore occurs when more than one person is involved in drawing up a plan for doing something.

Co-production: production is what happens when the raw materials needed to do something are brought together and combined to generate something new. Working out what to do is design work, doing it is production. So the person who invented airplanes is a designer, but a person who assembles them is a producer. Co-production occurs when more than one person is involved in making something happen.

Co-creation: is a term being used to encompass the entire process of design and production.

Policy is not developed in isolation. To ensure that the partnership approach outlined under population accountability is established and maintained, policies should be developed in partnership with stakeholders, with voluntary and community groups, charities etc, as well as the people who are most likely to be impacted or otherwise affected by the implementation. In this way there is real buy-in to the policy intervention being proposed, through a genuine co-design or co-production process.

People feel a sense of understanding of what is planned, why it is being done in a certain way, and what the proposed/expected outcomes will be. In this way there is a shared sense of ownership in the policy. People and organisations are invested in it, and will be more likely to make it a success.

Click HERE to read a case study of the OFMDFM Summer Camps Co-Design process.

CHAPTER 7:

Evaluation

Have we achieved what we set out to achieve?

This should be the starting point for evaluation. Additionally, evaluation should be seen as a continuous process – very few policies are ever 'achieved' in the sense that the reason for the intervention ceases to be a problem. What happens instead is that the reasons change over time to reflect the successes and the failures of previous attempts to get the policy intervention right. In other words it is a process which requires continual assessment, refinement and adaption, before the policy cycle starts again.

Evaluation is an objective process of understanding how a policy or other intervention was implemented, did it have any effect, for whom, how and why. By comparing intended outcomes to/with those actually achieved, good quality evaluations play a significant role in determining the effectiveness of the policy on achieving priorities and objectives, demonstrating accountability and providing defensible evidence to independent scrutiny. They also contribute valuable insight and knowledge to the policy evidence base, feeding into future policy development and as such have a crucial role in the policy cycle.

Not evaluating or poor evaluation makes it difficult to show that an intervention had the desired effect. It will also undermine or hinder attempts at future policy development.

Past experience shows that delivery of policy is rarely a one-off task. It is best understood not as a linear process - leading from policy ideas through implementation to change on the ground - but rather as a more circular process involving continuous learning, adaptation and improvement, with policy changing in response to implementation as well as vice versa. It is therefore important to undertake effective appraisal of policy options initially, and to build ongoing monitoring and review mechanisms into the delivery of policy from the outset.

Equally, formal evaluation has a crucial role in assessing whether policies have actually met their intended objectives. To be effective, policy making must be a learning process which involves finding out from experience what works and what does not and making sure that others can learn from it too. This means that effective ex ante evaluation or appraisal should be carried out as part of the policy development process; new policies must have evaluation of their effectiveness built in from the start; established policies must be reviewed regularly to ensure that they are still delivering the desired outcome; and the lessons learned from evaluation must be available and accessible to other policy-makers. Good evaluation should be systematic, analytical, study actual effects and judge success.

The principal mechanism for learning lessons is through evaluation of new policies and by monitoring and regular review of existing policies. Systematic assessment of policies, programmes and projects helps to improve the design and delivery of current and future policies. It also reinforces the use of evidence in policy making by helping policy-makers find out 'what works'.

The evaluation process can be broken down into 10 key parts outlined in the following figure. This framework should be flexible in recognising that circumstances differ within and between programmes. However, the items listed are the essential ingredients of policy or programme evaluation and will permit a consistency of approach across evaluations.

i. **Planning an evaluation** - Programmes to be evaluated should be prioritised on the basis of importance, openness to influence and adequacy of information. Evaluation should be planned before a programme starts. It is necessary to decide what questions the evaluation will address and who should undertake it, and to ensure that the costs of evaluation are outweighed by the lessons to be learnt.

ii. **Establish the scope and purpose of the evaluation** - This might depend on whether the objective is to identify weaknesses which need to be addressed (a process evaluation) or to assess the overall success of a programme with a view to continuing, expanding or reducing it (an outcome evaluation).

iii. **Establish the rationale, aims and objectives of the policy or programme** - These should be clearly defined prior to programme implementation, but if not, the evaluator should determine them. Is the policy instrument the most effective to address the rationale? This stage also involves identifying indicators of need and establishing the more specific targets which underlie the objectives.

iv. **Specify measures and indicators** - Effectiveness and efficiency measures, and input, output and outcome/impact indicators, in order to assess the value for money of policies. As far as possible, these should allow international comparisons to be made.

v. **Establish the base case for comparison** - What would have happened if the programme had not been implemented? It may be possible to set up a control group for comparison with a group affected by the policy. Alternatively, 'before and after' comparisons can be made.

vi. **Define assumptions** - These may involve assumed causal relationships between a policy and outcomes, or may relate to the external environment.

vii. **Identify side effects and distribution effects** - Effects (beneficial or otherwise) beyond those originally envisaged for the policy; equality/equity impacts and impacts on voluntary activity and the voluntary sector.

viii. **Analysis** - This will depend on whether it is a process or outcome evaluation. Both quantitative and qualitative analysis may be important. The key measure is net additional output. Cost Benefit Analysis provides a useful framework.

ix. **Evaluation outcome** - Recommendations such as programme continuation, modification, succession or termination. This leads into reappraisal and appraisal of new proposals. Sensitivity analysis should be carried out.

x. **Presentation and dissemination of results** - The evaluation process and outcome should be adequately documented. The report must reach senior management and be widely disseminated to staff concerned with future project design, planning, development and management. Seek advice on the use of data analytics and graphics when considering the format of the document.

More detail on taking forward appraisal and evaluation can be found in the Northern Ireland Guide to Expenditure, Appraisal and Evaluation; and

the Treasury Green Book.

CHAPTER 8:

OBA - Outcomes Based Accountability

We all want to know if we are making a difference.
We all want to improve the lives of our customers/citizens.

Outcomes Based Accountability (OBA) helps us do that. It is an outcomes based approach that enables services to understand their impact on customers'/citizens' lives.

Developed by Mark Friedman and described in his book, 'Trying Hard is Not Good Enough,' OBA is being used throughout the world, to produce measurable change in people's lives.

At its heart, OBA asks us three questions:

- **How much do we do?**
- **How well do we do it?**
- **Is anyone better off?**

If we can answer those three questions we will be well on the way to knowing our impact. We can use OBA's 'Turning the Curve' tool to understand trend data and construct strategies for improving our outcomes.

NICS has chosen OBA because it is easy to use, provides a common language, is outcomes focused and it is a framework that staff can embrace. For example, the current Programme for Government has been developed using an outcomes based approach.

Click HERE to watch a Powerpoint presentation outlining OBA.

So, what is OBA?

OBA is a framework that provides step-by-step methods that turn data into action. Starting with quality of life conditions (called “outcomes”), agencies and cross-agency partnerships identify indicators, produce trend lines, consider best practice, and develop strategies, action plans and budgets that are then implemented, monitored and continuously improved.

When considering outcomes there are some fundamental issues to consider:

- The starting point for any planning process should be a clear statement of the conditions of well-being desired (ie the outcomes);

OBA is a conceptual approach to planning services and assessing their performance that focuses attention on the results - or outcomes - that the services are intended to achieve.

It is also seen as much more than a tool for planning effective services. It can become a way of securing strategic and cultural change: moving organisations away from a focus on ‘efficiency’ and ‘process’ as the arbiters of value in their services, and towards making better outcomes the primary purpose of their organisation and its employees.

Further distinguishing features of the approach are

- The use of simple and clear language;
- The collection and use of relevant data;
- The involvement of stakeholders, including service users and the wider community, in achieving better outcomes should be measured by the use of appropriate data (indicators);
- Having the data and knowing the historical trends and likely forecast for the chosen indicators is necessary to develop understanding of what is driving them (the ‘story behind the baseline’);
- This in turn is essential to inform what could be done to improve the situation (the Action Plan); and
- Any strategy to improve quality of life indicators for people in communities should be simple, based on common sense, written in plain language and, most importantly of all, be useful.

The Northern Ireland Context

To develop effective policy it is necessary not only to understand what policy is and how to develop it but also to understand the context in which it is being developed.

Following an election, the Executive agrees a Programme for Government (PfG) that sets a strategic direction for the work of Government. This is the Executive's articulation of the shared aspiration of society, and the ultimate purpose of public sector activity. It is developed through a process of engagement with stakeholders, citizens, representative organisations, businesses, and community and voluntary organisations. By allocating a budget and agreeing an annual work programme the Executive manages the delivery of the Programme drawing collaboratively on the resources of all of those with a contribution to make, with the aim of achieving better outcomes, and greater wellbeing, for everyone in society.

The current PfG has been developed using an outcomes based approach. It starts by expressing clearly the desired end result or outcome and works back to ascertain and deliver what needs to be done to achieve it. It asks two simple questions:

- What quality of life conditions do we want to create for people?
- How will we know if we're making progress towards these?

This encourages us all to focus on the difference that we make and not just on the inputs and processes we control. Success for the Executive and its Public Bodies is about achieving outcomes and it is right that it should be held to account for creating real improvements to the quality of people's lives, whilst also reflecting that public services have a cost to citizens through taxes, duties and charges.

The overarching vision of the PfG will be achieved through the implementation of many different interventions, programmes and services, focusing on improving the quality of life of individuals, groups and families. The cumulative effect of all these interventions will enable progression towards the achievement of outcomes, and the overarching PfG vision.

The development of interventions is where policy development occurs - whether relating to a single service or a wider programme. Not all policy development will result in new interventions – decisions to modify, combine or stop existing interventions are equally valid.

Similarly, not all policy development arises in pursuit of PfG goals. Sometimes specific issues will arise that were not anticipated, but which require a policy response. Equally, individual Ministers will often have policy agendas related to party positions that they will wish to implement.

A wide variety of agencies and organisations in the public, private, community and voluntary and social economy sectors are doing things, or could be doing things that have the potential to contribute to the delivery of better outcomes for people. In line

with OBA methodology, engagement must take place with these stakeholders to determine what interventions could and should be implemented to improve population outcomes.

Two of the key ways to promote adoption among stakeholders is to provide bespoke guidance to stakeholders commensurate with their role in the overall OBA process and highlighting the internal benefits to stakeholders in adopting the process in terms of using the evaluation of outcomes achieved to inform future strategy planning and delivery.

Effective policy development acknowledges this complexity – and uses the influence of government to move towards better outcomes – based on the best available information and evidence.

Generally, although not exclusively, the primary purpose of public policy development is to support the achievement of the vision set by the Executive. Doing this successfully will require navigating a complex environment and fostering more effective connections between the many agencies active in society.

This guidance follows the outcome-focused approach adopted in the Programme for Government, and seeks to support effective alignment between policy development and the strategic direction set by the Executive.

OBA Definitions:

Language Discipline: OBA starts with language discipline. If we are not disciplined about language, then we are not disciplined about thought. There is an appalling lack of language discipline in social enterprises around the world. Five definitions are necessary for clear communication about the very complex content of social change. What is important about these definitions is the distinction between the five ideas and not the particular words used to label these ideas.

"Outcomes" (or "Results") are conditions of well-being for children, adults, families and communities. Outcomes include such things as Safe Communities, Socially Included Families, Clean Environment, Prosperous Economy.

"Indicators" are measures that quantify the achievement of results. So, for example, the unemployment rate helps quantify Prosperous Economy. The rate of homelessness helps quantify Socially Included Families.

"Performance Measures" are measures that tell if a programme, agency or service system is working well. OBA uses a simple three part categorisation scheme for performance measures: How much did we do? (e.g. # served), How well did we do it? (e.g. % timely service), Is anyone better off? (e.g. % showing improvement)

"Turning the Curve" means turning the baseline or trend line in the right direction.

"Strategies" are coherent sets of actions that have a reasoned chance of turning the Curve.

OBA in a Nutshell 2-3-7

2 Kinds of Accountability

- Population-or Community-Level Quality of Life
- Performance-or Programme-Level

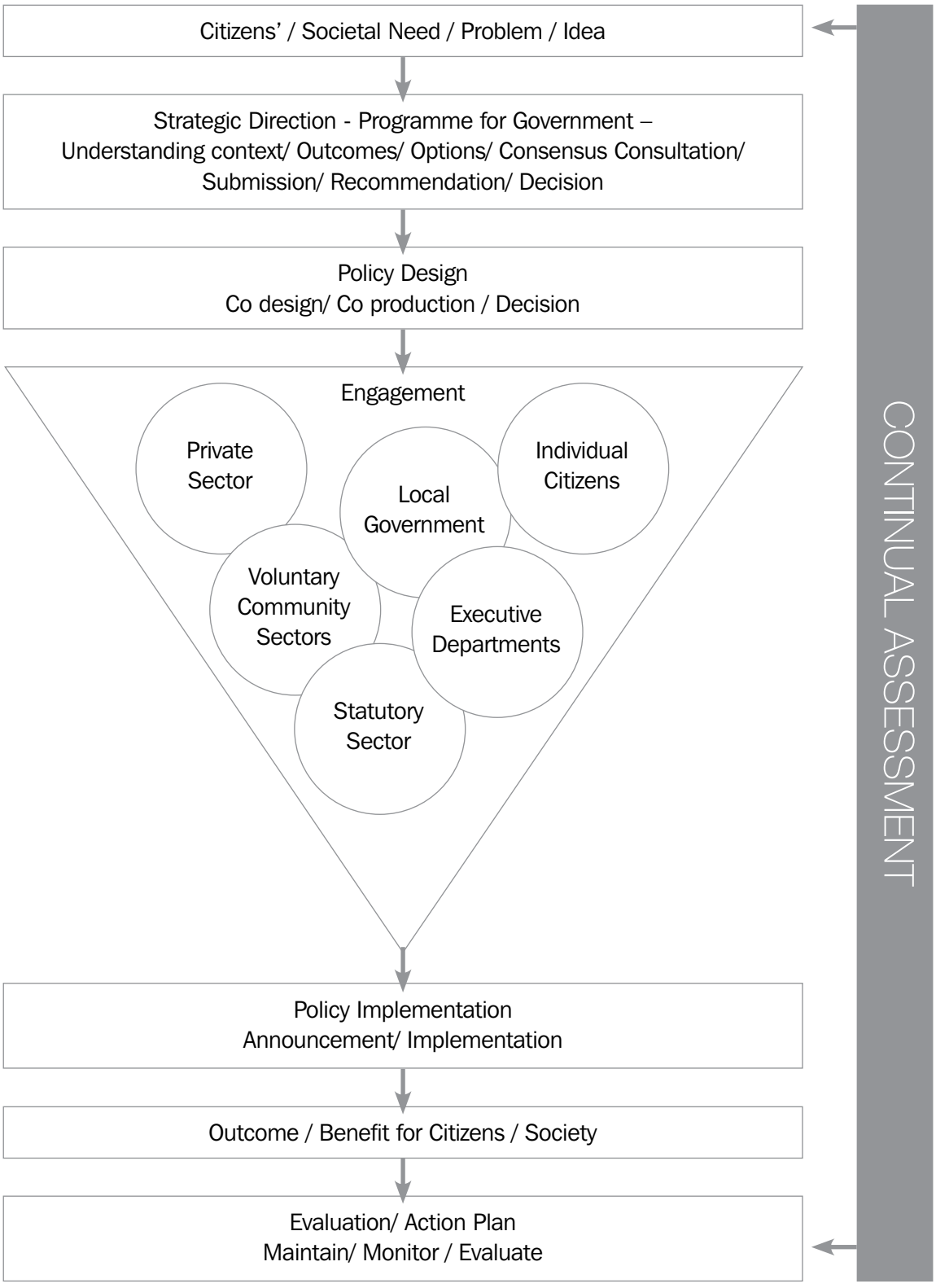
3 Kinds of Performance Measures

- How much did we do?
- How well did we do it?
- Is anyone better off?

7 Questions

- From Ends to Means (In less than an hour)

Outcomes focused approach to policy making



Click HERE to read a case study from Leeds which sets out the OBA process they used to make Leeds a child-friendly city.

CHAPTER 9:

Accountability: Population and Performance

OBA makes a fundamental distinction between Population Accountability and Performance Accountability.

Population Accountability is about quality of life in a geographic area such as a community, city, county, local or regional council area, state or nation. Making progress on population quality of life requires the participation of a wide range of partners. No single agency or level of government can bear sole responsibility for quality of life. Quality of life partnerships require new ways of working together that bridge across different systems and different cultures. In many countries, such partnerships have now successfully used OBA to turn the curve on critical quality of life indicators.

For example, the Connexions Council in Newcastle UK has used these methods to make dramatic progress on the percentage of young people "Not in Education, Employment or Training." Click HERE to read this case study.

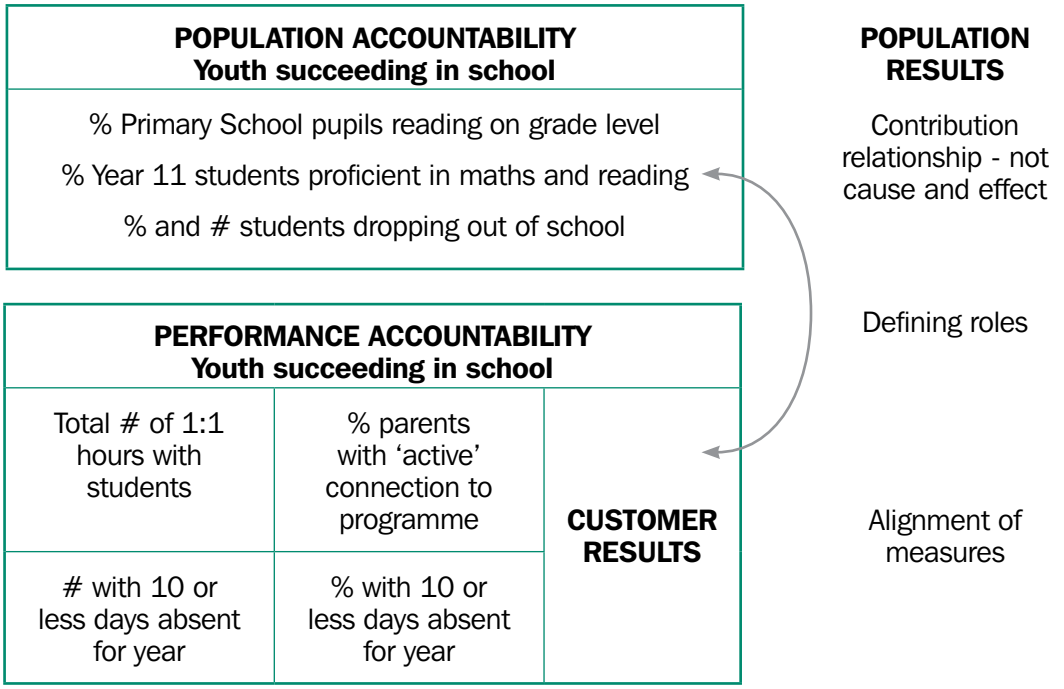
Performance Accountability, by contrast, is about how well government and nongovernmental services are delivered and whether they are making a difference to the lives of their customers. OBA provides a five step method for identifying the most important performance measures for any service. Trend lines are then prepared for these measures. Agency managers and executives use seven OBA questions to monitor and improve performance on a monthly or quarterly basis. For example, in North Lincolnshire, UK, staff from Social and Housing Services used OBA methods to produce a significant increase in the occupancy rate for public sector housing.

OBA has been used successfully in countries around the world, including Australia, Canada, Chile, Ireland, Israel, Moldavia, the Netherlands, New Zealand, Norway and the UK. It can provide OECD countries with a common way of working across geographic boundaries, across service systems and across cultures to make a difference to the lives of their citizens. Where data has been seen as the domain of specialists, OBA shows that data is something everyone can understand and use.

Linking population and performance accountabilities together

By linking population and performance accountabilities together, we can see how client results, delivered by agencies, programmes and service systems, contribute to quality of life results for a whole population.

The linkage between population and performance



For example a six week "parenting teens" programme that improves parenting skills and knowledge, contributes to "young people being healthy and safe", which is a quality of life condition for a population group (a population result / outcome).

The next diagram shows the clear lines of accountability for an individual programme (youth mentoring programme) that is only responsible for its own clients and not for keeping all young people healthy and safe. But the results it achieves for its clients contribute to the wellbeing of the whole youth population.

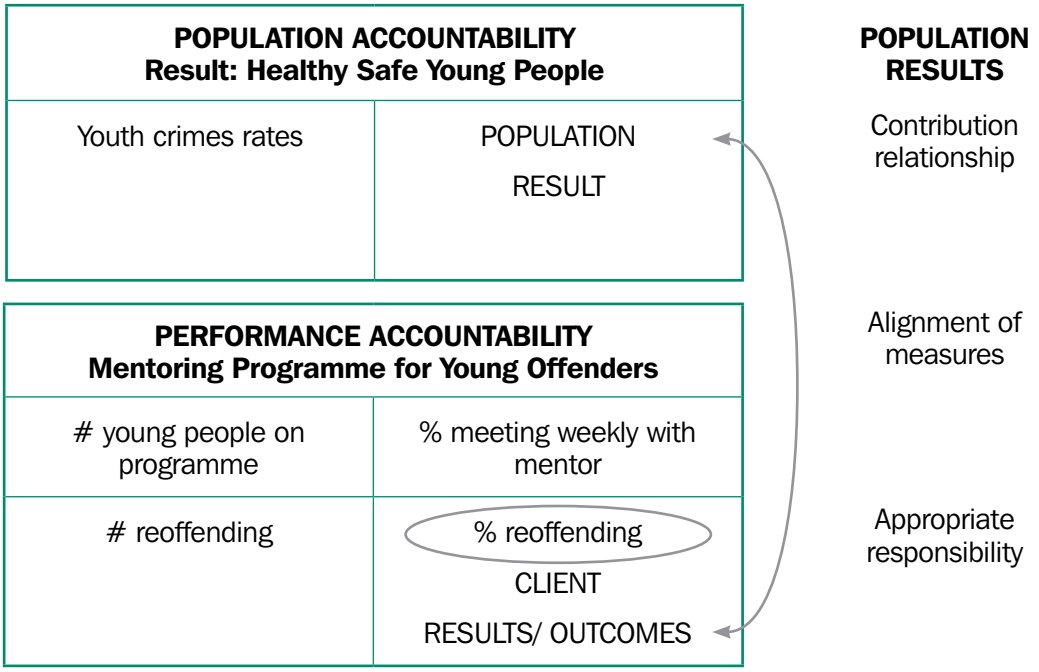


Diagram explanatory text: The diagram shows the relationship between population accountability and performance accountability. It provides an example of how the performance measure in the bottom right quadrant for client outcomes from a youth mentoring programme for young offenders, contributes to the population result (healthy safe young people) and the population indicator (rates of youth crime). The diagram shows that the programme is only held responsible for the outcomes of its clients – not all young people. It also shows how OBA helps align performance measures, population indicators and results - creating a clear line of sight between these measures.

There is a difference between attribution and contribution. No single programme can improve a population results, but a programme can show how it has contributed to a population result through measuring client outcomes.

CHAPTER 10:

The 7 Questions

Here is the 7 step thinking process that can be used at the national, regional, council, city or neighbourhood levels **to improve quality of life:**

The 7 Population Level Questions:

1. What are the quality of life conditions we want for the children, adults and families who live in our community?
2. What would these conditions look like if we could see or experience them?
3. How can we measure these conditions?
4. How are we doing on the most important measures? (baselines[*] and causes)?
5. Who are the partners that have a role to play in doing better?
6. What works to do better, including no-cost and low-cost ideas?
7. What do we propose to do?

When addressing these steps, always include the associated Statutory Equality and Human Rights considerations. See the section on Policy Scrutiny for more information.

[*] Note, the word "baseline" has many possible definitions. The definition used in OBA comes from the field of budgeting and finance, where both historical data and a policy neutral forecast is shown. The word baseline and trend line are often used interchangeably.

Here is the 7 step thinking process that can be used by government and non-government managers **to improve the performance of their services:**

The 7 Performance Level Questions:

1. Who are our customers, clients, people we serve? (e.g children in a child care programme)

   Many programmes have more than one customer group. A complete inventory of who these groups are will need to be developed. Sometimes it might seem that some groups have little in common so it might be helpful to distinguish between direct and indirect customers, or primary and secondary, or internal and external.

2. How can we measure if our customers/clients are better off? (performance measures about client results – e.g. percent of children with good literacy skills)
3. How can we measure if we are delivering services well? (e.g client staff ratio, unit cost, turnover rate etc.)

   These are the second most important measures to develop. They are usually about what staff do and how well the functions of the programme are performed. Think about the most meaningful measures and whether sufficient data exists.

4. How are we doing on the most important of these measures? Where have we been; where are we headed? (baselines and the story behind the baselines)
5. Who are the partners who have a potential role to play in doing better?
6. What works, what could work to do better than baseline, (including no-cost and low-cost items)?

   Each cause or problem points to actions that could be taken to address it and each partner has something to contribute. Consider undertaking fresh research; if possible adopt examples from elsewhere. What is already being done? What is working? What is not working? Why might it not be working? Be creative. Take advice from Research and Statistician colleagues about what different types of resource are possible. Discuss with stakeholders to find out about best practice, existing interventions that work (evidence based) and what actions can be taken. This can be supplemented/verified by research from statistical colleagues.

7. What do we propose to do? (multi-year action plan and budget.)

   This is the most important question. It is the part where we move from thought to action. Organise these actions into a plan that specifies the person responsible for each task, the start and end dates and necessary resources. In the early stages of the process this plan will include partners to contact, data to gather and other actions identified through the questions.

These questions should be used in monthly meetings or planning sessions. All 7 questions should be asked and answered at every meeting, so that the overall coherence of the process is maintained. As managers and partners repeat this process, their answers will get better. Each set of 7 questions leads to an action plan (what we propose to do.) which should include no-cost and low-cost elements that can be acted on immediately

See http://raguide.org/index-of-questions/ for more on this.

See below for practical guidance on identifying performance measures.

How to identify Performance Measures

The 5 Step Process below will help you identify performance measures, select the most important ones and identify a data development agenda.

Step 1. HOW MUCH WE DO (Upper Left):
Draw the four quadrants on a big piece of flip chart paper. Start in the upper left quadrant. First put down the measure "# of customers served." in the upper left quadrant. Ask if there are better more specific ways to count customers or important subcategories of customers, and list them. (e.g. # of families served, # of children with disabilities served etc.). Next ask what activities are performed. Convert each activity into a measure (e.g. "we train people" becomes # of people trained.) When you're finished, ask if there are any major activities that are not listed.

Step 2. HOW WELL DO WE DO IT? HOW WELL DO WE PERFORM THESE ACTIVITIES? (Upper Right):
Ask people to review the standard measures for this quadrant that apply to most if not all programmes, services or activities (e.g. unit cost, staff turnover, etc.) These are shown on the Performance Matrix in the upper right quadrant under "common measures". Write each answer in the upper right quadrant. Next take each activity listed in the upper left and ask if there are measures that tell whether that particular activity was performed well. If you get blank looks, ask if timeliness matters, if accuracy matters. Convert each answer into a measure and be specific (e.g. the timeliness of case reviews becomes "percent of case reviews completed on time" or "percent of case reviews completed within 30 days after opening."

Step 3. IS ANYONE BETTER OFF? (Lower Left and Lower Right):
Ask "In what ways could clients be better off as a result of getting this service? How we would know if they were better off in measurable terms?" Create pairs of measures (# and %) for each answer (e.g. # and % of clients who get jobs above the minimum wage). The # answers go in the lower left; the % answers go in the lower right.

There are two ways to state these kinds of measures: point in time and improvement over time (e.g. % of children with good attendance this report card period vs. % of children whose attendance improved since the last report card period).

This is the most interesting and challenging part of this process. Dig deep into the different ways this can show up in the lives of the people served. Explore each of the four categories of "better-offness": skills/knowledge, attitude, behaviour and circumstance. If people get stuck, try the reverse question: "If your service was terrible, how would it show up in the lives of your clients?"

Look first for data that is already collected. Then be creative about things that could/ should be counted and the ways in which data could be generated. It is not always necessary to do 100% reporting. Sampling can be used, either regular and continuous sampling or one time studies based on sampling. Pre and post testing can be used to show improvement in skills, knowledge or attitude. Surveys can be used which ask clients to self report improvement or benefits.

NOTE: Every performance measure has two incarnations: a lay definition and a technical definition. The lay definition is one that anyone could understand (e.g. Percentage of clients who got jobs) and a technical definition which, for percentages, exactly specifies the numerator and denominator (e.g. the number of clients who got jobs this month, divided by the total number of clients enrolled in the programme at any time during the month).

Now you have filled in the four quadrants with as many entries as you can. Next we select the most important measures and a data development agenda. Here's a SHORT CUT way to do that:

Step 4. HEADLINE MEASURES: Identify the measures in the upper right and lower right quadrants for which there is (good) data. This means decent data is available today (or could be produced with little effort). Circle each one of these measures with a colored marker. Ask "If you had to talk about your programme with just one of these circled measures, which one would it be?" Put a star by the answer. Then ask "If you could have a second measure… and a third?" You should identify no more than 4 or 5 measures. And those should be a mix of upper right and lower right measures. These choices represent a working list of headline measures for the programme.

Step 5. DATA DEVELOPMENT AGENDA: Ask "If you could buy one of the measures for which you don't have data, which one would it be?" Mark that with a different colored marker. "If you could have a second measure… and a third?" List 4 or 5 measures. This is the beginning of your data development agenda in priority order.

The longer and more thorough method for selecting performance measures involves rating each measure High Medium or Low on three criteria: Communication, Proxy and Data Power.

1. Communication Power: Does the performance measure communicate to a broad range of audiences? It is possible to think of this in terms of the public square test. If you had to stand in a public square and explain the performance of this programme to your neighbours, what two or three measures would you use?
2. Proxy Power: Does the performance measure say something of central importance about the programme (agency or service system)? Can this measure stand as a proxy for the most important things the programme does?

3. Data Power: Do we have quality data on a timely basis? We need data which is reliable and consistent. And we need timely data so we can see progress – or the lack thereof – on a regular and frequent basis.

Both methods will lead to the same list. The SHORT CUT works because the "forced choice" process leads people intuitively to think about communication and proxy power. When they do this for measures where they have data, the selected measures are the Headline Measures. When they do this for measures where they do not have data, the selected measures are the Data Development Agenda.

The headline measures are the starting point for using data to improve programme performance.

For more information: see What do we do with performance measures once we have them? How can we use performance measures to improve performance? **and following questions.**

Several things to keep in mind here:

1. It is best if the programme or service, for which performance measures are developed, has some organisational identity. Performance accountability is about holding managers accountable for the performance of what it is they manage. If the thing to be measured has no organisational identity, then there is no person or persons who can be held accountable for its performance.

   This does not mean that the thing to be measured must be a box on the organisation chart or a physical unit in a single geographic location. In matrix management, for example, it can be a function that cuts across organisation lines for which some person or persons has been given lead responsibility (for example budgeting or staff development, where some staff may be decentralized but the function is still managed or "lead" by someone.) It can be a programme which operates in many different locations. The notion of fence drawing is flexible enough to work with any organisational structure old or new.

2. Second thing to keep in mind: When you are trying to teach these ideas to new people start with small units which have a clear identity. Then move on to larger units and functions without physical organisational identity.

3. Third thing: performance measurement starts with the idea of customers or clients. CUSTOMERS are people who can be made better or worse off by the services of the programme.

Performance measurement is an easier discussion for organisational entities that can clearly identify their customers. So, for example, direct service programmes like child support enforcement or mentoring will have a head start on programmes or activities where this discussion is unclear.

Performance measurement of customer well-being is harder for administrative functions such as budget, personnel, general services etc. It will be necessary to spend some quality time helping these people understand/discover who their customers are. Hint: for administrative functions the customers are often the managers of the agency itself. And customer satisfaction turns out to be the most important lower right quadrant measure.

One of the best ways to teach this method is to conduct a "fishbowl" at the front of the room. Get four or five people to volunteer who know a particular programme well. Position them in chairs in a small semi-circle at the front of the room, facing forward (i.e. back to everyone else). Conduct a short session (15 to 20 minutes) using the technique above. Periodically pause to ask if the larger audience has any questions. If time permits, break the larger group into groups of 6 and have them pick a programme. One member of the group then leads the group through the 5 steps of the technique above. Depending on time, two or three rounds of this could be done. Debrief the large group. "What worked and didn't work about this experience? What did you learn? How many think they could lead a small group of coworkers through this thinking process?"

Technical note: Some people correctly point out that client results actually have two components which parallel the difference between outcomes and indicators at the population level, i.e. a plain language statement of client well-being (clients are self sufficient) and a measurement that describes this condition of well-being (# and % of clients who get jobs and keep them 6 months or more). In practice, these two ideas are addressed in a single step in the thinking process which asks "In what ways could clients be better off as a result of getting this service? How we would know if they were better off in measurable terms?" (step 3 above). Experience suggests that when these two questions are separated as they are (and must be) at the population level (e.g. first fully answer in plain language, then take each plain language statement and identify measures that can serve as proxy) then the process loses its common sense feel and becomes unnecessarily complicated and time consuming.

One interesting and usable variation of this approach, used by the Department of Developmental Services in California, listed all client results in plain language, and then developed a set of measures for the group of client results as a whole (i.e. not condition by condition).

CHAPTER 11:

Evaluation in an Outcomes Framework

Within the context of Outcomes based policy development it is important that the question of how a particular policy or intervention is to be evaluated is considered at the earliest stages of development. This is done through the development of the performance measures of a policy. In Outcomes based policy development evaluation of performance or intervention outcomes is based around the following simple questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

OBA Performance Matrix

Below is a table that outlines the performance matrix and includes some example measures.

	Quantity	**Quality**
Input	**How much did we do? (#)** • Customers served • Activities delivered	**How well did we do it? (%)** • Common measures (e.g. % participants completing course) • Activity specific (e.g. % completed on time, % appointments kept) • Cost £ & Costs per unit £
Outcome	**Is anyone better off as a result? (#)** • Skills or knowledge (e.g qualifications gained) • Attitudinal or opinion (e.g. towards school) • Behaviour (e.g attendance) • Circumstance (e.g in work) • Global metrics (see additional guidance)	**Is anyone better off as a result? (%)** • Skills or knowledge (e.g qualifications gained) • Attitudinal or opinion (e.g. towards school) • Behaviour (e.g attendance) • Circumstance (e.g in work) • Global metrics (see additional guidance)

< back to Step 2

Not all Measures are created equal

The most important measures will be those under the 4th quadrant "Is anyone better off as a result? (%)" as these determine the overall success of the policy as it will contribute to the overall outcomes as set out in the PfG.

The upper left is the least important. And yet we have some people who spend their whole careers living in this quadrant counting cases and activity. Somehow we have to push the discussion to the lower right quadrant, the one that measures whether our customers are better off.

Measuring effort, effect, quantity & quality

	QUANTITY OR QUALITY	
Input Effort	**Least important**	**Important**
Output Effect	Is anyone better off as a result	**Most Important**

CHAPTER 12:

Reference Section

Policy Champions Network

The Policy Champions Network (PCN) is a group of senior civil servants, whose role it is to build capability in policy making across the NICS.

Each of the Policy Champions has a role and a responsibility to actively engage with their Departmental policy-makers to identify needs and to promote and lead new policy development approaches in their own Department.

PCN has wide representation from each of the NICS departments, as well as the Heads of Profession in Economics, Statistics and the Office of the Legislative Counsel.

Collectively, it works to create an open and inclusive policy making process where knowledge and experience can be pooled to develop policies that deliver real and sustainable benefits. PCN has progressed a wide range of initiatives to ensure effective policy support for Departmental Boards and policymakers alike. As the NICS faces up to a challenging agenda in the coming years, PCN will work to ensure that policy-makers have the necessary skills, support, encouragement and expertise to deliver on these challenges.

PCN meets quarterly and is supported administratively by a small team based within the Department for Infrastructure.

Case Studies

There are a growing number of case examples where the application of OBA has produced a clear measurable improvement in the well being of a defined population. Here is one example from Newcastle, UK, paraphrased from a report by Sara Morgan–Evans, Local Connexions Manager.

Newcastle Council - improving the number of NEETS

Connexions is a service tasked with providing information, advice, guidance, support and referral to all young people in England aged between 13 and 19 and up to 25 for those with learning difficulties and/or disabilities. The key measure of success is the number of 16-18 year olds who are not accessing education, employment or training (NEET). Within the Tyne and Wear region of north-east England, the Newcastle Connexions team is tasked with delivering the Connexions service to the 30,000+ young people educated in the City of Newcastle.

In November 2003 the Newcastle NEET figure stood at 15%, roughly the same level as the previous decade. By January 2009, the Newcastle Connexions team had reduced this figure to 8.5%, the largest reduction of any comparable area in the UK. The local Connexions manager attributes much of this success to training in Outcomes-Based Accountability. After the Local Manager attended an OBA training session, she delivered OBA training first to the Connexions management team and then the whole Connexions team.

Staff began to look at their work with young people in a different way, placing less significance on how many times or how long they spent with clients and changing the emphasis to the difference that their interventions made. Staff also began to look more closely at the barriers facing young people who were NEET and the importance of networking with other agencies to support the removal of those barriers.

Managers took a fresh look at the team delivery plan and the plans delivered in partnership with other organisations such as schools. Plans were reviewed in terms of the impact that they would have rather than a matter of fixed allocation (e.g. assigning staff time based on school enrolment regardless of the characteristics of the students). New approaches were tried including linking with adult services to target workless households.

At least part of the success of Newcastle's reduction in NEETs was due to the dissemination of OBA as a way of working to all staff in the team. Practitioners working directly with young people saw that they could have an impact on individual lives and that impact on individuals could translate into an impact on the community.

Newcastle's success with OBA is not unique. Between 1995 and 2004, Vermont showed similar progress in reducing the blood lead content level for young children. Between 1994 and 2002, Santa Cruz County, California produced significant reductions in teen alcohol and drug use. Between 1996 and 2004, Dayton Ohio significantly improved elementary and secondary school attendance. Between 2002 and 2005, North Lincolnshire, UK increased occupancy rates in public housing. And more recently in 2009, Christchurch, New Zealand changed the trend on the rate of graffiti site tagging in the city.

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Making Leeds a Child-friendly city for Children, Young People and Families in Leeds, UK Using Outcomes-Based Accountability

Leeds is the third largest city in the UK, with a diverse population of more than 750,000 people, including 180,000 children and young people. It is an affluent and prospering city, but also has some of the most deprived communities in the country. In July 2009, the Office for Standards in Education (Ofsted) carried out an inspection of city services for vulnerable children and young people, as part of an ongoing high-profile national inspection programme. The inspection was extremely critical of services in the city, finding that the city failed to adequately safeguard children and young people. Subsequently the government gave the local council a 'notice to improve' and for a short time established an independently chaired improvement board to guide and support improvements.

In 2010 the council responded by making some significant changes. A new Chief Executive, Tom Riordan and a newly elected Executive Council Member for Children's Services, Councillor Judith Blake, appointed Nigel Richardson as Director of Children's Services. This appointment, along with a new leadership team, acted as the catalyst for a new 'whole system' approach to services for children and young people. From the outset, Outcome based accountability (OBA) was chosen as the means through which the Council and the wider partnership would manage and judge the effect of their collective efforts.

Working with a partnership of key service providers, a new plan for children's services was developed and implemented. This plan centred on creating a single, unifying narrative about the ambition for children in the city: To be the best city in the UK to grow up in, and to be recognised as a Child Friendly City. At the heart of this ambition was an emphasis on adopting three fundamental behaviours to guide every aspect of work with children and families: The first centred on listening to the voice of the child so that their thoughts and feelings would guide the decisions practitioners make that affect them. The second was about using approaches, techniques and language that works with families to solve problems, rather than doing things to them, for them, or not doing anything at all. This restorative approach empowers families to safely and appropriately find their own solutions to the problems they face. The third behaviour was about using OBA to constantly and consistently question whether anyone is better off as a result of the work being done and to shape and improve services accordingly. The combination of these three behaviours, within a whole-system, city-wide approach, has underpinned the improvement journey in Leeds between 2010 and 2015.

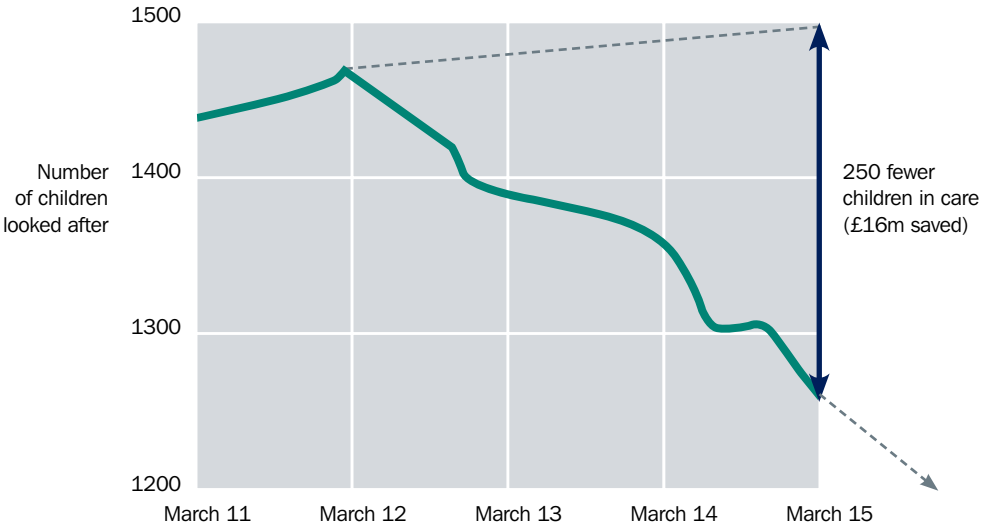
The new Children and Young People's (CYP) Plan for the city was designed using OBA principles and practice. Under the Child Friendly City vision, it set out five outcomes and 12 priorities that would guide all work for children, young people and families. It identified the need to relentlessly focus on three areas in particular, referred to as the Leeds three 'obsessions.' Based on the theory that 'anywhere leads to everywhere', making an impact on these areas would have a positive knock-on effect right across all work with children and families.

The three obsessions are:

- Safely and appropriately reducing the need for children to be looked after.
- Reducing the number of young people who are Not in Education, Employment or Training (NEET)
- Improving school attendance

The OBA methodology was used to develop turning the curve 'scorecards' for each of the obsessions. These scorecards have been regularly employed to report progress to the city's Children and Families Trust Board - comprising senior figures from services working most closely with children and young people. Crucially, the scorecards were used to track the effectiveness of the partnership's collective efforts to 'turn the curve'. The reports made it possible to visualise the difference between the likely course of events based on the historical trajectory (e.g. if the number of children in care had continued to increase in line with past trends), and the impact that the various interventions were having on helping to 'turn the curve' (e.g. the number of children looked after declines from its current level). By using such graphs Leeds was able to show the impact of new initiatives and investment at different times during its improvement journey.

The example in the figure below demonstrates this in relation to the number of children in care in Leeds:



Although this approach provided a framework for using OBA to track progress, the bigger challenge for a city as large and diverse as Leeds was implementing and then embedding the outcome-based approach consistently across all of its work, including frontline practice as well as in 'enabling' services such as human resources (HR), information technology (ICT), finance, asset management. To do this, over five years Leeds consistently emphasised an outcome-based approach as one of the three fundamental behaviours that underpinned work with children and families. In addition the city developed a number of incremental steps from awareness-raising, through training and then application at a local and citywide level, to embed OBA across different areas of work. Leeds has particularly emphasised the use of OBA across local 'clusters' of services.

In Leeds clusters are the local partnerships between schools and the other services within a given area that must work together to provide a holistic approach to improving outcomes for children and young people. This includes children's centres, health professionals, youth services, voluntary sector organisations and the police. Local elected members also sit on clusters linked to their ward. In total there are 25 clusters across the city.

Each cluster has completed an OBA workshop, on each of the three obsessions, drawing together partners to focus on how to make a difference at a local level. OBA has become a key tool for clusters to review and refocus their work. The clusters used OBA as a basis for developing the 'top 100 methodology', identifying those families causing the greatest challenges for service providers in the local area. This has then enabled a more targeted, co-ordinated and consistent approach to multi-agency support for those families.

Across its wider improvement work, Children's Services used OBA to progress a variety of specific projects where a clear impact could be demonstrated. For example:

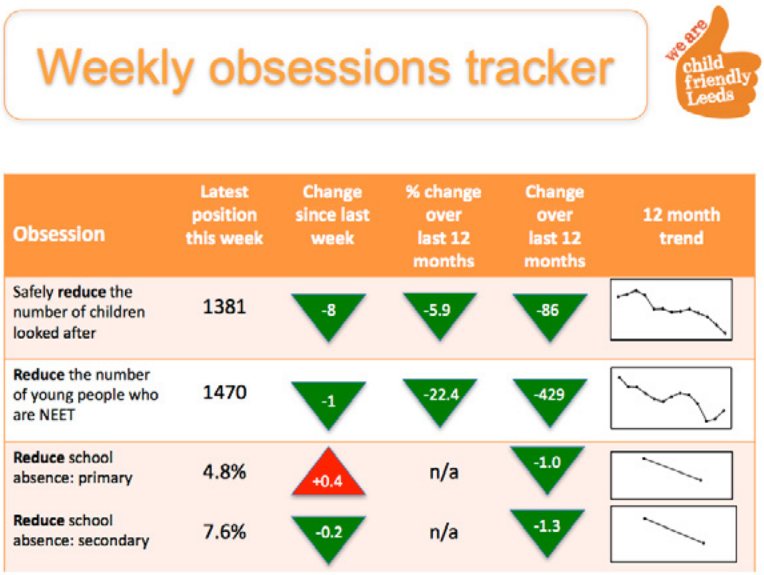
- OBA was used as the methodology to address school place planning across the city, providing a framework to tackle a shortage of places given a rapidly growing population. Over 1400 additional primary school places have been created through this work.
- An OBA session followed the launch of the custody pathfinder programme (which aims to reduce the need for children to be remanded or sentenced to custody). The actions implemented reduced custody "bednights" by almost one third over 18 months.
- The OBA approach has been used to launch and develop the Families First initiative in Leeds (part of the UK's national troubled families programme). It looked at how to use data and what each partner could bring to the programme. It enabled the programme to progress quickly and with clear focus. Leeds successfully supported all 2500 families involved in the first phase to achieve improved outcomes and was nationally recognised for its approach.

  In each case it was the combination of the three Leeds 'behaviours': using an OBA methodology; running events and planning in a way that works restoratively with people; and ensuring the voice of children and young people featured strongly in the process; that proved a successful combination for turning talk into action in a way that involved people in decisions that affected them.

OBA was increasingly adopted in Leeds not just by children's services, but as a city-wide approach for any issue where the methodology could help find solutions.

In 2014 the city launched a series of high profile 'breakthrough' projects on issues such as housing need, city centre improvement, domestic violence and healthy living. These cross-cutting projects were intended to bring multi-agency partners together to concentrate attention on some of the most difficult issues facing the city. In each case an OBA launch session and methodology was used to drive the planning and development of this work and ensure consistency of approach across different partners.

With OBA established as a city-wide approach, Leeds Children's Services sought to broaden ownership of the feedback data it generated right across the city, to ensure everyone could see how their work was contributing to a collective effort to address the biggest priorities. This work is best demonstrated by the use of a weekly 'Obsessions progress tracker', (see the example shown). It was produced in a format that enabled all staff/partners to quickly see the difference their collective contributions were making.



The tracker, which became known in Leeds as the 'Thing of Beauty,' arrived weekly in people's inbox and was used in various meeting agendas to inform key discussions and debates about the three OBA performance questions – How much did we do? How well did we do it? Is anybody better off? Leeds also broke this data down to a 'cluster' level. This enabled city-wide and local performance data to be considered against the three obsessions so that action could be taken quickly to target areas where progress was lagging. Mike Pinnock, who has been involved in the introduction and development of OBA in Leeds, emphasised that the tracker was an example of how feedback data could be used to engage and energise staff across the partnership, "We deliberately chose a graphical format that people would associate with the sorts of data they use in their daily lives - like a weather report or a stock market index. The intention was to bring some focus and immediacy to the partnership's efforts. Like a weather report, the primary role of the weekly "Thing of Beauty" was to keep people's attention on something that was important - not to explain it".

In January 2015, the Ofsted inspectors returned to Leeds and found a transformed service.

Between 2011 and 2015, the number of looked after children had safely and appropriately reduced from 1,450 to less than 1,300. Primary school attendance and secondary school attendance increased by 2% and 2.2% respectively. The number of young people not in education employment or training declined by nearly 500 (a 22% decline). The Inspector's final report stated... 'The application of the outcomes based accountability approach... is facilitating a shared understanding of priorities for children... (and) the 'three obsessions' are providing a sharp focus for strategic and operational thinking'. The inspectors rated the services as 'good' overall and 'outstanding' for leadership, management and governance, the highest rating available for the strand, which incorporates performance management.

Co-Design Case Study

OFMDFM GOOD RELATIONS DIVISION - SUMMER CAMP PROGRAMME - STAKEHOLDER ENGAGEMENT

Extensive stakeholder engagement has been a key feature of the design of the Summer Camp Pilot Programme in 2015/16 and the further development the Programme for 2016/17.

In designing the Pilot Programme four co-design workshops were held in late 2015 and early 2016 with a wide range of stakeholders, including the community and voluntary sector, and this generated useful feedback which informed the design of the Pilot Programme. Running in parallel to these workshops were 4 youth engagement sessions and the feedback from these sessions also contributed to the design process.

A Co-design Forum was then established and again this included membership from the community/voluntary sector. A Youth Team worked in parallel to this and the teams considered the feedback from the engagement sessions and made recommendations regarding the detailed design/criteria for the Programme in 2015/16 including potential delivery models. These recommendations were subsequently accepted by Ministers and the 2015/16 Programme was launched.

Following the Programme in 2015/16, four Shared Learning Forums were held across Northern Ireland to gather feedback from all the Summer Camps applicants in 2015/16 and other key stakeholders. Representatives from the community/voluntary sector attended those Forums. Three meetings were also held with groups of young people, who attended Summer Camps, so their input could be included in the design of the next programme.

The Co-Design Forum was also reconvened in order to consider all the feedback and develop/design proposals for a substantive Summer Camps programme in 2016/17. Once again proposals were brought to Ministers for their consideration and were accepted.

We currently have a stakeholder list of approximately 3000 and also use social media (Twitter and Facebook pages for TBUC Summer Camps) to communicate with our stakeholders.

Policy Scrutiny Process

Overarching policy issues
This section outlines a number of the overarching policy issues and commitments of the administration and suggests how they can be taken into account in developing a policy. These issues include Equality and Human Rights. The section also covers proofing policies in terms of aspects such as their environmental, health and rural impacts.

The key consideration here is to ensure that the approach to policy development is holistic in approach. In other words, that as the policy is being developed through the steps set out in this guide, consideration is being given at the same time to the equality and human rights implications and that the overall impact assessment process is an integral part of the development of the policy and not a last minute add-on.

The Statutory Equality Duties
Section 75 of the Northern Ireland Act 1998 requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status, or sexual orientation;
- men and women generally;
- persons with a disability and persons without; and
- persons with dependants (ie people with caring responsibilities) and persons without.

Without prejudice to the above obligation, public authorities, in carrying out their functions relating to Northern Ireland, are also required to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

The Act also requires public authorities to prepare Equality Schemes stating how they propose to fulfil these duties. The core of all Schemes, in terms of the duty to have due regard to the promotion of equality of opportunity and regard to the promotion of good relations, is the Equality Impact Assessment (EQIA) of policies. However, not all policies or proposals for legislation require an EQIA. A policy does not require an EQIA if it has been screened out at an early stage of policy development by answering the four screening questions set down by the Equality Commission on page 36 of its Guide to the statutory duties (and reproduced in all departmental Equality Schemes). A note should be kept of the reasoning behind such assessment. Where an EQIA is required, the Equality Commission has issued helpful Practical Guidance on Equality Impact Assessment. Each Department has equality personnel who can advise on these issues.

It is essential that there is a statement in all Executive papers covering:

- a summary of the outcome of an EQIA; or
- if an EQIA has not yet been carried out, when it will be done; or
- a statement that it is the Minister's view that there are no equality issues and a brief explanation as to the reasoning behind this view. It may be useful to refer to the screening criteria used.

Equality Impact Assessment

All policies need to be proofed or have their impact assessed against a wide range of criteria. All policies where screening indicates that it is necessary need to undergo Equality Impact Assessment under Section 75 of the Northern Ireland Act 1998. Proofing is also necessary in relation to Human Rights, and there are requirements introduced either by the Executive or as a result of UK Government or international obligations for environmental, rural, regulatory, sustainability and health impact assessments.

Public authorities have obligations under Section 75 of the Northern Ireland Act to ensure that equality of opportunity and good relations are central to policy making, policy implementation and review, as well as service delivery.

Public authorities also have employer and/or service provider responsibilities, to promote equality and good practice, not to discriminate and also have disability duties.

The Equality Commission for Northern Ireland has extensive guidance on how public bodies can meet their legal obligations.

Some links to useful sources of information are below:

http://dfponline.intranet.nics.gov.uk/index/corporate-guidance/dfp-communication/staff-brief-archive/staff-brief-march-2012/section75-the-revised-arrangements-presentation.pdf

http://www.equalityni.org/Employers-Service-Providers/Public-Authorities/Section75/Section-75/What-is-an-EQIA

http://www.equalityni.org/ECNI/media/ECNI/Publications/Employers%20and%20Service%20Providers/PracticalGuidanceonEQIA2005.pdf

Regulatory Impact Assessment
The Northern Ireland Better Regulation Strategy requires all departments, arms length bodies and other public bodies to consider a Regulatory Impact Assessment (RIA) as part of their policy development process.

An RIA is a tool which informs policy decisions. It is designed to help with the consideration of potential economic impacts and would therefore be considered with other tools utilised to assess social and environmental impacts on policy development.

Furthermore when an RIA is deemed necessary, consideration should also be given to the inclusion of a review clause or end clause to any regulation as part of conducting the RIA.

A Regulation can be defined as: a rule or guidance with which failure to comply would result in the regulated entity or person coming into conflict with the law or being ineligible for continued funding, grants or other schemes. This can be summarised as all measures with legal force imposed by central government and other schemes operated by central government.

There is extensive guidance on RIAs available from
http://online.intranet.nics.gov.uk/bpm-ria.pdf

Health Impact Assessment
Health Impact Assessment (HIA) is already included in NICS Policy Toolkit and will continue to be a practical tool which will be used to support Health in All Policies (HiAP) by judging the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. HIA can inform the decision-making process with the aim of maximising the proposal's positive health effects and minimising its negative health effects.

The Strategic Framework for Public Health, Making Life Better 2013-2023 highlights the importance of all Government and public sector policies and strategies taking account of their impact on health and well-being. HIA can be used as a tool to reinforce and influence the HiAP concept as described above and carrying out an HIA on all Departments' policies and programmes is still seen as a critical means of addressing the social determinants of health and reducing health inequalities.

HIA can help acknowledge the wide ranging health related issues which occur from the application of other policies and initiatives and helps to identify relevant stakeholders. HIA also provides an integrated perspective to policy development and encourages joined-up thinking and working. Guidance on Health Impact Assessment can be found HERE.

Poverty
The policy area on Poverty and Child Poverty has transferred to the Department for Communities. The Welfare Reform and Work Act amended the Child Poverty Act (CPA) 2010 to rename to 'Life Chances Act 2010';

Work to progress implementation of the Child Poverty Strategy 2016-19 will be taken forward by the Department for Communities. Work to progress the development of a strategy to tackle poverty, social exclusion and patterns of deprivation based on objective need will also be taken forward by the Department for Communities. As work continues to develop a new Programme for Government and a new Social Strategy work to tackle poverty and child poverty will be integral to this.

Human Rights
Although TEO has overarching responsibility for equality and human rights policy in the NICS, Departments are responsible for equality and human rights issues that fall within their areas of responsibility. The NICS is supported in its human rights work by the Northern Ireland Human Rights Commission (NIHRC).

The introduction of the Human Rights Act 1998 on 2 October 2000 and the establishment of the Northern Ireland Human Rights Commission on 1 March 1999, had a significant impact on the work of the NI departments. Everyone in a department, or an agency, or in a public body, needs to be aware of the effect the ECHR might have on their work. If the policy has an impact on the rights of individuals, you will need to bear in mind the need to comply with the Convention. You will need to be aware of the possibility of your decisions, or decisions taken by Ministers acting on your advice, being challenged on ECHR grounds.

Where necessary, existing legislation must be examined to identify provisions which might not be compatible with the ECHR and future policy and legislation developed taking account of the ECHR, the Human Rights Act and the Northern Ireland Act. There must be a statement that the human rights implications of the proposed policy/ legislation have been assessed and that the Minister is satisfied that the proposals are compatible with Convention Rights as incorporated by the Human Rights Act 1998. If such a statement cannot be made then there has to be an explanation.

Detailed information is available in the Northern Ireland Civil Service Human Rights Guide. Each Department also has a designated 'Human Rights contact'. You are encouraged to seek further advice, particularly from departmental solicitors.

Sustainable Development
The Executive Office oversees the implementation of the Sustainable Development Strategy across government. The department has responsibility for:

- the development, oversight and monitoring of the Northern Ireland Sustainable Development Strategy and Implementation Plan;
- policy co-ordination and mainstreaming sustainable development across Government;
- delivery of a number of key strategic objectives directly

Rural Needs Act (Northern Ireland) 2016
Section 1 of this Act places a duty on government departments, along with other public authorities, to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans and when designing and delivering public services.

The Regional Development Strategy for Northern Ireland 2035
This provides an overarching statutory strategic planning framework to address a range of economic, social, environmental and community issues, which are relevant to delivering the objectives of achieving sustainable development and social cohesion in Northern Ireland.

Importantly, it provides a framework within which choices can be made on key decisions about the infrastructural development of Northern Ireland. Transport Policy, Strategy and Legislation Division of the Department for Infrastructure will provide any additional guidance and advice as necessary.

Link to CAL catalogue:

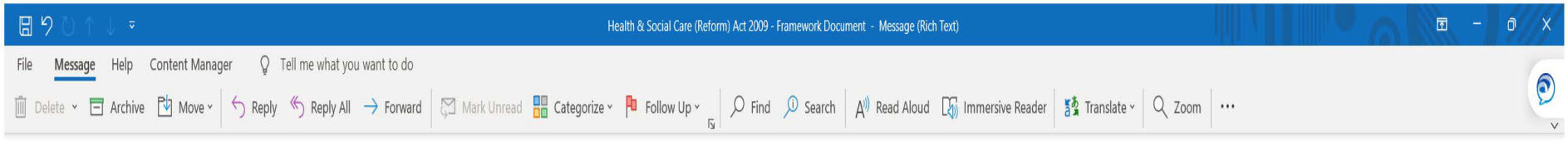
http://nical.nigov.net/cal-catalogue.htm

Web Links

http://raguide.org/wp-content/uploads/2014/04/RAPACaseStudies.pdf

https://www.nfer.ac.uk/publications/OBA02/OBA02CaseStudies.pdf

http://www.aecf.org/resources/turning-curves-achieving-results/



Health & Social Care (Reform) Act 2009 - Framework Document

[redacted]

Health & Social Care (Reform) ...

DHSSPS Framework Doc...

cc: NDPB Chief Executives
Chairs of All DHSSPS ALBs
Chairs of LCGs

Christine McKee
Personal Secretary to
Dr Andrew McCormick, Permanent Secretary
Department of Health, Social Services & Public Safety
Room C5.11
Castle Buildings
Stormont Estate
BELFAST

[redacted]

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

CORPORATE GOVERNANCE

in the Health and Personal Social Services

Code of Conduct
Code of Accountability

CODE OF CONDUCT

Public Service Values

1. Public service values must be at the heart of the Health and Personal Social Services. High standards of corporate and personal conduct, based on a recognition that patients and clients come first, have been a requirement throughout the HPSS since its inception. Moreover, since the Health and Personal Social Services are publicly funded, they are accountable to the Northern Ireland Assembly for the services they provide and for the effective and economical use of taxpayers' money.

2. There are three crucial public service values which must underpin the work of the Health and Personal Social Services.

Accountability – everything done by those who work in the HPSS must be able to stand the test of Assembly scrutiny, public judgements on propriety and professional codes of conduct.

Probity – there should be an absolute standard of honesty in dealing with the assets of the HPSS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of HPSS duties.

Openness – there should be sufficient transparency about HPSS activities to promote confidence between the HPSS body and its staff, patients, clients and the public.

General Principles

3. Public service values matter in the HPSS and those who work in it have a duty to conduct HPSS business with probity. They have a responsibility to respond to staff, patients, clients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The success of this Code depends on a vigorous and visible example from the boards of HPSS bodies and the consequential influence on the behaviour of all those who work within the organisation. Boards have a clear responsibility for corporate standards of conduct and acceptance of the Code should inform and govern the decisions and conduct of all board members.

Openness and Public Responsibilities

4. Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, with patients and clients and with staff as the need for change emerges. It is essential that the reasons for change are fully explained before decisions are reached. Information supporting those decisions should be made available and positive responses should be given to reasonable requests for information.

5. HPSS business should be conducted in a way that is socially responsible. As a large employer in the local community, HPSS bodies should forge an open relationship with the local community and should conduct a dialogue about the service provided. HPSS organisations should demonstrate to the public that they are concerned with the wider health and social well-being of the population including the impact of the organisation's activities.

6. The confidentiality of personal and individual patient/client information must, of course, be respected at all times.

Public Service Values in Management

7. It is unacceptable for the board of any HPSS organisation, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board members have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all HPSS boards. Accounting, tendering and employment practices within the HPSS must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be issued in good time to all individuals and groups in the community who have a legitimate interest in health and social services issues to allow full consideration by those wishing to attend public meetings on local health and social services issues.

Public Business and Private Gain

8. Chairs and board members should act impartially and should not be influenced by social or business relationships. No one should use their public position to further their private interests. Where there is a potential for private, voluntary or charitable interests to be material and relevant to HPSS business, the relevant interest should be declared and recorded in the board minutes and entered into a register which is available to the public. When a conflict of interest is established, the board member should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

9. Board members should set an example to their organisation in the use of public funds and the need for good value in incurring public expenditure. The use of HPSS monies for hospitality and

entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. HPSS boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage respect for the HPSS in the eyes of the community.

Relations with Suppliers

10. HPSS boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and the decision should be recorded. HPSS boards should be aware of the risks in incurring obligations to suppliers at any stage of a contracting relationship.

11. Suppliers should be selected on the basis of quality, suitability, reliability and value for money.

Staff

12. HPSS boards should ensure that staff have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, breaches of this code and other concerns of an ethical nature. The board and non-executive directors in particular must establish a climate that enables staff to have confidence in the fairness and impartiality of procedures for registering their concerns.

Compliance

13. Board members should satisfy themselves that the actions of the board and its members in conducting board business fully reflect the values in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others have been fully investigated, and acted upon.

Code of Accountability

CODE OF ACCOUNTABILITY

This Code of Practice is the basis on which HPSS organisations should seek to fulfil the duties and responsibilities conferred upon them by the Department of Health, Social Services and Public Safety.

Status

1. HPSS organisations are established under statute as corporate bodies so ensuring that they have separate legal personality. Statutes and regulations prescribe the structure, functions and responsibilities of the boards of these bodies and prescribe the way chairs and members of boards are to be appointed.

Code of Conduct

2. All staff should subscribe to the HPSS Code of Conduct and chairs, directors and their staff should be judged upon the way the Code is observed.

Statutory Accountability

3. The Department has a statutory duty to secure the provision of health and personal social services for the population of Northern Ireland and uses statutory powers to delegate functions to HPSS bodies, who are thus accountable to the Department and through it to the Assembly. The Department is responsible for directing the HPSS, ensuring policies are implemented and for the effective stewardship of HPSS resources. Along with those of the Department itself, finances of all HPSS bodies are subject to statutory review by the Comptroller and Auditor General for Northern Ireland on behalf of the Assembly.

organisation: the chair and non-executive board members are responsible for monitoring the executive management of the organisation and are responsible to the Department for the discharge of these responsibilities.

6. HPSS boards have six key functions for which they are held accountable by the Department on behalf of the Minister:

- to set the strategic direction of the organisation within the overall policies and priorities of the HPSS, define its annual and longer term objectives and agree plans to achieve them;
- to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- to appoint, appraise and remunerate senior executives; and
- to ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

7. In fulfilling these functions the board should:

- specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the board can fully undertake its responsibilities;

Code of Accountability

- be clear what decisions and information are appropriate to the board and draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions to secure compliance with the board's wishes;

- establish performance and quality targets that maintain the effective use of resources and provide value for money;

- ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

- establish audit and remuneration committees on the basis of formally agreed terms of reference which set out the membership of the sub-committee, the limit to their powers, and the arrangements for reporting back to the main board; and

- act within statutory financial and other constraints.

The Role of the Chair

8. The chair is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

9. It is the chair's role to:

- provide leadership to the board;

- enable all directors to make a full contribution to the board's affairs and ensure that the board acts as a team;

- ensure that key and appropriate issues are discussed by the board in a timely manner;

- ensure the board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;

- lead non-executive directors through a formally appointed remuneration committee of the main board on the appointment, appraisal and remuneration of the chief executive and (with the latter) other executive directors;

- appoint non-executive directors to an audit committee of the main board; and

- advise the Minister, through the Department, on the performance of non-executive directors of the board.

10. A complementary relationship between the chair and the chief executive is important. The chief executive is accountable to the chair and non-executive members of the board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with government policy and public service values and for the maintenance of proper financial stewardship. The chief executive should be allowed full scope, within clearly defined delegated powers, for action fulfiling the decisions of the board.

Non-Executive Board Members

11. Non-executive board members are appointed by the Minister for Health, Social Services and Public Safety to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the Department, to the Minister and to the local community.

12. Non-executive board members will be able to contribute to board business from a wide experience and a critical detachment. They have a key role in working with the chair in the appointment of

Code of Accountability

the chief executive and other executive board members. With the chair, they comprise the remuneration committee responsible for the appraisal and remuneration decisions affecting executive board members. Non-executive board members normally comprise the audit committee.

13. In addition, they undertake specific functions agreed by the board including an oversight of staff, relations with the general public and the media, participation in professional conduct and competency enquiries, staff disciplinary appeals and procurement of information management and technology.

14. HPSS board members currently play important roles in relation to the handling and monitoring of complaints. Being both informed and impartial, non-executives are able to act effectively as lay conciliators or adjudicators in relation to individual complaints. With the chief executive, they can also take responsibility for ensuring that their organisation's complaints procedures are operated effectively and that lessons learned from them are implemented.

Reporting and Controls

15. It is the board's duty to present, through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to:

- the Department, on behalf of the Minister;
- external auditors appointed by the Department; and
- the local community.

16. The detailed financial guidance issued by the Department, including the role of internal and external auditors, must be scrupulously observed.

Declaration of Interests

17. It is a requirement that chairs and all board members should declare any conflict of interest that arises in the course of conducting HPSS business. That requirement continues in force. Chairs and board members should declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care and any connection with a voluntary or other body contracting for HPSS services. These should be formally recorded in the minutes of the board. Directorships and other significant interests held by members of HPSS boards should be declared on appointment, kept up to date and set out in the annual report.

18. HPSS boards must comply with legislation and guidance from the Department on behalf of the Minister, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Appointments to posts in the HPSS should always be fair and should normally be by means of open competition.

19. The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care. The board should ensure, through the appointment of a remuneration committee, that executive board members' total remuneration can be justified as reasonable in the light of general practice in the public sector. All board members' total remuneration from the organisation of which they are a board member should be published in the annual report.

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

To: Chairs of Health & Social Care Bodies

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

[redacted]

Our Ref: AMCC 3932

Date: 18 July 2012

Dear Colleagues

CODE OF CONDUCT AND CODE OF ACCOUNTABILITY FOR BOARD MEMBERS OF HEALTH AND SOCIAL CARE BODIES

I am writing to advise you that the Department has updated the Code of Conduct and Code of Accountability for board members of HSC bodies to reflect the considerable changes made to the HSC under the RPA reforms, as well as relevant best practice developments in this field.

While the fundamentals of the documents remain unaltered, I would draw your attention to the following changes:

- an introductory section has been added briefly noting the context;
- the whole document has been updated in line with the new legislative framework set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009;
- three public service values (accountability, probity and openness) have been replaced by the *Seven Principles of Public Life* (the 'Nolan Principles'). The original codes were drafted before Government had accepted the Nolan report;
- the responsibility of the chair of the HSC body to annually assess the performance of individual board members has been added;
- a bullet point on the board's role in ensuring that the HSC body has in place robust and effective arrangements for clinical and social care governance and risk management has been added;
- two paragraphs on, respectively, the audit committee and the remuneration committee have been added to clarify the composition and roles of these committees;

- a paragraph on the role of board members in the monitoring and handling of complaints has been removed. Under the old HSC Complaints Procedures non-executive directors in the former HSS Boards were appointed to act as Convenors for Independent Review. Independent Review has been removed under the new complaints procedure;

- the code of accountability now includes a section on the requirement that boards should keep a register of interest appropriate to the body's activities. This good practice precept was established in DFP's *Public Bodies: A guide for NI Departments*.

An electronic copy of the guidance is attached to this letter. Please ensure that each of your board members is aware of and has received a copy of the revised Codes.

These Codes replace the previous guidance 'Corporate Governance in the Health and Personal Social Services - Code of Conduct and Code of Accountability (2005)'.

Yours sincerely

Andy McGrath

ANDREW McCORMICK

cc: Chief Executives

CODE OF CONDUCT AND CODE OF ACCOUNTABILITY FOR BOARD MEMBERS OF HEALTH AND SOCIAL CARE BODIES

This document comprises a Code of Conduct and a Code of Accountability for board members of Health and Social Care (HSC) bodies. These codes provide the basis on which HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by the Department of Health, Social Services and Public Safety.

This document is being issued to all existing board members and will be issued to all new appointees. All board members should subscribe to these codes and should be judged upon the way the codes are observed.

CODE OF CONDUCT

Public Service Values

1. Public service values must be at the heart of Health and Social Care (HSC) services in Northern Ireland. High standards of corporate and personal conduct, based on a recognition that patients and clients come first, have been a requirement throughout the HSC since its inception. Moreover, since the HSC is publicly funded, it is accountable to the Northern Ireland Assembly for the services provided and for the effective and economical use of taxpayers' money.

General Principles

2. Public service values matter in the HSC, and those who work in it have a duty to conduct HSC business with probity. They have a responsibility to respond impartially to staff, patients, clients and suppliers, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The success of this Code depends on a vigorous and visible example from the board of each HSC body and the consequential influence on the behaviour of all those who work within the organisation. Given their prime responsibility for establishing and maintaining high corporate standards of conduct, the Code's precepts must inform and govern the decisions and conduct of all board members.

3. All board members must follow the Seven Principles of Public life set out by the Committee on Standards in Public Life (the 'Nolan Principles'):

Selflessness	Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity	Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity	In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
Accountability	Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness	Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
Honesty	Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
Leadership	Holders of public office should promote and support these principles by leadership and example.

Openness and Public Responsibilities

4. Health and social care needs and patterns of provision do not stand still. There should be a willingness to be open and to actively involve the public, patients, clients and staff as the need for change emerges. It is essential that the

reasons for change are fully explained and views from the public, patients and clients are actively sought and taken into account before decisions are reached. Information supporting those decisions should be made available, along with a summary of comments received from patients, clients and the public, and positive responses should be given to reasonable requests for information.

5. HSC business should be conducted in a way that is socially responsible. As large employers in their local communities, HSC bodies should forge an open relationship with their local communities and should conduct a dialogue with clients, patients and their carers about the planning and provision of the services provided. HSC bodies should demonstrate to the public that they are concerned with the wider health and social well-being of the population.

6. The duty of confidentiality of personal and individual patient/client information must be respected at all times.

Public Service Values in Management

7. It is unacceptable for the board of any HSC body, or any individual within the organisation for which the board is responsible, to ignore public service values in achieving results. Chairs and board members have a duty to ensure that public funds are properly safeguarded and that at all times the board conducts its business as efficiently and effectively as possible. Proper stewardship of public monies requires value for money to be high on the agenda of all HSC boards. Accounting, procurement and employment practices within the HSC must reflect the highest professional standards. Public statements and reports issued by the board should be clear, comprehensive and balanced, and should fully represent the facts. Annual and other key reports should be made available in good time to all individuals and groups in the community who have a legitimate interest in health and social care issues to allow full consideration by those wishing to attend public meetings on local HSC issues.

Public Business and Private Gain

8. Chairs and board members should act impartially and should not be influenced by social, political or business relationships. They should not use information gained in the course of their public service for personal gain or for political purposes nor seek to use the opportunity of public service to promote private interests or those of connected persons, firms, businesses or other organisations. Where there is a potential for private, voluntary, charitable etc interests to be material and relevant to HSC business, the relevant interest should be declared and recorded in the board minutes and entered into a register which is publicly available. When a conflict of interest is established, the board member should withdraw and play no part in the relevant discussion or decision.

Hospitality and Other Expenditure

9. Board members should set an example to their organisation in the use of public funds and the need for good value when incurring public expenditure. The use of HSC monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. All expenditure on these items should be capable of justification as reasonable in light of approved practice in the public sector. HSC boards should be aware that expenditure on hospitality or entertainment is the responsibility of management and is open to challenge by the internal and external auditors. Ill-considered actions can diminish public respect for the HSC.

Relations with Suppliers

10. HSC boards should have an explicit procedure for the declaration of hospitality and sponsorship offered by, for example, suppliers. Their authorisation should be carefully considered and decisions should be recorded. HSC boards should be aware of the risks in incurring – or seeming to incur – obligations to suppliers at any stage of a contracting relationship.

11. Suppliers should be selected on the basis of quality, suitability, reliability and value for money, in line with Northern Ireland public procurement policy.

Staff Concerns

12. HSC boards should ensure that staff have a widely publicised and understood procedure for raising concerns about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest, including breaches of this code and other concerns of an ethical nature. The board and non-executive directors must promote a culture of safety built on openness and accountability. Staff must be reassured that it is safe and acceptable to speak up and that their concerns will be handled with sensitivity and respect for confidentiality.

Compliance

13. Board members should satisfy themselves that the actions of the board and its members in conducting board business fully reflect the values in this Code of Conduct. They must ensure that, as far as is reasonably practicable, concerns expressed by staff or others have been fully investigated and acted on.

CODE OF ACCOUNTABILITY

Status

1. HSC bodies are established under statute as corporate bodies, which means that they are separate legal entities. Statutes and regulations may prescribe the structure, functions and responsibilities of these bodies and may prescribe the way chairs and members of boards are to be appointed.

Statutory Accountability

2. The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which HSC bodies operate. Under section 2(1) of the 2009 Act, the Department has a general duty to promote an integrated system of:
    - health care designed to secure improvement in the:
        - physical and mental health of people in Northern Ireland; and
        - prevention, diagnosis and treatment of illness, and
    - social care designed to secure improvement in the social well-being of people in Northern Ireland.

3. In terms of service commissioning and provision, the Department discharges its duty under section 2(1) of the Reform Act primarily by delegating its statutory functions to the Health and Social Care Board (HSCB) and by establishing bodies to exercise specific functions on its behalf. All these bodies are accountable to the Department for the manner in which they perform their devolved duties, manage their assets and for adherence to high standards of public administration. The Department is in turn accountable, through the Minister, to the Assembly for the manner in which this overall duty is performed.

4. Along with those of the Department itself, the finances of all HSC bodies are subject to statutory review by the Comptroller and Auditor General for Northern Ireland on behalf of the Assembly.

5. The boards of HSC bodies must cooperate fully with the Department, the Department's appointed auditors and the Northern Ireland Audit Office in accounting for the use they have made of public funds, the delivery of patient care and other services, and compliance with statutes, directions, guidance and policies of the Department.

The Board of Directors

6. The composition of the board of each HSC body is specified in its founding legislation. Typically, a board comprises executive board members, employees of the HSC body, and part-time non-executive board members under a part-time chair appointed by the Minister for Health, Social Services and Public Safety. Whatever its composition, board members share corporate responsibility for all decisions of the board. There is a clear division of responsibility between the chair and the chief executive. The chair's role and the board functions are set out below. The chief executive is directly accountable to the chair and non-executive members of the board for the operation of the organisation and for implementing the board's decisions. Boards are required to meet regularly and to retain full and effective control over the organisation. The chair and non-executive board members are responsible for monitoring the executive management of the organisation and are responsible to the Department for the discharge of these responsibilities.

7. HSC boards have corporate responsibility for ensuring that the organisation fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources. To this end, the board shall exercise the following key functions:

- to establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister;
- to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;
- to appoint, appraise and remunerate senior executives;
- to ensure that there is effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; and
- to ensure that the HSC body has robust and effective arrangements in place for clinical and social care governance and risk management.

8. In fulfilling these functions the board should:

- specify its requirements in terms of the accurate and timely financial and other information required to allow the board to discharge its responsibilities;
- be clear what decisions and information are appropriate to the board and draw up standing orders, a schedule of decisions reserved to the board and standing financial instructions to secure compliance with the board's wishes;
- establish performance and quality targets that maintain the effective use of resources and provide value for money;

- ensure that proper management arrangements are in place for the delegation of programmes of work and for performance against programmes to be monitored and senior executives held to account;
- establish audit and remuneration committees on the basis of formally agreed terms of reference which set out the membership of the committee, the limit to their powers, and the arrangements for reporting back to the main board; and
- act within statutory, financial and other constraints.

The Role of the Chair

9. The chair is responsible for leading the board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The chair is accountable to the Minister through the Departmental Accounting Officer.

10. The chair has a particular leadership responsibility on the following matters:

- formulating the board's strategy for discharging its duties;
- ensuring that the board, in reaching decisions, takes proper account of guidance provided by the Department and other departmentally designated authorities;
- ensuring that risk management is regularly and formally considered at board meetings;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging high standards of propriety;
- representing the views of the board to the general public;

- ensuring that the board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual board members; and
- ensuring that all board members are fully briefed on the terms of their appointment, their duties, rights and responsibilities and assess, annually, the performance of individual board members.

11. A complementary relationship between the chair and the chief executive is important. The chief executive is accountable to the chair and non-executive members of the board for ensuring that board decisions are implemented, that the organisation works effectively, in accordance with government policy and public service values, and for the maintenance of proper financial stewardship. The chief executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the board.

Non-Executive Board Members

12. Non-executive board members are appointed by the Minister for Health, Social Services and Public Safety to bring an independent judgement to bear on issues of strategy, performance, key appointments and accountability, through the Department, to the Minister and to the local community.

13. The contribution of non-executive board members to board business derives from their wide experience and their detachment from the job of management. They have a key role in working with the chair in the appointment of the chief executive and other executive board members. The chair and non-executive board members comprise the remuneration and audit committees.

14. In addition, they undertake specific functions agreed by the board including an oversight of staff, relations with the general public and the media, participation in professional conduct and competency enquiries, staff disciplinary appeals

and procurement of information management and technology. Their exercise of such functions should be in a non-executive capacity.

Remuneration Committee

15. The Remuneration Committee will make recommendations to the board on all aspects of remuneration and terms and conditions of employment for the Chief Executive and other executive directors. Directions issued by the Department on pay must be scrupulously observed. The Remuneration Committee should comprise the board chair and at least two non-executive directors. None of these members should be members of the audit committee.

Audit Committee

16. The audit committee supports the board and Accountable Officer with regard to their responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge. It has no authority in its own right, either over the management of risk, control, governance etc or over the operations of those bodies which conduct audit and assurance work in the organisation. It may, however, offer opinions or recommendations on the way in which such management is conducted. An audit committee that is asked to act as a risk committee needs to take particular care to avoid taking up the executive risk management function and to maintain its independence. The audit committee should comprise at least three non-executive directors. None of these members should be the chair or members of the remuneration committee.

17. The Audit Committee will provide the board with a means of independent and objective review of:
    - systems of internal control; and

- compliance with statutory requirements, guidance and codes of conduct.

Reporting and Controls

18. It is the board's duty to present, through the timely publication of an annual report, annual accounts and other means, a balanced and readily-understood assessment of the organisation's performance to:
    - the Department, on behalf of the Minister;
    - external auditors appointed by the Department; and
    - the local community.

19. The detailed financial guidance issued by the Department, including that concerning the role of internal and external auditors, must be scrupulously observed.

Declaration of Interests

20. It is a basic requirement that chairs and all board members should declare any conflict of interest that arises in the course of conducting HSC business. Chairs and board members must declare on appointment any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for HSC services. These should be formally recorded in the minutes of the board. Directorships and other significant interests held by members of HSC boards must be declared on appointment, kept up to date, and set out in the annual report.

21. In addition, HSC boards must keep a register of interest appropriate to the body's activities. The register should, as a minimum, list direct or indirect pecuniary interests which members of the public might reasonably think could

influence board members' judgement. Board members are urged to register non-pecuniary interests which relate closely to the body's activities, and interest of close family members and persons living in the same household as the board member.

22. Registers of interests must be open to the public. Details of how access can be obtained should be made widely available and included in annual reports. Registers of interests should be published annually.

Employee Relations

23. HSC boards must comply with legislation and guidance from the Department (whether or not issued explicitly on behalf of the Minister), respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. Appointments to posts in the HSC should always be made on the basis of merit and should normally be my means of open competition.

24. The terms and conditions agreed by the board for senior staff should take full account of the need to obtain maximum value for money for the funds available for patient care, and of extant departmental direction or guidance on the subject. The board should ensure, through the appointment of a remuneration committee, that executive board members' total remuneration can be justified as reasonable in the light of general practice in the public sector. All board members' total remuneration from the organisation of which they are a board member should be published in the annual report.

Personal liability of board members

25. Legal proceedings by a third party against individual board members are very exceptional. A Board member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may

commit a breach of confidence under common law or a criminal offence under insider dealing legislation, if he or she misuses information gained through their position. However, the Department has indicated that individual board members who have acted honestly, reasonably, in good faith and without negligence will not have to meet out of their own personal resources any personal civil liability which is incurred in execution or purported execution of their board functions. Board members who need further advice should consult the Department.

Department of Health, Social Services & Public Safety
April 2011

MMcG- 152

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HSC BOARD MEMBER HANDBOOK

A resource to support the delivery of safe and effective care

May 2021

Foreword from Robin Swann MLA

Minister of Health

On 31 January 2018 the report of the Inquiry into Hyponatraemia Related Deaths (IHRD) was published. In his report into the deaths of five children in hospitals in Northern Ireland, Mr Justice O'Hara concluded that the culture of the health service, the arrangements in place to ensure the quality of services and the behaviour of individuals at the time were not acceptable.

Ultimate accountability for the quality and safety of health and social care rests with me as Minister and with my Department. I am committed to addressing the serious failings of the past and ensuring that care is safe and accountable now and in the future. It is essential that those of us with leadership responsibilities take action to address the issues raised in the report and make sure that we support the great many Health and Social Care staff who strive to do the right thing every day, often in very challenging circumstances. We owe this to the families of those five children first and foremost but also to all those who use our services.

Mr Justice O'Hara made 96 recommendations in his report, including 16 specifically in relation to leadership and governance. In response, the Department of Health set up an extensive programme involving over 200 individuals from a range of backgrounds, including service users and carers, health and social care staff and Board members, and representatives from the third sector to take these recommendations forward. I acknowledge that it has taken some time for implementation of the recommendations to start. This is regrettable, but sadly inevitable owing to the need to deal with the Covid-19 crisis. This handbook is the first product to emerge from the IHRD report and I intend, now that the worst of the pandemic is hopefully behind us, that the pace of implementation will increase.

The Duty of Quality workstream has been responsible for taking forward the key recommendations on leadership, clinical and social care governance and Board effectiveness and has developed this handbook as a resource to assists Boards to

scrutinise the safety and quality of services. I welcome the publication of this handbook which has been produced for and by Non-Executive Directors to prepare and support them in their important leadership role.

I want to see a culture that enables the people who work across health and social care to deliver high quality, continually improving and compassionate care in an open and supportive environment. I count on all members of the HSC to play their part: compassionate leadership with a strong focus on quality improvement, learning from error and ensuring that service users and staff have a voice is key to building this culture.

I am certain that Board members will find this an invaluable resource throughout their leadership journey. It has value now and in the future as a source of information and training and, as a digital resource, it will be kept relevant by regular updates with ongoing input from Board members.

I would like to thank each of the members of the workstream for the expertise, knowledge and drive for improvement that they have demonstrated. In particular, the Non-executive directors involved have played a key role in underlining the primacy of patient safety and working diligently to rebuild public confidence in the care provided, whether in hospitals, the community or primary care.

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Preface

There has been an increased focus on the role and performance of Health and Social Care (HSC) Boards, NHS and Arm's Length Bodies (ALBs) in assuring the quality and safety of services. This was highlighted in a number of inquiries and reviews.

> *"Leadership is about vision. But it is also about listening and involving and having the courage to take difficult decisions in making choices. Leadership in adult care and support needs to be set within a values framework, as social care leadership has many levels. And leadership in this context has to be about more than simply sharing power and control with people receiving services and carers –* ***fundamentally it's about the transfer of power."***

Power to People – The Expert Advisory Panel Report on Adult Social Care Support 2017

The role of ALB Board Members was particularly highlighted in some reports.

> *"The Board of an Arm's Length Body (ALB) has a particular responsibility to ensure that the care provided to service users is safe and of good quality. To discharge this responsibility the Board must be engaged. It must not be ignored, side-lined or kept less than well informed. It cannot be the passive recipient of what the Executive chooses to tell it. It must be able to hold the Executive to account. It must identify the range of information on which it routinely seeks assurance from the Executive. The Board cannot do its duty to service patients best interests if important matters are not brought to its attention and if it does not seek to inform itself.*
>
> *The safety of patients and the quality of care they care that they receive is a matter of fundamental importance to the Board. The Board must agree with the Executive a range of information about the safety and quality of care which must be reported to it and which will inform the Board about the Trust's performance. This information*

will include matters called for by regulators, but will go further to cover all matters agreed by the Board and between the Board and the Executive."

Solihull Hospital Kennedy Breast Care Review 2013

Mr Justice O'Hara highlighted the critical role of leadership in setting the tone for and changing the culture of organisations to learn from mistakes and improve care.

"Building a culture where the natural response to error is to learn from it is …the responsibility of leadership at every level. Change in culture will take time and expert leadership.

The directors of each HSC Trust now have the major role to play in achieving the appropriate learning culture within each organisation. The best leadership is critical and there should be investment in the best.

The Permanent Secretary observed that 'leadership is not about position, it's about behaviours that drive each individual to do the right thing all the time…' I believe that to achieve the 'right thing' that there should be visible leadership at every level of an organisation. Leaders at all levels and especially at Board level must not be inaccessible. They should do more than appear on the occasional senior management walk-round."

The Inquiry into Hyponatraemia Related Deaths (IHRD) Report January 2018

This handbook has been developed for the use of HSC Board Members, both Non-Executive and Executive Directors, to support them in the performance of these important functions and in the critical leadership role in ensuring services are safe and can learn when things go wrong. Not all sections or areas will apply or be of interest and it is anticipated that Board Members will use it as a core reference source as required

HSC Board Member Handbook

SECTION 1: Introduction

Congratulations on being a Board Member of a Health and Social Care (HSC) Arm's Length Body (ALB). It is hoped that you will find your time on the Board enjoyable and fulfilling.

In this introductory section, you can find information on:

- The structure of the HSC system in Northern Ireland from the Northern Ireland Assembly down to individual HSC organisations;
- The legislation framework which sets out the functions of all HSC organisations and the parameters within which each body must operate;
- The accountability arrangements in place for all HSC ALBs;
- Key strategic documents relevant to your role; and
- How the rest of this handbook will support you in your role as a Board Member.

1.1 Structure of the HSC system in Northern Ireland

1.1.1 Northern Ireland Assembly and Health Committee

The Northern Ireland Assembly is the devolved legislature for Northern Ireland. It is responsible for making laws on transferred matters in Northern Ireland, including health, and for scrutinising the work of Ministers and Government Departments.

The Assembly has a number of statutory committees, including the Committee for Health. These committees advise and help each Northern Ireland Minister to develop policy in specific areas and have a role in the scrutiny of performance and governance of the Department and ALBs.

Programme for Government

The Programme for Government Framework (PfG) sets out the major outcomes that the Northern Ireland Executive wants to achieve for Northern Ireland society. It forms the basis for all Departments and sectors, including health and social care, to develop plans and actions that contribute to the strategic outcomes set out in the Framework. By setting clear priorities, the PfG Framework should also inform the

targeting of funds. HSC organisations will reflect these priorities and strategic outcomes in their own strategic directions and set these out in their corporate plans.

The outcomes are supported by indicators and measures which will monitor progress and demonstrate performance against each. A key feature of the new draft PfG Framework is its dependence on collaborative working between organisations, groups, individuals and communities throughout the public, voluntary and, private sectors.

Although the draft PfG Framework is intended to cut across departmental lines with no outcome being taken in isolation, there are a number that are particularly relevant to the HSC. More information about the outcomes and their associated indicators can be found here.

1.1.2 Department of Health including the Minister and Permanent Secretary

The Department of Health (DoH) is one of nine Government Departments in Northern Ireland.

It is the Department's mission to improve the health and social well-being of the people of Northern Ireland and it has three main business responsibilities:

- Health and Social Care, which includes policy and legislation for hospitals, family practitioner services and community health and personal social services;
- Public Health, which covers policy, legislation and administrative action to promote and protect the health and well-being of the population; and
- Public Safety, which covers policy and legislation for fire and rescue services.

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009 the Department can direct the HSCB, in consultation with the Public Health Agency, to prepare and publish an annual commissioning plan which provides details of the

health and social care services that it will commission. The direction sets out the priorities, aims and improvement objectives for the HSC for the year. The commissioning plan should align with, and support:

- The implementation of the Minister's vision (as set out in Health and Well-being 2026: Delivering Together);
- Delivery of the priorities for health and social care detailed in the draft PfG Framework; and
- The Executive's population health framework Making Life Better.

The Minister in charge of the DoH is responsible and answerable to the Assembly for the exercise of the powers on which the administration of the Department depends. The Minister has a duty to the Assembly to account, and be held to account, for all the policies, decisions and actions of the Department and its ALBs.

The Permanent Secretary is the Departmental Accounting Officer and is personally responsible and accountable to the Assembly for the organisation and quality of management of the Department, including its use of public money and the stewardship of its assets.

1.2 Appointment of HSC Non-Executive Board Members

1.2.1 Representing the interests of the Minister

Board Members of an HSC ALB are appointed by the Minister to ensure the delivery of, or advise upon, his/her policies and priorities. The representation of an ALB's views to the Minister by the Board is of course perfectly legitimate and acceptable, but such action should be viewed within this wider context. Crucially, Board Members should be clear about the Minister's policies and expectations for their ALB; if they are in any doubt on this point at any time, they should seek clarification from the Chair.

1.2.2 Appraisal and reappointment to the Board

Board Members will have been appointed to the Board because their personal skills and knowledge match the criteria for the post and meet the needs of the ALB. Prior to any decision being taken with regard to the reappointment of a Board Member, the Department, along with the Chair, will review the Board's balance of skills and knowledge and decide whether or not they are still appropriate. This will allow any gaps to be identified.

A Board Member may be reappointed for a second term, in the same[1] role, by open competition.

Performance appraisals will be carried out on an annual basis throughout the term of a Board Member's appointment. The Chair conducts the appraisals of Board Members and a senior official from the Department will normally conduct the appraisal of the Chair with input from Board Members.

The terms and conditions of an appointment to the Board and the review procedure should be explained to each Board Member by the Department upon appointment. Further information on the roles and responsibilities of HSC Board Members is set out in section 3 of the handbook.

1.3 Legal framework

1.3.1 The Health and Social Care (Reform) Act (Northern Ireland) 2009

'The Reform Act' (The Health and Social Care (Reform) Act (Northern Ireland) 2009) provides the legislative framework within which the HSC structures operate. It sets out the high-level functions of the various HSC organisations. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

1 Under review in 2019 and subject to change.

The Reform Act requires the Department of Health, Social Services & Public Safety ('the Department') to produce a 'framework document' setting out, in relation to each HSC body:

- The main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;
- The matters for which the body is responsible;
- The manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and
- The arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC organisations.

The Reform Act defines HSC bodies as:

- The Regional Health and Social Care Board (known as the Health and Social Care Board);
- The Regional Agency for Public Health and Social Well-being (known as the Public Health Agency);
- The Regional Business Services Organisation (known as Business Services Organisation);
- HSC Trusts;
- Special Agencies (i.e. Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency);
- The Patient and Client Council; and
- The Regulation and Quality Improvement Authority.

The focus of the framework document is the HSC system in Northern Ireland, and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland Fire and Rescue Service is outside the scope of the framework document.

All of the HSC organisations referred to above remain ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. The changes introduced by the Reform Act augment, but do not detract from, that fundamental accountability.

Independent family practitioners also play a significant role in the delivery of health and social care. Health and social care objectives can only be achieved with the engagement of a high-quality primary care sector that is accessible, accountable and focused on the needs of patients, clients and carers.

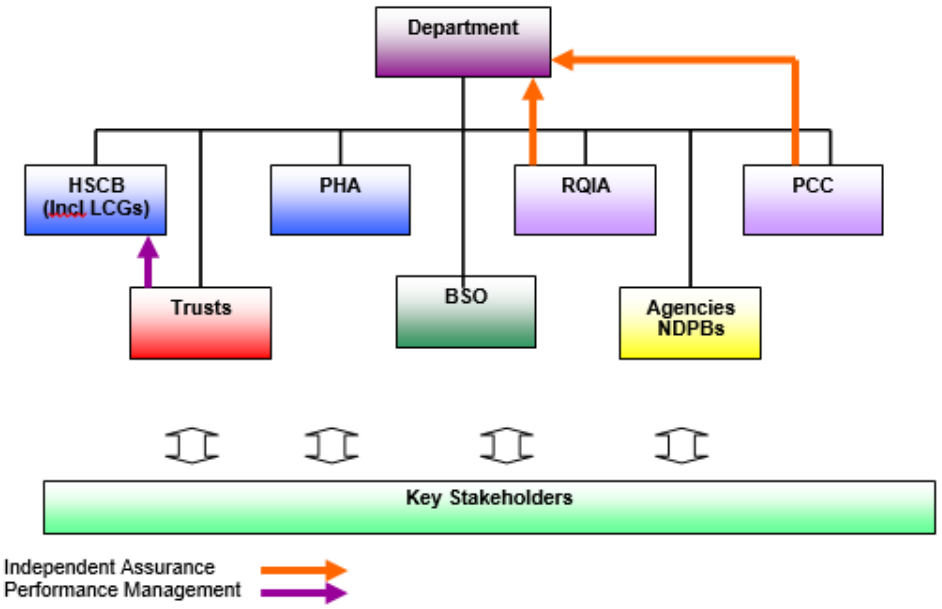


Figure 1: Structure of the Health and Social Care system

The Framework can be found here.

Other useful information includes the Managing Public Money NI and Management Statement and Financial Memorandum documents.

Definitions

The '**public'** is defined in this Section of the Act as *"individuals, a group or community of people and a section of the public, however selected".*

A body is responsible for health and social care under this Section of the Act if it (a) provides or will provide care to individuals; or (b) if another person provides, or will provide, that care to individuals at that body's direction, on its behalf, or in accordance with an agreement or arrangements made by that body with the other person. This also includes care that is provided jointly with another person.

1.3.2 Health inequalities

Under the Health and Social Care (Reform) Act (Northern Ireland) 2009, Section 2 sets out the "Department's general duty in respect of health and social care and the specific responsibility for the improvement of health and social well-being and the reduction of health inequalities" as follows.

"1) The Department shall promote in Northern Ireland an integrated system of:
(a) health care designed to secure improvement
(i) in the physical and mental health of people in Northern Ireland, and (ii) in the prevention, diagnosis and treatment of illness; and
(b) social care designed to secure improvement in the social well-being of people in Northern Ireland.

2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must:
(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland".

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

For some people in Northern Ireland there are still unfair and avoidable inequalities in their health and in their access to and experiences of HSC services. There are also actions that can be taken on the social determinants of health which can reduce these health inequalities, for example education, employment and housing.

The Making Life Better (2013–2023) public health strategy for addressing health inequalities sets out the responsibilities of HSC organisations for achieving a healthier Northern Ireland. It identifies the importance of what is done collaboratively through both policy and practice to influence the wide range of factors that influence lives and choices. The framework is not just about actions and programmes at Government level, but also provides direction for work at both regional and local levels with public agencies, including local government, local communities and others, working in partnership. This is set out in more detail in section 4.3 of this handbook.

1.4 HSC ALBs

ALBs or Arm's Length Body is the commonly used term covering a wide range of public bodies, including Non-Ministerial Departments, Non-Departmental Public Bodies (NDPB), executive agencies and other bodies, such as public corporations. In the HSC system in Northern Ireland ALBs regulate the HSC system, establish national standards, protect patients and the public, and provide central services to the HSC. These include:

- Belfast Health and Social Care Trust;
- Business Services Organisation;
- Health and Social Care Board;
- Northern Health and Social Care Trust;

- Northern Ireland Ambulance Service;
- Northern Ireland Blood Transfusion Service;
- Northern Ireland Guardian Ad Litem Agency;
- Northern Ireland Medical and Dental Training Agency;
- Northern Ireland Practice and Education Council;
- Northern Ireland Social Care Council;
- Patient and Client Council;
- Regional Agency for Public Health and Social Well-being;
- Regulation and Quality Improvement Authority;
- South Eastern Health and Social Care Trust;
- Southern Health and Social Care Trust; and
- Western Health and Social Care Trust.

1.4.1 Health and Social Care Board

The Health and Social Care Board (HSCB) is responsible for commissioning services, to ensure that delegated functions are carried out. The HSCB is also responsible for quality assuring the discharge of delegated functions. It is required to agree the Trust's monitoring arrangements as well as the information that will be provided and at what intervals. This will include the provision of an annual report approved by each Trust Board on how the Trust has discharged its statutory functions.

Primary care in general and family practitioner services in particular are central to the HSC system. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy.

1.4.2 Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003)

The RQIA has an independent role in the system, keeping the Department informed about the availability and quality of services and encouraging improvement in the quality of services. The RQIA can provide HSC organisations with independent validation of their internal arrangements for clinical and social care governance through their review programme, and works closely with HSC Trusts in the discharge of its functions relating to the regulation of independent sector providers.

1.4.3 The Patient and Client Council

The Patient and Client Council (PCC) was established under Section 16 and Schedule 4 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.[2] The high-level functions of the PCC in relation to the provision of health and social care are set out in Section 17 of the Health and Social Care (Reform) Act 2009 Act as follows[3]:

- **To represent the interests of the public.** The Patient and Client Council must consult the public about matters relating to health and social care and report the views of those consulted to the DoH (where it appears to the Council to be appropriate to do so) and to any other body to which this Section of the Act applies who appears to have an interest in the subject matter of the consultation.

- **To promote the involvement of the public.** The Patient Client Council shall promote the involvement of the public in consultations or processes leading (or potentially leading) to decisions by a body to which this Section of the Act applies would or might affect (whether directly or not) the health and social well-being of the public.

2 Health and Social Care (Reform) Act (Northern Ireland) 2009, www.legislation.gov.uk/nia/2009/1/contents
3 Article 17. Health and Social Care (Reform) Act (Northern Ireland) 2009, www.legislation.gov.uk/nia/2009/1/section/17

- **To provide assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to Health and Social Care.** The Patient Client Council shall arrange, to such an extent as it considers necessary to meet all reasonable requirements, for the provision (by way of representation or otherwise) of assistance to individuals making or intending to make a complaint of a prescribed description.

- **To promote the provision of advice and information to the public about the design, commissioning and delivery of Health and Social Care.**

- **"Such other functions as may be prescribed."**

The 2009 Act also provides that the Patient and Client Council shall carry out research into the best methods for consulting with the public about involving them in health and social care and to provide advice about these methods to certain HSC bodies.

1.4.4 Northern Ireland Social Care Council

The Northern Ireland Social Care Council (NISCC) regulates the social work and social care workforces, holding a register of over 46,000 people. NISCC sets the standards of practice for social workers and social care workers and the standards for social work and social care qualifications. It supports improvement in social work and social care through the provision of post qualifying education and training for social workers, and learning and development resources for social care workers. Through these regulatory activities the Social Care Council provides assurance of the quality of social work and social care practice and education in Northern Ireland.

1.4.5 Health and Social Care Trusts

There are a total of six HSC Trusts in Northern Ireland, as set out in Appendix 2.

Five HSC Trusts provide integrated HSC services across Northern Ireland: Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust

and Northern HSC Trust. They manage and administer hospitals, health centres, residential homes, day centres and other HSC facilities and they provide a wide range of HSC services to the community. The Northern Ireland Ambulance Service (NIAS) is the sixth HSC Trust dedicated to providing a range of transport services, from a Helicopter Emergency Medical Service (HEMS) to the rapid response vehicles needed for emergency call outs, the Northern Ireland Critical Care Transfer Service (NICCATS), the Northern Ireland Specialist Transfer and Retrieval Service (NISTAR) as well a regular patient transport service.

The six HSC Trusts were established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising, on behalf of the HSCB, certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003), and to do so in a way that meets their obligations under equality legislation.[4]

Each Trust has a duty to exercise its functions with the aim of improving the health and social well-being of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

1.5 Accountability within HSC system

1.5.1 Accountability of HSC organisations

ALBs have a role in the process of government but are not a Government Department or part of one. They operate at arm's length from Ministers but remain

4 An example of a Trust Equality Scheme is given at: https://belfasttrust.hscni.net/download/289/internal-documents/5235/equality-guidance-for-board-members.pdf

accountable to the Department for the discharge of the functions set out in their founding legislation.

While ALBs should operate with a level of autonomy to deliver their services, the Minister is answerable to the Assembly for the overall performance and delivery of its ALBs and, therefore, ultimate accountability for the exercise of proper control of financial, corporate, clinical and social care governance in the HSC system rests with the Minister.

As set out in Managing Public Money NI, the ALB Chief Executive is the designated Accounting Officer for the ALB, responsible to the Department's Accounting Officer for the sponsoring branch. They are also accountable to the ALB Board for their stewardship of the organisation. The Department's Accounting Officer will make arrangements to satisfy themselves that the ALB Accounting Officer is carrying out their responsibilities and that their organisation (and any organisation funded by them) operates effectively and to a high standard of probity.

It is, therefore, important that the Department engages with ALB Boards and Chief Executives to assure itself that the requisite governance systems are in place to ensure delivery of the ALB's prescribed functions and compliance with statutory responsibilities.

The Executive's outcome-based approach (as set out in the Programme for Government) relies on collaborative working and a joined-up approach. The Department and its ALBs must have a strategic alignment between their aims, objectives and outcomes and both partnership and effective engagement between them is critical to the delivery of high-quality public services.

Partnership agreements which supersede the Management Statement Financial Memorandum will be phased in from 1 April 2020. The partnership agreement template can be found here. They are based in a mutual understanding of strategic aims and objectives and recognise the distinct roles of both the Department and the ALB. Partnership agreements set out the overall governance framework for ALBs, including the necessary assurances that they must provide. Partnership agreements, and the relationship they represent, must be based on trust, shared outcomes, transparency and clear lines of accountability and responsibility, as set out in the NI Code of Good Practice in Appendix 5 (ii).

The Department and its ALBs will also agree an annual engagement plan (this is included in the partnership agreement above) specific to each ALB, setting out the timing and nature of the engagement between the ALB and the Department. The engagement plan should be centred on partnership working, understanding shared risks and working together on business developments that align policy objectives. It will set out the agreed management and financial information to be shared over the course of the year.

The Department will appoint a senior lead official to manage the relationship with each ALB and ensure effective partnership working, without straying into operational oversight. **Departmental sponsor branches** will manage this relationship on a day-to-day basis and are the ALBs primary point of contact within the Department on assurance and accountability.

The accountability of all HSC ALBs is set out in Figure 2.

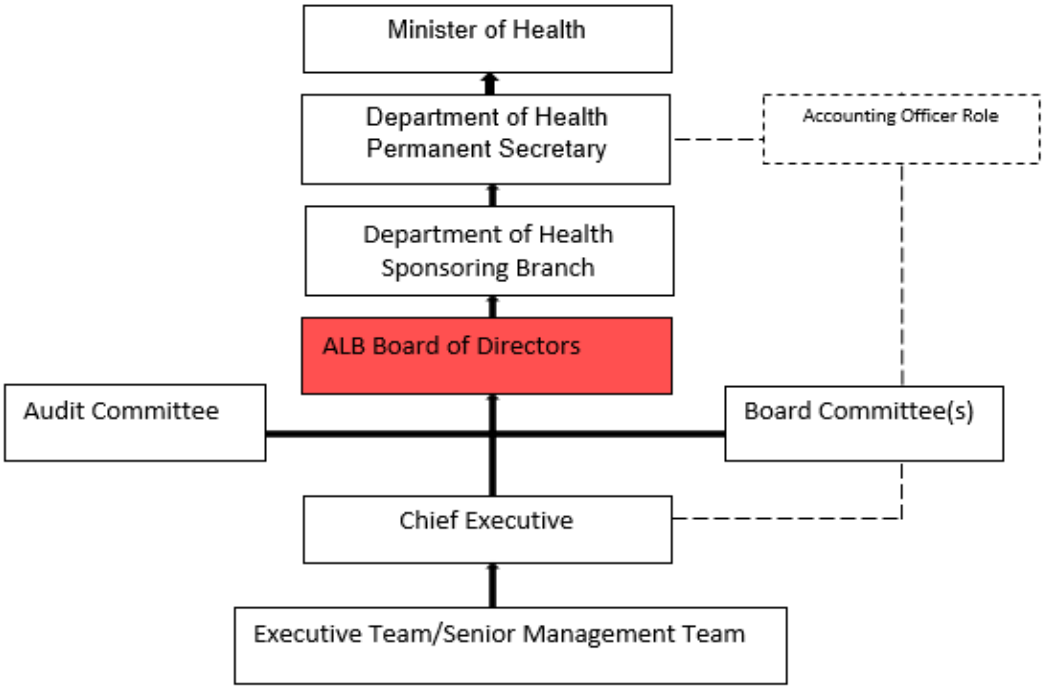


Figure 2: Accountability process for HSC ALBs

1.5.2 Autonomy for ALBs

The Guidance on Proportionate Autonomy for Arm's Length Bodies is set out in DAO (DoF) 06/19 and summarised in Appendix 5 (i) and Annex A of the guidance in Appendix (ii).

Proportionate autonomy

The guidance on proportionate autonomy provides guiding principles, rather than being detailed and prescriptive, due to the different nature and challenges across all ALBs. It will therefore be for individual Departments and ALBs to develop their relationship and approach to partnership working, and associated departmental activities in a way that is consistent with the principles set out in the guidance, whilst focusing on the delivery of agreed outcomes. The agreed approach and level of autonomy should be reflected in the engagement plan within the partnership agreement.

It is important to note that some ALBs may already operate with an appropriate degree of autonomy from Departments. It is also important to highlight that as autonomy is continuous and ongoing, this means it is flexible and should be regularly reviewed as appropriate.

Departments should also engage with their finance divisions (who in turn should engage with DoF as appropriate) to give effect to the principles outlined, and to identify where it is possible to streamline processes and monitoring requirements, while maintaining an appropriate level of assurance.

1.5.3 Accountability of individual HSC Board Members

To what extent can a Board Member be held liable at law for their actions?

Basically, if an individual Board Member incurs a civil liability in the course of carrying out their responsibilities for the Board, they will not have to pay anything out of their own pocket provided that they have acted **honestly and in good faith**.

However, it should be noted that this indemnity does not protect any Board Member who has acted recklessly, criminally or in bad faith. The issue of Board Member indemnity cover should be covered in the letter of appointment and in the ALB's code of conduct for Board Members.

In many cases, the founding legislation or standing orders will set out the grounds on which a Board Member may be removed and these may include the following:

- Bankruptcy;
- Being unable, unfit or incapable of performing their duties as a Board Member;
- Poor attendance; and
- Being convicted of an indictable offence which has not expired.

Legal duties as a Trustee (for example of an endowment fund)

Some Trusts have charitable endowment funds, for the benefit of patients and staff which are registered charities in their own right. Board Members who are appointed as Trustees of this or any other charity will assume personal responsibilities as a Trustee including:

Ensure the charity is carrying out its purposes for the public benefit

Trustees must make sure that the charity is carrying out the purposes for which it is set up, and no other purpose. This means a Trustee needs to:

- Understand the charity's purposes as set out in its governing document and its registration with the Charity Commission;
- Be able to explain how all of the charity's activities are intended to further or support its purposes; and
- Understand how the charity benefits the public by carrying out its purposes.

Spending charity funds on the wrong purposes is a very serious matter; in some cases Trustees may have to reimburse the charity personally.

Comply with the charity's governing document and the law

Trustees must:

- Make sure that the charity complies with its governing document;
- Comply with charity law requirements and other laws that apply to the charity; and
- Take reasonable steps to find out about legal requirements, for example by reading relevant guidance or taking appropriate advice when needed.

Act in the charity's best interests

Trustees must:

- Do what the Trustees (and no one else) decide will best enable the charity to carry out its purposes;
- Make balanced and adequately informed decisions, thinking about the long term as well as the short term;

- Avoid putting themselves in a position where their duty to the charity conflicts with personal interests or loyalty to any other person or body including the Trust/ALB; and
- Not receive any benefit from the charity – this also includes anyone who is financially connected to a Trustee, such as a partner, dependent child or business partner other than in exceptional circumstances.

Manage the charity's resources responsibly

Trustees must act responsibly, reasonably and honestly. This is sometimes called the duty of prudence. Prudence is about exercising sound judgement. Trustees must:

- Make sure the charity's assets are only used to support or carry out its purposes;
- Avoid exposing the charity's assets, beneficiaries or reputation to undue risk;
- Not over-commit the charity;
- Take special care when investing or borrowing; and
- Comply with any restrictions on spending funds or selling land.

Trustees should put appropriate procedures and safeguards in place and take reasonable steps to ensure that these are followed. If not, Trustees risk making the charity vulnerable to fraud or theft, or other kinds of abuse, and being in breach of their duty.

Act with reasonable care and skill

As those responsible for governing a charity, Trustees:

- Must use reasonable care and skill, making use of the skills and experience of Trustees and taking appropriate advice when necessary; and
- Should give enough time, thought and energy to their role, for example by preparing for, attending and actively participating in all Trustees' meetings.

Ensure the charity is accountable

Trustees must ensure compliance with statutory accounting and reporting requirements. Trustees should also:

- Be able to demonstrate that the charity is complying with the law, is well run and effective;
- Ensure appropriate accountability to members (if the charity has a membership separate from the Trustees); and
- Ensure accountability within the charity, particularly where Trustees delegate responsibility for particular tasks or decisions to staff or volunteers.

Any breach of these legal responsibilities could have serious consequences for a Trustee personally.

Likewise, Board Members who are nominated as Directors to any organisation constituted as a company will have legal duties as Directors.

It is essential that anyone appointed to a charity or separate company by reason of their role as a Board Member (or staff member) of an ALB receives induction and ongoing training on their roles and responsibilities. If a Board Member is in any doubt as to their position, they should take legal advice and discuss with their Chair.

1.6 Strategic documents and founding legislation

- HPSS (NI) Order 1991 establishment of the Health and Social Services Boards and Trusts then augmented by;
- HPSS (NI) Order 1994 (to include the Scheme of Delegation of Statutory Functions);
- HPSS Quality, Improvement and Regulation (NI) Order 2003 defined the arrangements for improving the quality of provision measured through clinical and social care governance;
- Quality Standards for Health and Social Care-Supporting Good Governance and Best Practice in the HPSS (DHSSPS, 2006); and
    - Departmental Circular, HSS (Statutory Functions) 1/2006;

- Health and Social Care (Amendment) Act (Northern Ireland) 2014 to properly reflect the purpose of the Business Services Organisation;
- DoH Integrated Governance Handbook February 2006; and
- The New Integrated Governance Handbook 2016: developing governance between organisations (GBO) by Dr John Bullivant Chairman GGI.

1.7 A Strategic Framework for Rebuilding Health and Social Care Services June 2020

COVID-19 posed unprecedented challenges for the HSC system in 2020, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within Health and Well-being 2026: Delivering Together. This is against a backdrop of financial constraints and single year budgets. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

The impact of COVID-19 on HSC has been profound and will be long lasting. Services have not able to resume as normal for some time due to the continued need to adhere to social distancing and for personal protective equipment (PPE) at volumes not required prior to the pandemic. The Department has collated a comprehensive assessment of the impact of COVID-19 across primary care and community services; secondary care; and a wide range of programmes and projects. This detailed assessment can be found here.

Other strategic documents – Health and Well-being 2026: Delivering Together

1.8 HSC governance during the COVID-19 pandemic

Given the unprecedented challenges posed by COVID-19 a number of changes to the governance framework have been implemented. The Department, through temporary amendments to the framework document, and the establishment of a **new management Board**, will give clear direction to the HSCB, Public Health Agency, HSC Trusts and the Business Services Organisation to reflect the Minister's priorities. In addition, the Minister will meet with the Chairs of the respective organisations on a regular basis to ensure that Non-Executive colleagues are clear as regards ministerial priorities, and have the opportunity to raise any areas of concern.

These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision-making in rebuilding HSC services.

The rebuilding of services will take some time and will require a response that is both agile and adaptable to ensure the system can respond to further surges of COVID-19, whilst optimising its ability to stabilise and move forward. The HSC system will continue to be significantly constrained in the delivery of services due to the ongoing prevalence of COVID-19. In this context the analysis of performance levels against pre-COVID-19 indicators and targets would be not be an appropriate basis for performance monitoring and management in the current environment.

The performance targets will therefore need to be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

1.9 HSC Board Members

All Board Members of HSC organisations have a crucial role to play in ensuring that their organisation is run efficiently and effectively and delivers high-quality health and care services. You have been appointed as a Board Member to bring your personal expertise and experience to the boardroom and you are personally as well

as corporately responsible for your actions and decisions as a Board Member. To facilitate the effective participation of HSC Board Members in the discharge of their responsibilities, this HSC Board Member Handbook includes the following information.

Leadership (section 2)

A summary of the HSC Collective Leadership Strategy and key role for HSC Board Members in developing maintaining a leadership culture as well as promoting openness and candour.

Roles and responsibilities of HSC Board Members (section 3)

What you do as an HSC Board Member and the specific accountabilities of Boards as well as a set of principles for how Board Members undertake these responsibilities.

Assurance and scrutiny (section 4)

The most comprehensive section of the handbook with information on: duty of quality; quality improvement and measurement; quality and safety; clinical governance, social care governance risk management; financial stewardship; being open and the duty of candour; internal and external involvement; professional regulation; scrutiny and challenge. For each of these, prompts are given to assist Board Members in exercising their scrutiny function.

Case examples (section 5)

Case studies are set out in summary, representing different aspects of good governance that enables Board Members to consider their role in scrutiny and assurance. Tips and prompts are provided.

Training and development (section 6)

Requirements for induction and continuous development for HSC Board Members. This section provides checklists of the areas to be covered, the aspects of appraisal and development of a personal development plan. It also provides information on self-assessment for HSC Boards.

HSC Board Member Handbook

SECTION 2: Leadership and culture

2.1 HSC Collective Leadership Strategy

The importance of leadership in HSC services has been highlighted by many reports and recommendations during recent years. As a response to this, the Northern Ireland Executive committed itself to:

> *"Develop an HSC-wide leadership strategy, to consider a five year approach and plan for development of collective leadership behaviours across our system".*

Health and Well-being 2026: Delivering Together (October 2016)

As a result, the HSC Collective Leadership Strategy[5] was launched in 2017. Based on evidence from the best-performing HSC organisations, it has identified leaders who have prioritised the development of a **common vision** for the service and focused on high-quality compassionate care and support.

Such organisations are characterised by a culture of collective leadership 'a community of leaders' as opposed to command and control. It also shows that it is **compassionate** leadership behaviours combined with a strong focus on quality improvement that creates cultures where people who work across Health and Social Care are able to deliver high-quality, continually improving, compassionate care and support.

The HSC Collective Leadership Strategy consists of four components

- Leadership is the responsibility of all;
- Shared leadership in and across teams;
- Interdependent and collaborative leadership; and
- Compassionate leadership.

5 HSC Collective Leadership Strategy Department of Health 2017

Figure 3: HSC Collective Leadership Strategy components

2.1.1 Leadership is the responsibility of all

The leadership task is to ensure direction, alignment and commitment within teams and organisations. Collective leadership means that all share in leadership responsibility across the organisation to ensure commitment comes from everyone in the organisation.

Each individual takes responsibility, with a knowledge and understanding of the common vision, and makes it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation.

In practice, this means that those leaders in formal roles must create the conditions in which power, authority and decision-making are distributed to all levels within and across the organisation. In developing leadership at all levels people need to be informed, enabled and empowered to deliver high-quality, continually improving, compassionate care and support.

2.1.2 Shared leadership in and across teams

Increasingly healthcare has to be delivered by an interdependent network of teams and organisations. This requires that leaders work together, spanning boundaries both within and between organisations, prioritising overall patient care rather than the success of their component of it. That means leaders working collectively to build a cooperative, integrative leadership culture – in effect, collective leadership at the system as well as organisational level.

> *"Collective leadership requires the development of shared leadership within teams and across teams based on open and supportive communication, candid and mutual feedback and agreed, shared and challenging goals. This builds communities of teams and creates a culture that values differences and enables decision-making at the closest point of contact with the users by teams rather than just individuals.*
>
> *Within teams there is a need to create a cohesive, optimistic and effective environment that stimulates and supports innovation, continuous learning and improvement."*

HSC Collective Leadership Strategy

2.1.3 Interdependent, collaborative leadership

Rapid innovation and adaptation to change require a collaborative, interdependent culture and solutions that cut across function, region, and profession. Leaders must learn to shift away from the 'individual expert' model so common in today's healthcare systems and move towards a model that works across boundary groups and teams and spans disciplines, levels, functions, generations, and professions.

> *"These new collaborations will be able to integrate knowledge throughout the system and to anticipate and solve unprecedented*

challenges — all while delivering efficient, high-quality, compassionate patient care across the continuum.“ [6]

Centre for Creative Leadership 2016

Interdependent, collaborative leadership means leaders must work effectively across boundaries. The HSC Collective Leadership Strategy sets out the key components for collaborative leadership:

- A compelling shared vision for transforming the health and well-being of the population across Northern Ireland;
- A shared commitment to work together for the medium and long term (not just the short term);
- Frequent contact between leaders who need to work together to build trust and make real progress to deliver a world class service;
- A shared agreement to identify and resolve conflicts quickly, fairly, transparently and without blame, and a commitment to collaborative problem solving;
- A commitment to establish shared learning for improvement rather than blaming for mistakes;
- A clear commitment to support and value each other’s organisations, mutually supporting system success in transforming health and well-being in our population;
- Equal partnerships between those who work in Health and Social Care and the people they serve, through a co-production approach.

Research consistently shows that HSC organisations need visionary leaders who can inspire and develop employees, build and mend relationships effectively, lead and motivate teams, and engage in participative/collaborative management.

In addition to these core competencies, new and different leadership skills will be required to see HSC organisations through periods of change. Transformation of

6 Collaborative Healthcare Leadership A Six-Part Model for Adapting and Thriving during A Time of Transformative Change Centre for Creative Leadership 2016.

services will see HSC systems leading such changes and managing a changing workforce.

An investment in leadership talent is one way to engage employees and prepare for future leadership needs. Clinical and social care staff who are promoted into leadership roles need support and development as they make the transition, enabling them to approach the role as effectively as possible. As in business, often the most technically proficient individuals are promoted to managerial positions without the self-awareness, emotional intelligence, and other leadership competencies required for success.

Throughout HSC organisations leadership talent can be grown and supported in multiple ways, including extensive use of feedback, coaching, and developmental assignments and challenges.

As part of a well-articulated business strategy, healthcare organisations need comprehensive strategies for identifying, hiring, developing, and retaining leadership talent. Building a culture rich with assessment, challenge, and support helps to grow the talent pipeline. Building and growing a pool of people capable of taking on larger and more complex leadership roles can both transform the organisation and maintain quality and safety standards.

For HSC Board Members collaborative leadership practices include:

- Re-defining a new leadership strategy in the face of the challenges of ensuring quality and safety of service users;
- Re-defining a new leadership strategy in the face of the new structures and models associated with reform;
- Identifying, developing, and retaining the leadership talent needed to create and implement solutions in the face of rapid and evolving change; and
- Creating a culture that encourages and values mutual respect and professional practice.

2.1.4 Compassionate leadership

It is recognised that an important starting point for those delivering health and social services is **compassion** – a core value of the HSC as a whole and its staff. Sustaining the HSC as a culture of high-quality compassionate care requires **compassionate leadership** at every level and in interactions between all parts of the system – from regional leaders to local teams.

Compassionate leadership in practice means leaders listening intently to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and then taking action to help or support them. Such leadership will begin to address the problems the service faces, because top-down solutions are not working. Meanwhile, patient care and staff health are being undermined.

> *"Virtually all NHS staff are committed to providing high-quality and compassionate care. They represent probably the most motivated and skilled workforce in the whole of industry. However, we impose on them a dominant command and control style that has the effect of silencing their voices, suppressing their ideas for new and better ways of delivering patient care and suffocating their intrinsic motivation and fundamental altruism. Released, their motivation and creativity will ensure commitment to purpose and performance. Their voices are needed to tell us how care can best be improved as the endless remote top-down plans often fail because they ignore the reality of day to day care."*

Kings Fund – 5 Myths of Compassionate Leadership 2019

The HSC Collective Leadership Strategy emphasises the need for a consistent approach to compassionate leadership in practice.

- **Attending:** paying attention to people – being present and listening with intent.

- **Understanding:** finding a shared understanding of the situation.
- **Empathising:** using emotional intelligence and engaging people.
- **Helping:** taking intelligent action to help.

It is well recognised that compassionate leadership relies heavily on emotional intelligence that would include:[7]

- Self-awareness – accurate self-assessment/self-confidence;
- Self-management – self-control, adaptability, initiative, achievement, orientation, integrity, value system;
- Social awareness – individual/organisational, empathy; and
- Social skill – influencing/communication.

In such a way, the leadership community is characterised by authenticity, honesty and openness, curiosity, decisiveness and appreciation.

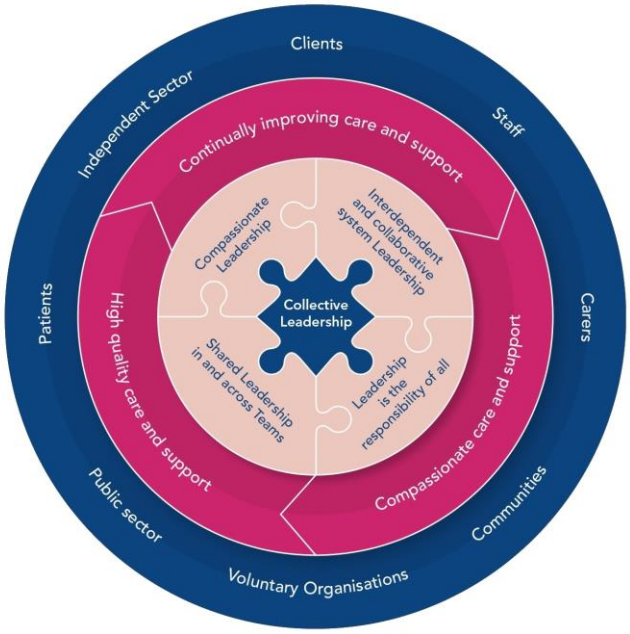


Figure 4: Additional HSC Collective Leadership Strategy components

7 Cavazotte, Flavia; Moreno, Valter; Hickmann, Mateus (2012). 'Effects of leader intelligence, personality and emotional intelligence on transformational leadership and managerial performance'. *The Leadership Quarterly*. **23** (3): 443–455. 2011.

Throughout the HSC Board Member Handbook the key **leadership role of Board Members** is stressed in setting the culture of the organisation, in working with others to set strategy, in ensuring accountability within and without the organisation, in the understanding and use of intelligence and in the development of a community of leaders.

2.2 Common values

The HSC has developed a core set of values for all staff and organisations that underpins the attitude and behaviours expected which align closely to the themes in the HSC Collective Leadership Strategy; these include:

- Working together;
- Compassion;
- Excellence; and
- Openness and honesty.

Table 1 sets out the meaning of each value and the expected behaviours.

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution. • I treat people with respect and dignity. • I work as part of a team looking for opportunities to support and help people in both my own and other teams. • I actively engage people on issues that affect them. • I look for feedback and examples of good practice, aiming to improve

		where possible.
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness. • I learn from others by listening carefully to them. • I look after my own health and well-being so that I can care for and support others.
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference. • I take responsibility for my decisions and actions. • I commit to best practice and sharing learning, while continually learning and developing. • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships. • I ask someone for help when needed. • I speak up if I have concerns. • I challenge inappropriate or unacceptable behaviour and practice.

Table 1: HSC Values, meaning and expected behaviours

2.3 A common vision

Research suggests that leaders in the best-performing health care organisations prioritised the development of a common vision and developed a strategic narrative focused on high-quality, compassionate care. In these organisations, all leaders (from the top to the front line) made it clear that high-quality compassionate care was the core purpose and priority of the organisation.[8] There is evidence that such alignment has an important influence on reducing the effects of 'fault lines'[9]/silos – a common problem in health care organisations.

A vision must also be translated into leadership actions because the messages that leaders send about their priorities are communicated more powerfully through their actions than their words. Leadership authenticity is revealed by what leaders monitor, attend to, measure, reward and reinforce and this in turn regulates and shapes the efforts of staff.[10]

2.4 Leadership culture

Why care about culture?

In its most basic form, culture is a mechanism for sustainability and survival. It also has the hidden power to derail strategic change initiatives. In fact, research shows the majority of strategic change initiatives ultimately fail because they don't address culture.

Leaders must understand and communicate a clear vision to **create** an environment that attracts people who share their same values. You lay the groundwork by being clear with your purpose, and by leading by example and modelling the behaviours you **would** like to see practiced.

- A culture is formed by beliefs that drive behaviours.

8 Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., and West, M. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Quality and Safety, 23 (2), 106–115.

9 Defined as group and status differences that interfere with effective collaboration Bezrukova, Thatcher, Jehn, Spell 2012.

10 Avolio B.J. & Gardner W.L. (2005). Authentic leadership development: getting to the root of positive forms of leadership. The Leadership Quarterly, 16 (3), 315–338.

- New beliefs lead to new behaviours and new possibilities emerge.
- Change the leadership mind-set and you change the organisational culture.[11]

Organisational culture is defined as "the values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and re-tell about their organisations".[12]

The key challenge facing HSC organisations is to nurture cultures that ensure the delivery of continuously improving high-quality, safe and compassionate healthcare.[13]

Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental.

2.5 Leadership activities specific to HSC Board Members

Board leadership is most effective when Boards:

- Enact the vision and values of their organisations through what they pay attention to and what they monitor, reprove or reward;
- Listen to service user and other stakeholder voices as the most important sources of feedback on organisational performance; and
- Listen to staff voices to discover how they can best support and enable staff to provide high-quality patient care.

Effective Boards ensure that:

- A strategy is implemented for nurturing a positive culture;

11 Collaborative Healthcare Leadership A Six-Part Model for Adapting and Thriving during A Time of Transformative Change. Centre for Creative Leadership 2016.
12 Schneider, B. & Barbera K.M. (eds.) (2014). The Oxford Handbook of Organisational Climate and Culture. Oxford, Oxford University Press.
13 Leadership & Leadership Development in Health Care: The Evidence Base – The King Fund 2015.

- Sense problems before they happen and improve organisational functioning;
- Promote staff participation and proactivity;
- Enable and encourage responsible innovation by staff; and
- Engage external stakeholders effectively to develop cooperative relationships across boundaries.

2.5.1 Leadership in shaping the culture

While leadership is the responsibility of all, HSC Board Members have a particular responsibility to ensure that the Board acts in the best interests of the public and is fully accountable to the Minister for the services provided by the HSC organisation and creates/ensures an organisational culture that supports this.

Figure 5: 'The Healthy Board': roles and building blocks[14]

'The Healthy Board' Principles for Good Governance NHS Leadership Academy 2013 sets out the responsibilities of Boards with a key element being **leadership for 'shaping culture'** in the organisation.

14 The Healthy Board' Principles for Good Governance NHS Leadership Academy 2013, www.leadershipacademy.nhs.uk

2.5.2 Shared leadership in and across teams

For HSC Board Members, shared leadership in and across teams is most clearly seen in the function of the Board alongside the Executive Director and Non-Executive Director roles, when they act together as well as act independently.

Acting together

Acting together is in the best interest for governing effectively and in doing so building patient, public and stakeholder confidence that their health and social care is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services;
- In ensuring that resources are invested in a way that delivers optimal health outcomes;
- In the accessibility and responsiveness of health services;
- That patients and the public can help to shape health services to meet their needs; and
- That public money is spent in a way that is fair, efficient, effective and economic.

Acting independently

Acting independently means to scrutinise and challenge through a system of integrated governance whereby systems and processes by which Trusts lead, direct and control their functions to achieve the organisational objectives of safety and quality, through which they relate to service users, wider community and partner organisations. This is set out in more detail in section 4.

HSC Board Member Handbook

SECTION 3: Roles and responsibilities

3.1 WHAT you do as an HSC Board

3.1.1 Strategy development

The overall purpose of a HSCB is to set the vision and strategy leading to the provision of safe and excellent health and care services for patients and people in the community, across the area of its responsibility. This is achieved through the efficient, effective and accountable governance of the organisation and by providing strategic leadership and direction that focuses on agreed outcomes.

Under the leadership of the Chair, the Board has corporate (collective) responsibility for four main functions:

- Ensuring that the organisation delivers its functions in accordance with statute, the Programme for Government and the Minister's policies and priorities;
- Providing strategic direction and leadership;
- Ensuring effective governance, especially financial stewardship; and
- Holding the Chief Executive and senior management team to account.

The Board fulfils its leadership role by developing a corporate strategy. The Board then agrees a corporate plan to turn this strategy into action over an agreed period of three years and promotes, then demonstrates, continuous improvements in corporate performance over this period.

Both the strategy and corporate plan must align with the Board's remit and indicate how it will contribute to enhancing the health and well-being of the population that it serves. The corporate plan should be approved by the Minister (or the Department on behalf of the Minister) and arrangements needs to be put in place for regular communication between the Board and the DoH to ensure effective monitoring and review.

At all times, the Board must ensure that it is focused on the design, implementation and delivery of safe and effective services and care to the community which will lead to the improvement of the health and well-being of the local population.

3.1.2 Accountability

In addition to the development of the organisation's strategy and direction, the Board has a clear and critical role in ensuring that there is effective and robust accountability for the three key areas of governance: **clinical and social care governance**, **staff governance** and **corporate governance**.

The Board should discharge this role by:

- Ensuring that there are effective clinical and social care governance arrangements in place through the development of a framework for continually improving the quality of the services and safeguarding high standards of care by the creation and maintenance of an environment in which excellence in clinical care will flourish.

- Ensuring that there is effective staff governance in place, demonstrating that staff are well informed, appropriately trained and developed, involved in decisions, treated fairly and consistently, with dignity and respect, in an environment where dignity is valued.

- Ensuring that staff are provided with a continuously improving and safe working environment, promoting the health and well-being of staff, patients and the wider community.[15]

- Putting person-centred care at the core of the delivery of high-quality services. Person-centred care is defined as "mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making".

15 The Sturrock Enquiry was a fully independent external review into allegations of a bullying culture at NHS Highland. The Scottish Government's response (2019) sets out a 65-point plan on what NHS organisations should do to develop a supportive culture.

- Promoting the safe, efficient, economic and effective use of staff and other resources including participation in shared services and collaborative service delivery arrangements.

- Ensuring that effective arrangements are in place to provide assurance on risk management, governance and internal control, the audit and risk assurance committee is a standing committee of the Board and should report to the Board on these areas.

- Receiving and reviewing regularly financial information on the management and performance of the organisation and being informed in a timely manner about any concerns.

- Taking into account relevant guidance issued by the Department and ensuring that systems are in place to notify the Department at an early stage about emerging issues which will impact on the operation or reputation of the organisation and/or the provision of health and care services to the population.

- Appointing (with the approval of the Minister) the Chief Executive and, in consultation with the Minister/Department, setting appropriate performance objectives and terms of remuneration (through the remuneration committee) linked to these objectives which give due weight to the proper management and use of resources within the stewardship of the organisation and the delivery of outcomes.

- Demonstrating high standards of corporate governance at all times, including openness and transparency in its decision-making.

- Ensuring that appropriate and effective mechanisms are in place for the Board and organisation to engage with service users, carers and the community in the planning and provision of HSC services and in addressing health inequalities.

3.1.3 The role of the Minister

Every ALB sponsored by the DoH is expected to be aware of, and work within, a strategic and operational framework determined by the Department. Every ALB falls within the portfolio of a specific Minister who will set its overall policy aims, define expected outcomes arising from implementation of that policy, and will review its progress against these actions.

The term **Arm's Length Body** does not mean that an organisation is beyond Ministerial control. The Minister will decide how much independence and flexibility each ALB should have, depending on its size and the nature of the functions it carries out.

Founding legislation gives the Minister the power to issue a formal direction requiring the ALB to take particular action. However, the use of these formal powers is rare.

The Minister is mainly responsible for:

- Considering and approving the ALB's strategic objectives and the policy and performance framework within which it operates;
- Securing and approving the allocation of public funds for the ALB;
- Approval of key documents such as the Management Statement and Financial Memorandum and the ALB's corporate plan;
- Making appointments to the Board;
- Approving the terms, conditions and remuneration of the Chair and Board Members, and in most cases the Chief Executive; and
- Issuing letters of strategic guidance.

The Minister may also seek to increase his/her understanding of the ALB through formal meetings with the Chair and Board and other more informal events. The Minister is responsible to the Northern Ireland Assembly and may be asked at any time to attend the Assembly or one of its committees to answer questions from Members of the Legislative Assembly (MLAs).

Representing the interests of the Minister

Board Members of an HSC ALB are appointed by the Minister in order to ensure the delivery of, or advise upon, his/her policies and priorities. The representation of an ALB's views to the Minister by the Board is of course perfectly legitimate and acceptable, but such action should be viewed within this wider context. Crucially, Board Members and the Board corporately should be clear about the Minister's policies and expectations for their ALB.

If they are in any doubt on this point at any time, they should seek clarification from the Chair.

As a 'fit and proper person', there is an expectation that Board Members should cause no embarrassment to Ministers during their time with the ALB.

3.2 HOW you do it as an HSC Board

3.2.1 Shaping a healthy community

The quality of care that patients and service users experience is affected by leaders and managers at all levels of an organisation. Effective leaders and managers have an impact on how organisations perform, how staff feel about their work and their motivation to deliver high-quality care, and how services are developed, delivered and improved.

Delivering high-quality services depends on an organisational culture and set of values that puts patients and service users first and encourages and celebrates innovation, improvement and learning. Non-Executive Board Members in particular have a key role in promoting and nurturing such a culture and values.

3.2.2 Governance and culture

A healthy organisational culture is not about what we do, but about how we do it. By developing and sustaining a healthy organisational culture, HSC Boards will create

the conditions for the delivery of high-quality health and care services. This should be through developing values and driving behaviours that support a healthy culture.

Good governance flows from a shared ethos or culture, as well as from systems and structures. Non-Executive Board Members play a lead role in establishing, modelling and promoting values and standards of conduct for the organisation and its staff.

Boards are responsible for ensuring that the organisation meets its statutory duties in relation to participation and equalities (Annex 2) and for promoting good practice by providing leadership as well as challenge.

The actions of all Boards are open to public scrutiny. Demonstrating a culture in which participation is encouraged, supported and valued can be a positive way of developing or reinforcing public confidence in the staff and services.

Non-Executive Board Members are expected to:

- Actively support and promote a healthy culture for the organisation and reflect this in their own behaviour; and
- Provide visible leadership in developing a health culture so that staff believe they are a safe point of access to the Board for raising concerns.

In practice this means:

- Promoting a positive culture which includes upholding and promoting the values of HSCNI;
- Being an ambassador of the HSC body, representing it honestly and positively, engaging with a wide range of organisations;
- Leading by example, including behaviour at Board meetings;
- Being visible to staff and patients; and
- Demonstrating a commitment to **openness, transparency and candour.**

Openness

Enabling concerns to be raised and disclosed freely without fear and for questions to be answered.

Transparency

Allowing true information about performance and outcomes to be shared with staff, patients and the public.

Candour

Ensuring that patients harmed by a healthcare service are informed of the fact, that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it. This includes providing sufficient information and not misleading by omission of information.

Board prompts

- These skills will develop with experience. Get out and about as much as possible; speak to other Board Members, staff, patients and members of the public.

What can Non-Executive Board Members do to help shape culture within the Board and the organisation?

- Ensure that Board business is conducted in an open and transparent manner;
- Think about whether Board Members encourage constructive debate and discussion;
- Ensure that the Board actively publishes information;
- Make sure that you know what the Board does to encourage staff to follow NHS Board principles;
- Consider how the Board monitors feedback from patients and what actions are then taken; and
- Make yourself visible and approachable to staff and members of the public.

3.2.3 Conduct and leading by example

The public has high expectations of those who serve on the Boards of public bodies and the way in which they conduct themselves in undertaking their duties. As a Board Member of an HSC body, it is your personal responsibility to meet these expectations by ensuring that your conduct is above reproach.

As follows, there are three fundamental principles of Board life to which all Board Members (including the Chair) must adhere.

Principle 1 – Corporate responsibility

While Board Members must be ready to offer constructive challenge, they must also share collective responsibility for decisions taken by the Board as a whole. If they fundamentally disagree with the decision taken by the Board, they have the option of recording their concerns in the minutes. However, ultimately, they must either accept and support the collective decision of the Board – or resign.

Board decisions should always comply with statute (in particular, the statute establishing the HSC body), Ministerial Directions as well as departmental guidance.

However, it is also important that Boards demonstrate a strong degree of independence in order to maintain credibility with the public and stakeholders.

Principle 2 – Confidentiality

All Board Members must respect the confidentiality of sensitive information held by the organisation. This includes commercially sensitive information, personal information and information received in confidence by the HSC body. It is also essential that debate of a confidential nature that takes place inside the boardroom is not reported outside it.

Principle 3 – Conduct

Board Members have a responsibility to set an example by demonstrating the highest standards of behaviour and complying fully with the Seven Nolan Principles of Public Life, summarised in Appendix 3:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership.

It is important that nothing a Board Member does or says when acting as a Board Member tarnishes in any way the reputation of the organisation or the Board.

If a Board Member has specific concerns about the manner in which the organisation is being run, these should be raised with the Chair in the first instance. If the Board Member fails to achieve resolution with the Chair, it is open to him or her to take their concerns to the relevant senior civil servant in the DoH – but Board Members should appreciate that this is a significant step and should not be taken lightly.

3.2.4 Being an effective Board Member

Effective Board Members (Executive and Non-Executive) are critical to achieving safe and excellent health and care services for patients and people in the community.

Effective Board Members are expected to constructively challenge and be a critical friend. However, it is not the role of the Chair and Non-Executive Board Members to have a detailed involvement in the day-to-day management of the organisation.

In order to be effective in their role, Board Members should:

- Actively participate in collective decision-making, and chair, or participate in, where required, one or more of the committees of the Board;

- Act in accordance with the principle of collective responsibility for decisions of the Board – no Board Member is appointed on a representative basis for any HSC body or group and Members are expected to bring an impartial judgement to bear on the business of the HSC Board;

- Question intelligently, challenge rigorously, debate constructively and decide dispassionately;

- Be sensitive to the views of others, inside and outside the boardroom;

- Be an ambassador for the organisation and support public involvement and engagement, demonstrating the ability to undertake a representational role across health services in Northern Ireland;

- Actively work with stakeholders in the local community, other Boards, regional support organisations and beyond to achieve the aims of the HSC body;

- Work with all other interested parties and fully represent the Board's activities, in an honest and positive way, whilst encouraging and maintaining good relationships;

- Put into action the Minister's policies and priorities in the context of the Board's area and remit;

- Develop an effective working relationship with other Board Members and staff within the health and care system;

- Gain the trust and respect of other Board Members;

- Support Executives and other senior staff in their leadership of the business while monitoring their performance and conduct;

- Commit to ongoing personal development activities in support of their Board role; and

- Uphold the highest ethical standards of integrity and probity and comply with the Board's code of conduct, derived from the Nolan Principles and the Code of Conduct and Code of Accountability for Board Members of HSC Bodies (July 2012).

3.2.5 Due diligence

Due diligence is often cited as a method to make sure that everything is the way it is supposed to be. It involves doing all the necessary homework, background checks, and analyses to identify problems, offer solutions, and document procedures. In terms of corporate governance, this may include asking the following questions:

- What is the strategic purpose and vision of the organisation?
- What are short, medium and long-term objectives for achievement to strive for?
- What are the key corporate risks?
- How are resources allocated to bring this about, in particular, the financial and human resources?
- How is the management structure geared to the achievement of the strategy?
- Financial controls – how do they work?
- Operational controls – how do they work?
- What are the management priorities in the near, intermediate and long term?
- Past and present performance – what progress has been made towards the achievement of the organisation's short, medium and long-term goals? How does our performance compare to that of other HSC organisations?
- What specific underlying factors or forces determined those results?

- Constituency protection – what mechanisms are in place to ensure that the interests of all stakeholders are addressed, and that the appropriate statutory or regulatory requirements are met?
- What arrangements are in place to identify and mitigate the risks in relation to litigation and disputes?
- How well is the organisation able to respond to crises, and what contingency plans and processes are in place?

3.2.6 Compassionate leadership

A compassionate leader, as well as being a compassionate person, encourages compassion and caring in the wider organisation. An effective Board Member, being a compassionate leader, encourages employees to talk about their problems and to provide support for one another. This is recognised in the HSC Collective Leadership Strategy, Department of Health 2018

Professor Michael West[16] and his work on leadership within the NHS provides a helpful perspective on a compassionate approach to leadership within the health service. Board Members may find the following video links useful in this regard.

Collaborative and compassionate leadership, Professor Michael West
Five myths of compassionate leadership
Leadership in today's NHS

Board Members also have a responsibility to ensure that staff have confidence in the fairness and impartiality of procedures for registering and dealing with their concerns and interests. The Public Interest Disclosure (Northern Ireland) Order 1998 gives legal protection to employees who raise certain matters or concerns, known as 'qualifying disclosures', without fear of reprisal.

As a Board Member, you should ensure that your organisation has a whistleblowing (or freedom to speak up) policy and appropriate procedures in place. This will allow

16 Visiting Fellow, Leadership and Organisational Development, The King's Fund and Professor of Work and Organisational Psychology at Lancaster University Management School.

staff to raise concerns on a range of issues such as fraud, patient safety, staff welfare/bullying etc. without having to go through the normal management structure.

In May 2018, NHS Improvement issued Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts.

3.2.7 An effective Chair

As follows, the Chair has additional responsibilities over and above those of the other Non-Executive Board Members, particularly in relation to leadership of the Board and the conduct of Board business.

Board leadership

Providing leadership to the Board, the other Non-Executives, the Chief Executive and Executive Board Members and ensuring the effectiveness of the Board in all aspects of its role, including directing the organisation towards achieving its own and the Minister's objectives. This includes:

a. Leading the Board's approach to strategic planning

Ensuring that the HSC body's policies and actions support the Minister's strategic priorities.

b. Monitoring

Ensuring the provision of accurate, timely and clear information to the Board and Board Members to enable them to monitor progress effectively and hold the Executive to account;

Overseeing the implementation of Board decisions; and

In consultation with the Board as a whole, undertaking an annual appraisal of the performance of the Chief Executive.

c. Board and Board Member recruitment and development

Ensuring that Executive and Non-Executive Board Members work together effectively as a team;

Ensuring that the Board, in accordance with recognised good practice in corporate governance, is diverse in terms of relevant skills, experience and knowledge appropriate to directing the Board's business;

Ensuring that the Minister and Department are advised of the Board's needs when vacancies arise;

Ensuring that the Chair and all Board Members receive appropriate induction training on appointment and are fully briefed on the terms of their appointment, duties, rights and responsibilities;

Assessing the performance of individual Board Members – Non-Executive and Executive – on a continuous basis and undertaking a formal appraisal at least annually; and

Sharing and using the relevant skills and expertise of all Board Members.

d. Representation

Representing the Board and organisation in links with the Minister (to whom the Chair is personally accountable), the Northern Ireland Executive, the Assembly and the public;

Ensuring effective communication with the Board, staff, service users and the public;

Ensuring good communication and feedback from Board Members representing the Board on internal and external committees; and

Promoting positive relationships with key partners and stakeholders.

e. Board business

Planning and chairing Board meetings;

Facilitating the effective contribution of Non-Executive Board Members;

Ensuring that the Board, in reaching decisions, takes proper account of guidance issued by the Department and other departmentally designated authorities;

Obtaining professional advice for the Board when needed, in particular when the Board is taking a decision on matters that pose a significant operational or reputational risk;

Leading the Board's approach to the establishment of committees and ensuring that the Board effectively considers substantive reports from committees; and

Ensuring that the work of the Board and any committees is subject to regular self-assessment and that the Board is operating strategically and effectively.

3.2.8 Board papers – what a Board Member should expect

Good quality Board papers are an essential pre-requisite to effective decision-making at Board meetings.

A major failing in many public bodies (and HSC ALBs) is the sheer volume and excessive length of papers that come to the Board. Very often, Board papers contain too much detail, much of which is irrelevant and/or of little use to Board Members in making decisions. Such papers are often not focused on the key issues and impacts/challenges.

Board papers containing excessive and superfluous detail can lead Board Members into focusing on operational issues, rather than strategic and governance issues and the reason for the paper coming to the meeting can often get lost in the process.

If a lengthy paper has to come to the Board, the author should provide a short summary at the beginning of the paper. Alternatively, the key points can be highlighted in a short paper with the lengthy document included as an appendix. In all cases, the key issues and points should be highlighted in a cover paper which should be attached to the front of each paper. Some suggestions for the format of such a cover paper are included in Appendix 4.

The Chair of the Board should sign off the agenda in sufficient time to allow papers to be developed for the meeting. The Chair should also review the papers coming to the meeting to ensure that they are pertinent to the discussion and remit of the Board, and that they are concise, focused and clear about what is being asked of the meeting. The Chair should ensure that there are few if any papers which are 'only for noting', or 'below the line' (not to be discussed at the meeting and only for information).

Papers should be sent to Board Members no later than a week in advance of the Board meeting. Only in exceptional circumstances should papers arrive later than this and only with the agreement of the Chair.

Effective governance is only possible if the right information is being presented for review, discussion and decision-making. Papers that progress through a series of stages before being considered by the Board should become progressively shorter in length.

Non-Executive Board Members should not be considering documents which have been developed specifically for other purposes/groups. Generally speaking, a paper being considered by the Board should be shorter and more condensed than a paper previously considered by a committee or an individual directorate/team.

One of the challenges for officers preparing reports that may be considered at different levels (for example manager, executive team, committee and Board) is to be able to develop and re-work papers that are not just duplicate reports but which provide appropriate information for each meeting.

Too much information presented too close to the date of a Board meeting does not allow Board Members to assimilate the details, prepare adequately or identify the key issues for reflection, dialogue and constructive challenge.

'Recycled' reports – which may not contain the most up-to-date information or which have not been revised to consider the purpose of presenting the report to different audiences (Board, committee etc.) – are generally unhelpful. Effective governance ensures that all reports describe clearly and succinctly the specific aim in presenting the report content to different audiences, as appropriate.

Governance is at its most effective when there is a balance of information presented in relation to the past and to the future, thus enabling an effective decision-making process.

A good Board paper will contain sufficient information to enable a Board Member to interpret and understand the issue under consideration. The paper should also contain enough detail on context to support informed discussion and decision-making.

The information presented to the Board should focus whenever possible on both process and outcome, if this is appropriate to the issue, and the implications and proposed actions.

Information reports should be brief and present information using a combination of text as well as graphs and diagrams when possible.

Non-Executive Board Members need to ensure that they have sufficient information to understand the performance of the whole organisation. It is important to ensure that there is sufficient information provided on services and processes that are working/performing well in addition to identifying the opportunities for learning and improvement from any system defects/failures.

3.2.9 Cover papers

Within your organisation, there should be guidance issued to all staff and a standard format agreed for the drafting of Board papers and reports, including the requirements for financial assessment and risk assessment of the impact of options presented to the Board.

A cover paper should be prepared for and attached to all Board papers.

The template for the cover paper should be tailored to each organisation's individual requirement, and a sample of this is set out in Appendix 4.

Non-Executive Board Members can ensure that the right information is collected and presented by:

Supporting and encouraging the presentation of **timely information** which should also clearly outline why this is being presented and what decisions are required;

When reviewing Board papers, consider **processes, outcomes and experiences** and if you do not have enough information ask for anything that you think is missing;

Communicating expectations that information is presented **succinctly,** with background information and in a way that reflects priorities for services, decision-making and assurance; and

Discouraging the use of '**for noting'** or 'for information' items and encourage more detail on what is to be noted and how the information being tabled relates to the requirement for any actions.

Once the minutes of the Board meeting are drafted, they should be reviewed by the Chair first, then the Chief Executive and then circulated (as amended) to Board Members within a short time of the Board meeting (normally 14 days). They should

then be amended (if required), agreed and signed off at the following Board meeting and published on the website.

Although this section specifically refers to Board papers, all of the principles and practices referred to are equally applicable to Board-level **committee papers**.

3.2.10 Board Secretary

The development of Board papers, etc. in accordance with the organisation's procedures and best practice should be facilitated and supported by a Board Secretary who is personally responsible to the Chair and the Board for:

- Ensuring that Board papers are produced to the appropriate standard and that, following each Board meeting, actions are taken within required timescales;

- Ensuring the full provision of information to Board Members so that they can maximise their ability to contribute to Board meetings, discussions etc.;

- Leading the continuous development and implementation of the Board's corporate governance system, providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance matters as required;

- Providing advice and guidance to ensure that the Board acts within its legal authority and statutory powers and that Board Members comply with the Nolan Principles and the code of conduct;

- Ensuring that Board business is conducted in a spirit of openness and transparency;

- Managing the administrative and secretarial support to the Board and appropriate committees to deliver effective administration support to Board business; and

- Providing personal support and guidance to the Chair and Chief Executive and managing the business of their private office, including the handling of Assembly Questions and enquiries from the Minister and other elected representatives.

Other areas where the Board Secretary should take a key role include the development of a strategic planning cycle that clearly indicates where the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans.

The Board Secretary should develop an integrated annual work programme and co-ordinated timetable for Board meetings, Board seminars/workshops and committee meetings. This programme should not only ensure that strategic planning is co-ordinated and the appropriate level of scrutiny is delivered, but also that decisions are taken in a logical sequence.

In some organisations, there will not be a specific post of 'Board Secretary'. In such instances, these duties and responsibilities are often discharged by a senior officer such as a Deputy Chief Executive, Director of Finance or Director of Corporate Services with the appropriate knowledge and expertise.

3.2.11 Personal development and how the Board supports its Members in their own learning

The following list of induction guidance and training is not prescriptive, but is designed to give an idea of the type of support that may be provided by HSC organisations. Further information is set out in section 6.

Meetings

A one-to-one meeting should take place with the Chair immediately following appointment to discuss in broad terms what is expected of a Board Member in the first year and any individual role he or she is expected to play. (The Chair and Board Member should meet on a regular basis as part of the appraisal process.) A new Board Member should attend an induction session within one month of appointment that should cover a range of relevant topics (see section 6.1.1)

Ideally, this session should be attended by all new Board Members and by some existing Board Members to allow the latter to pass on experience. Some other members of the senior management team may also attend, as may the Board Secretary.

New Board Members may require support in certain areas. The induction process should explore development needs for all new Board Members and agree a development plan.

It may also be appropriate for a Board Member to meet with other key staff in the organisation – for example, with the Chief Executive who will be able to advise on his/her role as the Accounting Officer, and, where the Board Member is to sit on a committee, with key staff.

Obtaining feedback from new Board Members on the induction they received will provide a useful source of information to those developing the induction programmes and will help ensure the process remains effective.

Publications

A list of publications and other documentation that Board Members should expect to receive as part of their induction is set out in section 6.1. Other useful publications include The Healthy NHS Board 2013 – NHS Leadership Academy 2013 and The Healthy NHS Board Principles for Good Governance 2011.

First Board meeting

Time should be allocated so that a new Board Member can be formally introduced to all present. In advance of this meeting, the new Member should be made aware of any protocols, for example in relation to making points at meetings, presenting information and overall expectations as to behaviour (being inclusive, respecting others etc.).

At the end of the Board meeting, the Chair should spend a few minutes with the new Board Member to allow them an opportunity to ask any questions or raise concerns that they may have.

Training and development[17]

It is important that all newly appointed Board Members attend the 'On Board' or other departmentally approved training programme within six months of their appointment; further information is set out in section 6.

The HSC body should also consider providing any further training deemed necessary to assist the Board, individually or collectively, to carry out its duties, particularly covering areas such as their roles and responsibilities, the financial management and reporting requirements of public bodies, ethical standards and any other differences which may exist between private and public sector practice.

There should also be an opportunity for Board Members to attend training and other networking events organised on a cross-HSC basis.

Induction for Board Chair

The induction of a new Chair is the responsibility of the Department and the Chief Executive of the HSC body in question.

When a new Chair is appointed, the Department should ensure that an early meeting is arranged with the Permanent Secretary to ensure that there is mutual

17 This is expanded further in section 6 Training and development.

understanding about what is expected of the HSC body. It may also be appropriate for an early meeting to be arranged between the Chair and the Minister.

The induction of the new Chair should cover all the topics already mentioned. In addition, there are some topics that are specific to new Chairs, including the following.

Appraisal[18]

The Minister (or as delegated) is responsible for setting objectives for the Chair and conducting his/her appraisal. The appraisal process encourages critical reflection and provides an evidence base upon which Non-Executives can build for future development. It takes place annually and is the basis on which personal development plans are formed.

Formal performance appraisal is a compulsory requirement of the Code of Practice[19] issued by the Commissioner for Public Appointments Northern Ireland.

Leadership

An important part of the induction process will be to explore with the Chair the experience he/she has, any training that is required and any development opportunities that may be appropriate for the new Chair.

Recruitment and selection

The Chair should be involved in the selection of other Board Members. Non-Executive Board Members should be involved in the selection and appointment of Executive and senior team members. It is important to ensure that he/she has undertaken appropriate training in conducting interviews, including equality awareness training.

18 The requirements for performance appraisal are set out in detail in section 6.2 in this handbook.
19 CPANI, Code of Practice JL2 December 2016 and Appendix A – Statement of Compliance Summary of Codes of Practice in Public Life set out in Appendix 7.

Further reading

The publications Challenges to Effective Board Reporting and Effective Board Reporting produced by the Chartered Governance Institute and Board Intelligence provide some useful insights into developing Board reporting.

3.2.12 Scrutiny and challenge

Processes, without intelligent and rigorous scrutiny, are not enough!

In order to ensure that all key functions are delivered effectively, Board Members need to hold the organisation to account for its performance by offering purposeful and robust scrutiny and challenge.

The key prerequisites for effective scrutiny

There are four things that need to be in place before effective scrutiny and challenge can happen:

1. Effective scrutiny is dependent on having **clarity in structures, roles and responsibilities.**

- A clear structure that clarifies responsibility for delivering performance from the Board to the point of care and back to the Board is needed. In particular, ensure that responsibility for functions related to patient safety and quality (improvement) are vested clearly and simply.

- A joint understanding is required between Board and Executive as to what should be scrutinised, by whom and how often. For example, what level of performance information should come to the Board, what should be considered at committee level, what matters are delegated to the Executive (and when should delegated matters be escalated to Board level)?[20]

20 The Board must also keep a track of delegated matters to ensure that these are being discharged effectively.

2. Effective scrutiny relies on Board Members having a **clear understanding of what is important.**

- The core purpose of an HSC body is to deliver safe, effective and excellent services to patients and people in the community, across the area of its responsibility – the focus of the Board has to be on 'quality and safety' as much if not more than on financial stewardship.

- Use quantitative targets with caution – although some quantitative targets do have an important role, they should never displace the primary goal of better healthcare. The most important performance indicators should be qualitative around the achievement of positive outcomes for patients and service users.

- Quality has to be a core part of all Board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions.

- Quality performance cannot be adequately covered at a Board meeting but will need to be considered in more detail by a 'quality' committee with membership that has the in-depth knowledge and expertise to add value.

- The focus of the Board should be on driving continuous quality improvement across the full range of its services – creating and sustaining a learning organisation and constantly evaluating what works and what doesn't and how we can do things better (including learning from experience elsewhere).

3. Effective scrutiny relies on the provision of **clear, timely, comprehensible summary (written) information** to the Board.

- The Board needs to set out its expectations to management about the nature, format, length and frequency of reports to the Board. The length of Board papers should be appropriate and proportionate to the issues to

be addressed with a presumption against unnecessarily long papers – important and key issues should not be 'buried' in a lengthy paper.

- Board Members should receive performance information in a clear, easily digestible format, using graphic overviews, trend analysis and brief commentary. High-quality Board papers are not purely descriptive – they include analyses that will actively direct the attention of Board Members to the key issues, implications and consequences.

- The Board should develop its intelligence through a range of sources and should review the sources and quality of intelligence as part of a periodic review of its decision-making processes.

- The Board (and each committee) should review its information requirements with the Executive on an annual basis.

A Board that is drowned in paperwork and a myriad of performance information cannot scrutinise effectively.

4. Effective scrutiny thrives within an organisational **culture that welcomes and encourages scrutiny and constructive challenge**; where no subject is considered to be off limits for Board discussion; and where disagreements are regarded as a normal feature of Board meetings.

- There should also be a rule of 'no surprises' between the Board and executive team – both ways.

The characteristics of effective scrutiny

So, what does effective scrutiny look like? Here are some of the tell-tale signs.

Effective scrutiny focuses on the most **important measures of performance and highlights exceptions** – it does not focus on minor issues or the merely interesting. Remember, scrutiny should always be linked to risk!

Effective scrutiny avails of every opportunity to **offer appreciation and encouragement** to staff etc., where there is excellent performance.

Effective **scrutiny seeks (and gets) assurance where remedial action** has been required to address performance weaknesses or concerns.

Effective scrutiny **looks beyond the written information** provided to Board Members and develops an understanding of the daily reality for patients and staff, to make data more meaningful.

- Research suggests that the governance of quality can be improved if Board Members **periodically step outside of the boardroom** to gain first-hand knowledge of the staff and patient experience.

Effective scrutiny does not mistake **reassurance** for **assurance** (particularly in relation to service quality and patient safety) but is demonstrated through robust and constructive challenge from all Board Members (Executive and Non-Executive).

- Vagueness is never good – papers and answers need to be evidence-based and credible.

- Always allow sufficient time for complex issues and never be rushed into a major decision.

- If the Board lacks knowledge or expertise, buy it in/access it internally or externally and make use of it before making any major decision.

- Good results still need scrutiny and challenge.

While having due regard to the **views of stakeholders** (for example from a regulator or the local community), this does not absolve you of your responsibility for robust scrutiny.

Effective scrutiny takes account of **different sources of information** and assurance and places a high value on independent scrutiny of performance (including from regulators), patient experience surveys etc.

- Always ask yourself the question ‘how does this information compare with our own experience, any other sources of assurance etc’?

- Where there are differing messages emerging from different sources, commission, or otherwise obtain another independent source of assurance.

- Where possible, obtain comparative data on the performance of similar organisations through benchmarking.

- Draw upon credible examples of good practice against which to compare and contrast local performance.

- Invite (and record) views/assurances on major issues from the Chief Executive and senior managers – and take advice from clinical leaders.

Effective scrutiny **welcomes any question** however relevant it might seem at first – when Board Members are unclear, unconvinced or have serious reservations in relation to a Board discussion or decision on a complex or specialist matter, they are not afraid to ask that question or seek additional assurance even if they might look foolish in so doing.

Effective scrutiny (with robust challenge) is ‘how we do business’.

- Scrutiny involves everyone on the Board and it is not just the Non-Executives challenging the Executives. Executive Board Members

challenge the Non-Executives and challenge each other – they do not restrict their contribution to their areas of executive responsibility.

- There are no ‘show’ Board meetings – Board Members do not feel obliged to put on a united front at public meetings because challenge and robust scrutiny might reflect badly on the organisation – challenge and scrutiny, that is just how we do business around here!

HSC Board Member Handbook

SECTION 4: Assurance and scrutiny

Ensuring the quality and safety of services through scrutiny and challenge.

The Good Governance Institute defines assurance as a "positive declaration that a thing is true. Assurances are therefore the information and evidence provided or presented which are intended to induce confidence that a thing is true amongst those who have not witnessed it for themselves. For an individual to 'be assured', they must trust the assurance(s) they have been provided with and therefore be confident themselves that the thing is true".[21]

HSC organisations operate on the principle of reasonable rather than absolute assurance. In determining reasonable assurance it is necessary for HSC Boards to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

Assurance draws attention to the aspects of risk management, integrated governance and control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. An effective integrated risk management framework and a risk-based approach to assurance helps an Accounting Officer and Board to judge whether or not its agenda is focusing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources. The Trust Board committees, and in particular the audit and governance committees, can help the Accounting Officer and Board to formulate their assurance needs, and then consider how well assurance received actually meets these needs by gauging the extent to which assurance on the management of risk is comprehensive and reliable.

Assurance cannot be absolute so the committees (and Trust Board sub-committees) will need to know that the organisation is making effective use of the finite assurance mechanisms at its disposal, targeting these at areas of greatest risk. The Board assurance framework and corporate risk registers and their

21 Good Governance Institute 2013.

functions in supporting a risk-based approach are considered in section 4 (b) of the handbook.

Central to being an effective Board is the ability of members to scrutinise information put in front of them, consider what other information is needed with an overarching responsibility to assure themselves of the quality and safety of services. Such information is presented through an integrated governance framework.

The following sections summarise these areas and suggest prompts that may be used by Board Members.

SECTION 4: (a) Quality

4.1 Duty of quality

4.2 Health inequalities

4.3 Quality improvement and measurement

4.1 Duty of quality

The statutory duty of quality (found in The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003) sets out a requirement that each HSC Trust puts arrangements in place to monitor and improve the quality of the health and social care which it provides and the environment in which it provides them. This means that all Board Members are accountable for quality and it should feature highly on the Board's agenda as a standing item. The Board may wish to establish a quality and safety standing committee to regularly discuss quality performance in more detail.

In 2006 the Quality Standards for Health and Social Care were published. They have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

4.1.1 Role of RQIA

In addition to introducing statutory duty of quality the Order of 2003 introduced a statutory duty of quality. The 2003 Order also requires the Regulation and Quality Improvement Authority to conduct reviews of, and make reports on, arrangements by statutory bodies for the purposes of monitoring and improving the quality of the HSC services for which they have responsibility.

RQIA reviews provide assurances about the quality, safety and availability of HSC services in Northern Ireland and they aim to encourage continuous improvements in HSC services. They offer an important opportunity for the Board to receive independent assurance about their organisation with regard to:

- Governance;
- The quality of HSC services provided;

- The effectiveness with which services are commissioned, planned and delivered; and
- Levels of compliance with statutory requirements as well as standards and guidelines endorsed by the Department of Health; and the extent to which departmental policy has been implemented/adhered to.

RQIA use a range of approaches to each review, including self-assessment, validation visits by panels of independent experts, involvement of lay people and service user feedback. They will produce a report for each review which highlights areas of good practice and makes recommendations for improvement. The findings are reported to the Minister for Health and to the relevant HSC organisations who will be expected to provide updates in relation to each recommendation. Lessons learned are shared across the wider HSC sector.

Reports from each review are publicly available on the RQIA website.

4.1.2 Role of the Board in quality

The Board should be the driving force for continuous quality improvement and the clinical and social care governance framework should provide a co-ordinated approach to, and focus on, these quality standards.

Boards must ensure that there are clear lines of responsibility and accountability for the overall quality of treatment and care. There should be proactive systems in place to identify and report poor performance, near misses and adverse incidents so that they can be dealt with appropriately and lessons can be learned and shared. There should also be effective systems to identify, value and share good practice.

There are a number of areas Boards should consider when assessing the effectiveness of governance systems.

Communication

- Are there clear channels of communication between staff?

- Do staff know when to escalate issues to senior staff?
- Are staff encouraged to raise concerns?
- Are senior staff proactive about seeking views from front line staff on the quality of services and how they can be improved?
- Are there clear systems in place to support the above points?

Data collection and analysis

- Is the right information collected?
- Is the information analysed?
- Is information collated in an accessible and easily retrievable manner?

Qualitative information

- What other qualitative information is routinely gathered (complaints, staff/user surveys, patient/client records, adverse incidents, staff observations)?
- Is this qualitative information collated and assessed in a way that informs quality assurance and improvement?

Board prompts

- Are there appropriate staff tasked with the correct levels of quality assurance?
- Are staff members aware of the responsibilities they and others have in terms of assurance?
- Do staff members carry out these duties routinely and robustly?
- Do they use appropriate types and levels of information to make reasonable and proportionate judgements?
- Are robust risk thresholds used to determine assurance levels, including when action is required and what represents reasonable and proportionate action?

4.2 Health inequalities

Section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 sets out the Department's general duty in respect of health and social care and the specific responsibility for the improvement of health and social well-being and the reduction of health inequalities:

> *"(3) In particular, the Department must:*
>
> *(a) Develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland."*

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

For some people in Northern Ireland there are still unfair and avoidable inequalities in their health and in their access to and experiences of HSC services. There are also actions that can be taken on the social determinants of health which can reduce these health inequalities, for example education, employment and housing.

The Making Life Better (2013–2023) public health strategy for addressing health inequalities sets out the responsibilities of HSC organisations for achieving a healthier Northern Ireland. It identifies the importance of what is done collaboratively through both policy and practice to influence the wide range of factors that impact on lives and choices. The framework is not just about actions and programmes at government level, but also provides direction for work at both regional and local levels with public agencies, including local government, local communities and others, working in partnership.

The framework intends to create the conditions for individuals and communities to take control of their own lives, and move towards a vision for Northern Ireland

where all people are enabled and supported in achieving their full health and well-being potential.

4.2.1 Health inequalities in Northern Ireland[22]

Regional health inequalities refer to the difference in health outcomes between the 20% most deprived and 20% least deprived areas of Northern Ireland according to the Northern Ireland Multiple Deprivation Measure.

4.2.2 A social gradient of health

Health inequalities are often considered in terms of the gap between the most and least deprived quintiles of the population. However this does not account for those areas of intermediate levels of deprivation in the socioeconomic spectrum that may also be relatively disadvantaged, meaning that health inequalities affect everyone. There is consistent evidence from throughout the world that people at a socioeconomic disadvantage suffer a heavier burden of illness and have higher mortality rates than their better off counterparts.

Different inequality measures can give information about different aspects of inequalities. Some measures concentrate on the extremes of deprivation such as the most/least deprived (or absolute) gap analysis presented in the main body of this report, whilst others include relative inequality gaps across the socioeconomic scale – taking into account the whole population – and can give quite different interpretations of inequalities.

4.2.3 Life expectancy and general health

In 2016–18 the life expectancy gender gap between males and females in Northern Ireland was 3.7 years. There was no change in the deprivation gap for male life expectancy at birth, although it improved across all areas. There was no change in female life expectancy at birth across all areas and therefore no change in the inequality gap. There was also no change in the male or female healthy life

22 Source: Northern Ireland Statistics and Research Agency (NISRA)

expectancy gaps, although male healthy life expectancy did improve for Northern Ireland overall.

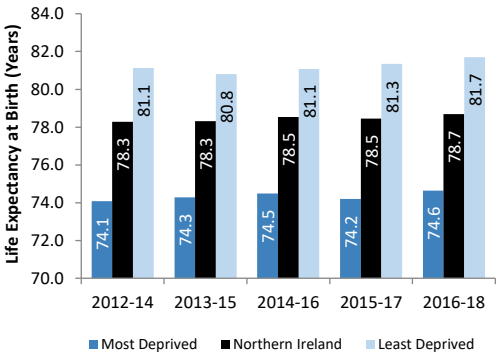


Figure 6: Male life expectancy at birth (Health Inequalities Annual Report 2020)

4.2.4 Premature mortality

Rates of premature mortality generally decreased over the period in Northern Ireland and its most and least deprived areas. The inequality gaps narrowed or remained broadly similar except for death rates among under 75s due to respiratory diseases, where the deprivation gap widened due to increased mortality in the most deprived areas. The inequality gaps for premature mortality remained large with the most deprived areas continuing to experience higher mortality rates than the least deprived areas. For respiratory mortality among under 75s, the rate in the most deprived areas was almost three and a half times that seen in the least deprived.

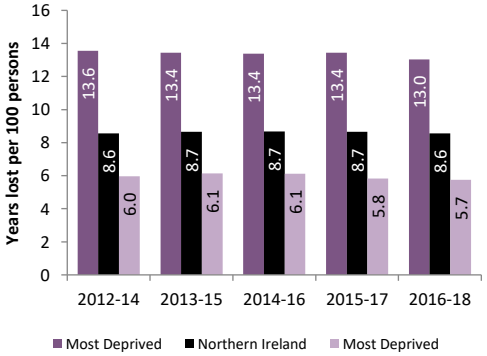


Figure 7: Potential years of life lost (Health Inequalities Annual Report 2020)

4.2.5 Major diseases

Inequality gaps for all indicators remained constant over the period. There were improvements in all indicators at a regional level, with the exception of admissions for respiratory conditions where there was no change, and cancer incidence where there was a negative change. There was also negative change in the most and least deprived areas for cancer incidence. The largest inequality gap was observed for admissions due to respiratory diseases, with the admission rate in the most deprived areas around double that of the least deprived areas, for all ages and for those aged under 75 years.

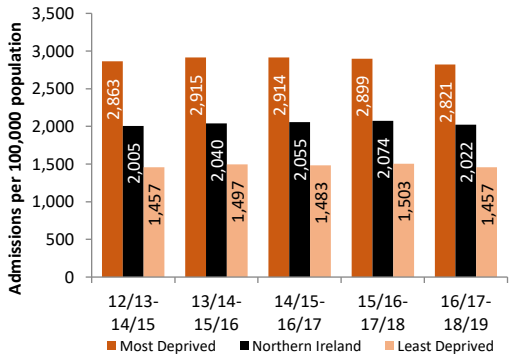


Figure 8: Standardised admission rate – respiratory (Health Inequalities Annual Report 2020)

4.2.6 Hospital activity

Inequality gaps for all indicators narrowed over the period, with the exception of emergency care attendances and elective inpatient admissions which remained constant. All admissions indicators improved across Northern Ireland and in its most and least deprived areas, with the exception of day case, which remained constant in the most deprived areas and increased in the least deprived areas. Emergency admissions continued to show the largest inequality gap of the four indicators analysed. Despite a narrowing of the gap, the rate among those living in the most deprived areas remained more than three-fifths higher than that in the least deprived areas.

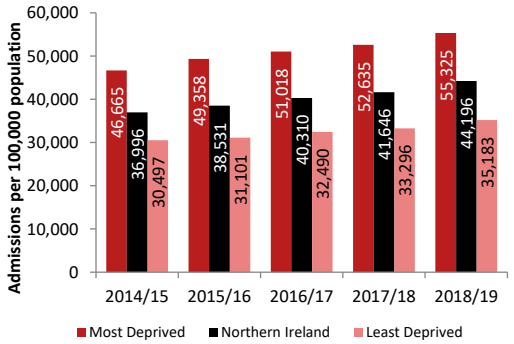


Figure 9: Standardised attendance rate – emergency care (Health Inequalities Annual Report 2020)

4.2.7 Mental health

Large inequality gaps continue to exist for mental health indicators, with the latest position showing that the rate of suicide in the most deprived areas was nearly three and a half times that in the least deprived areas, with the gap widening. There was positive change regionally and in the most and least deprived areas for admissions due to self-harm, with the inequality gap narrowing. Prescription rates for mood and anxiety disorders increased in Northern Ireland and its most and least deprived areas.

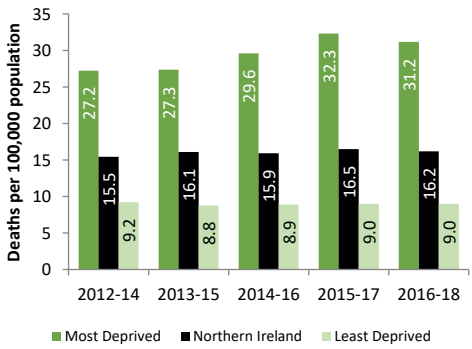


Figure 10: Crude suicide rate (Health Inequalities Annual Report 2020)

4.2.8 Alcohol, smoking and drugs

Alcohol, smoking and drug related indicators continued to show some of the largest health inequalities monitored in Northern Ireland. For alcohol, specific mortality and alcohol-related admissions, the rate in the most deprived areas is approximately four times that seen in the least deprived areas. Although there has been no change

in the inequality gap for lung cancer incidence, the rate has increased in Northern Ireland and its most deprived areas. While the admission rate for drug related causes decreased across all areas, the opposite was true for the death rates for drug related causes and drug misuse which rose with a widening of the inequality gaps.

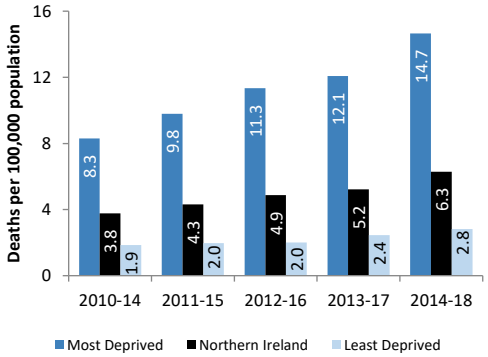


Figure 11: Standardised death rate – drug misuse (Health Inequalities Annual Report 2020)

4.2.9 Pregnancy and early years

Changes over the period in inequality gaps related to pregnancy and early years tended to vary across the indicators analysed. The low birth weight inequality gap narrowed, due to negative changes in the least deprived areas. The gap between the most and least deprived areas for smoking during pregnancy widened due to positive changes in least deprived areas. The inequality gaps for the under 20 teenage birth rate and the proportion of mothers smoking during pregnancy still remain very large. For both, the rate in the most deprived areas was five times the rate in the least deprived areas.

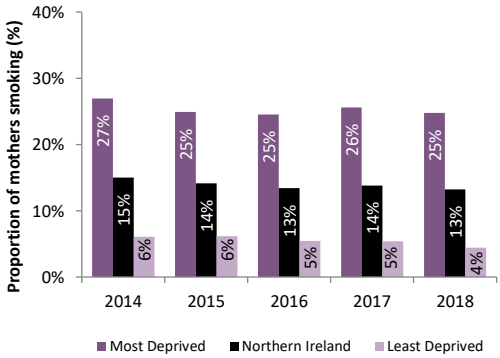


Figure 12: Smoking during pregnancy (Health Inequalities Annual Report 2020)

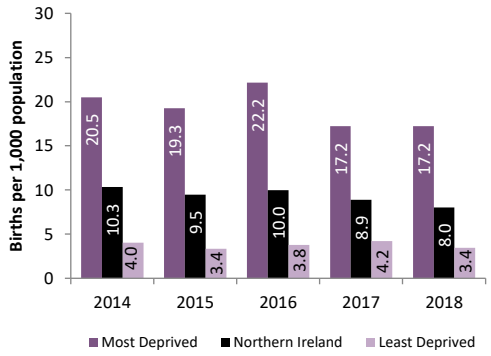


Figure 13: Teenage birth rate U20 (Health Inequalities Annual Report 2020)

4.2.10 Childhood obesity

Over the period analysed there was no notable change in the proportion of Primary 1 children reported as overweight or obese. It should be noted that as the underlying figures are somewhat low, small annual changes can have a large impact on the observed inequality gap. However, rates of obesity are continually higher in the most deprived areas.

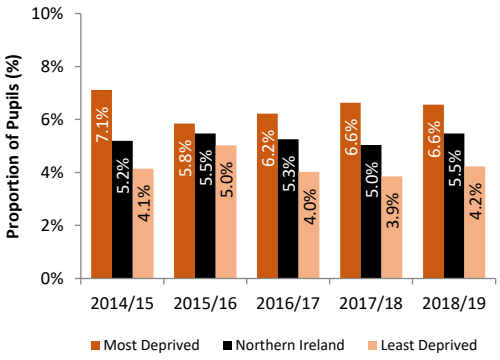


Figure 14: Obesity – Primary 1 BMI (Health Inequalities Annual Report 2020)

4.2.11 Summary of changes in sub-regional equality gaps over the past five years[23]

Changes in deprivation-related inequality gaps

Over the period analysed, with the exception of the Belfast Trust, there were more inequality gaps that widened than narrowed in each HSC Trust. This was also true for the majority of Local Government Districts, with the exception of Ards and North Down; Armagh City, Banbridge and Craigavon; Belfast; and Newry, Mourne and Down.

Comparison of an area's health outcomes against the regional average

The following areas had a majority of health outcomes that were better than the Northern Ireland average:

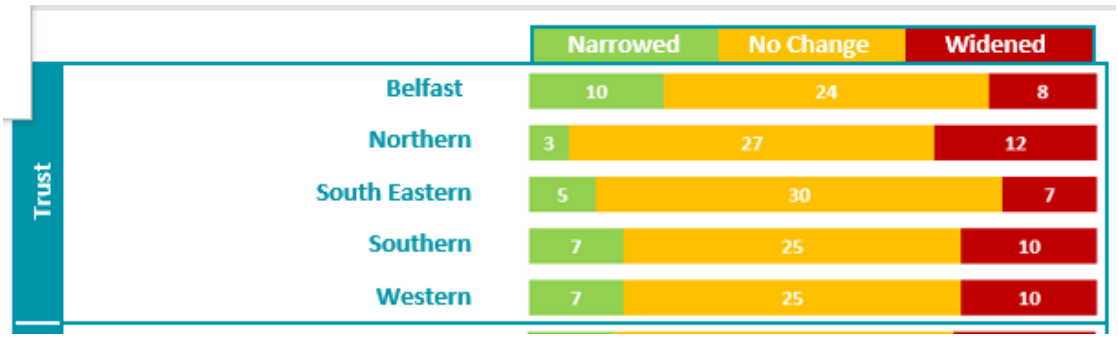
- South Eastern HSC Trust
- Ards and North Down
- Causeway Coast and Glens
- Lisburn and Castlereagh

The following areas had a majority of health outcomes that were worse than the Northern Ireland average:

- Belfast HSC Trust
- Belfast Local Government District
- Derry City and Strabane

For each area analysed, the following chart shows the number of indicators that widened, narrowed or did not show a notable change across the period.

23 NISRA Report on Health Inequalities 2020



* For the purposes of this graphic, gaps which reversed direction, but remained similar in magnitude have been included in the 'no change' category.

Figure 15: Health Inequalities Annual Report 2020

4.2.12 Urban-rural analysis

Compared with the regional average, rural areas experienced better outcomes across the majority of indicators analysed, however fire and ambulance response times continue to remain higher in rural areas. There were no notable changes in rural Northern Ireland gaps over the analysed period, with the exception of ambulance response times where the gap decreased from 61% in 2015 to 32% in 2019.

Board prompts

- Do we know where an improvement is needed?
- What do we need to do as a Board to identify and encourage the spread of this improvement to these areas?
- Is there anything the Board needs to do to unblock a barrier to spread? Or, what can we learn from this failure?
- Am I generous in acknowledging success?
- How do I support the Chief Executive and other leaders?
- How do I approach the challenges in improving health inequalities?
- How do I go about challenging or criticising? Am I supportive or do I only discourage?

4.3 Quality improvement and measurement

What is quality improvement and why is it important?

Quality improvement (QI) is a systematic approach to improving health services and the quality of care and outcomes for patients based on iterative change, continuous testing and measurement, and empowerment of front line teams.

Quality improvement tools can play a key role in improving health care, including improvements in time-savings, timeliness of service provision, cost reductions and a decrease in the number of errors or mistakes. At a time of severe financial restraint, rising demand for services and significant workforce pressure, quality improvement approaches offer opportunities to improve the quality of care and increase productivity.[24]

4.3.1 What are the key lessons for senior leaders in adopting a quality improvement approach?

Adopting a quality improvement (QI) approach involves significant and sustained cultural change within organisations, which will require time and resource. Before starting on a quality improvement journey, organisations – and particularly leadership teams – should establish a clear rationale for pursuing a QI approach and accept that it is neither a 'quick fix' in the face of huge operational pressures nor a form of 'turnaround' strategy.

QI methods require a fundamental change to how organisations work, and leaders need to ensure that staff are engaged with and actively involved in developing a shared vision of the quality improvement strategy. QI approaches require a very different leadership style from the one many organisations have: leaders need to commit to a shift from 'problem-solving' to being enablers of change.

It is vital to build Board-level commitment to the principles of QI and support for the shift in emphasis from assurance to improvement.

24 https://www.kingsfund.org.uk

4.3.2 What are the key enablers for embedding a culture of QI?

In order to successfully embed quality improvement approaches, organisations need to develop a new approach to leadership that moves away from imposing top-down solutions to recognising that front line teams, service users and carers are often best placed to develop solutions.

Patient involvement and co-production is a key enabler for a successful QI strategy. Staff engagement – through developing a shared vision, sharing progress and allowing staff the time and space to make changes and innovate – is also vital for success. In addition, leaders should recognise the need to allocate sufficient time and resources to quality improvement – including time for staff away from their 'day jobs' to undertake training or participate in quality improvement activities.

Resources are also required to invest in an educational infrastructure that means staff can be trained in the tools and techniques of the chosen approach. At its core, QI is about change and commitment to continuous improvement.

There are various approaches that include Lean, Six Sigma and Plan-Do-Study-Act (PDSA) cycles. Studies have noted the importance of fidelity to one improvement methodology as it may be more straightforward to build an infrastructure around one approach, and train and build capacity in one methodology. There is a counter argument, however, that, with the complexity of health and social care, we need the flexibility to fit one method to the particular context to get the best possible outcomes.

4.3.3 How can we judge the impact of QI initiatives?

Evaluating and communicating the impact of quality improvement is not straightforward. Individual QI initiatives often take considerable time to demonstrate impact, and even the most successful efforts will face obstacles and setbacks along the way. Although more work is needed to understand how quality QI can be robustly and meaningfully evaluated, those engaged in quality improvement have already begun to use a series of informal indicators as a guide. These included

qualitative comments from staff on the quality improvement approach in staff surveys, and the demand for places on QI training courses and subsequent attendance.

4.3.4 What is the role of the Non-Executive Director in ensuring their organisation prioritises quality improvement?

The Non-Executive Director plays an essential role in ensuring that their organisation priorities QI, including the measurement of quality and achievement of quality-related outcomes.

Board prompts

- Lead by example.
- Be aware that QI is everyone's business.
- Be aware that data is used differently for improvement and for the management of performance and be clear what type of problem the data presented to the Board addresses.
- Ask the right questions to ensure your support and provide oversight of quality improvement in your Board and understand the answers to these questions.
- Make the connections at strategic level that ensure QI activity is held together by an infrastructure and intent for QI across the Board area.

Further information can be accessed here.

4.3.5 What is the aim of the improvement initiative?

Non-Executive Directors can ask how a particular improvement aim was formulated. If it was developed by a group having looked at a problem and who used data to identify and define it, and the problem is understood, then the chances of producing a successful approach to addressing the problem are high.

The 'data' might be survey results from patients, or complaints from staff or patients; it does not have to be quantitative. An aim is most easily formulated where there is

a clear evidence base to inform the actions that will achieve it; sometimes a judgement is necessary where the evidence base is not so clear. A Non-Executive Director can help question if in fact energy is being invested in making the right changes. They will need to be clear that the organisation has the right aims that address what those who receive care most need.

It is important to remember that improvement aims are intended to generate unease with the status quo and to support a sense of urgency that a change is necessary. The change usually involves a redesign of a system or process. It does not involve exhorting people to work harder in the same way. An improvement aim is aspirational and not a target which tempts people to ‘game’ the system or which is used for judgement.

Organisations will have different starting points. Often, a ‘best in class’ organisation will find it harder to reduce a poor practice, for example, by 50%, than an organisation that is an outlier where the poor practice is more evident.

It is important to understand the importance of having an aim that is locally challenging and causes interest.

Examples of the questions that a good aim provokes are:

- How did ward 10 achieve 366 ‘days between’ a patient developing a preventable pressure ulcer?
- How did the GP surgery achieve a reduction of wasted appointments (do not attends) of 45%?

Board prompts

- What is the problem this aim seeks to address?
- Is there data that describes the problem?
- What is the vision behind this aim?
- Is there a clear approach to how those concerned will know the aim is achieved? How has the aim been forged?
- Are unintended consequences likely?
- Do I believe in the aim?
- Does my experience suggest that this is an unrealistic aim?
- Is it appropriate to challenge this aim – or do I need to think and understand more about this?
- Is it the correct change?

4.3.6 Enthusing, involving and engaging staff

It is vital not to undervalue the importance of involving all relevant staff. Breaking down traditional hierarchies for a multidisciplinary approach is essential to ensure that all perspectives and ideas are considered, and all staff are engaged in all levels of improvement. Without involvement, the organisation cannot expect commitment, ownership or further innovation through testing changes. The Non-Executive Director can ask how staff are being engaged in the improvements reported on to the Board.

4.3.7 Involving patients and co-production

Patients, carers and the wider public are the only people who experience the whole healthcare journey from start to finish. They therefore have a significant role to play, both in designing improvements, and also monitoring whether these changes have delivered the anticipated impact.

Patients and their families frequently define quality differently from clinicians and managers (King's Fund, 2011). What they view as a problem or value within a service may be unexpected. They have a role to play not only in person-centred care improvements but in safety and effectiveness too. Therefore, leaders must

ensure patients and their families are able to contribute meaningfully to their organisation's quality improvement programmes.

Board prompts

- Are we improving the right things for maximum impact?
- Is there evidence that there is a problem and something really needs to be improved?
- Does our data about patient and staff experience suggest this would be a good change?
- Do I believe this change is a good use of attention and resource?
- Will fulfilling the aim make a difference to care in this HSC Board area?
- When I walk in the area where this work is taking place and talk to staff, do they know about it?

4.3.8 Is there a clear change method?

When working to improve a situation, it is important to be clear on the change method being used and to consider whether it is appropriate to the issue being addressed. When working to address system level challenges, improvement often requires a combination of approaches. The approach must be appropriate for the 'problem'.

Quality improvement methodologies

There are various quality improvement techniques or methodologies that include PDSA cycles, Lean and Six Sigma.

Models of change – when do we use QI methodology in healthcare?

In some cases, wider systems changes will be necessary to bring about improvement. These could include a change of legislation, or professional regulations. Similarly, the introduction of training to existing staff or introducing a new component to pre-registration courses so that new staff entering a system will bring a new skill will bring about change.

QI methodologies work within the current legislative, professional and regulatory frameworks and challenging these is beyond the scope of these techniques. Parallel activity may of course work to make these changes.

Skill is required to discern which method is most applicable to the issue being addressed. For example, repeated actions that follow a particular sequence, such as the insertion of catheters, or the issuing of repeat prescriptions, are well suited to being improved through the model for improvement that requires rapid hypothesis building, testing and retesting. Redesigning pathways of care that are inefficient and unreliable may lend themselves to lean techniques. An example would be making the distribution of medicines throughout a series of hospitals more efficient.

It is important to recognise that QI usually takes time; the more people who are involved and more complex the environment the longer it will take to make and then embed improvements.

Crucially, Board Members are in a strong position to support the wider cultural changes that will be necessary if these QI methodologies and the 'habit' of QI are to become part of the local culture.

PDSA cycles

PDSA cycles are used to test an idea by trialling a change on a small scale and assessing its impact, building upon the learning from precious cycles in a structured way before wholesale implementation. To learn more about PDSA cycles click here.

Process mapping

Although technically not an improvement methodology, since a map is simply a description, process mapping has been included here, since developing a process map is often the first step in any improvement initiative. The sequence of steps in a process are identified and drawn. Quite often this act of investigating and describing a process will immediately show areas where there are inefficiencies or blockages. This can then lead to improvement action to 'unblock' and streamline the process.

To find out more about process mapping, click here.

Lean

To read about how lean thinking is being applied in NHS Scotland, click here.

Six Sigma

To read about Six Sigma click here.

As healthcare is an extremely complex system, involving many human factors, it is important to consider which methodology will suit the intended improvement and the local context. It is also important to remember that improvement has a 'result' and is not only an activity. An understanding of why a particular improvement was identified and why a particular method was selected suggests fluency with the methodologies. If a Board is to lead by example this is a requirement. Changes may also have unintended consequences and the role of a Non-Executive Director is to be alert for the impact on the whole system.

In a large organisation, the narrative draw of one approach may engage staff powerfully and support culture change. Whether one approach or a variety of approaches is adopted, strategic support, integration, intent and planning for QI are important.

Board prompts

- How was the change method decided?
- Were other methodologies considered?
- Is the degree of attention to the problem proportionate and risk based?
- If the change happens, will the result matter? (So what?)
- Do I need to know more before I can properly understand this?
- Am I leading by example in introducing and/or supporting improvements at Board level?
- Do I have a preferred change methodology that blinkers me to others?

4.3.9 Can we measure and report progress on our improvement aim?

Non-Executive Board Members need to be aware that measurement can be used for different purposes. Measurement for improvement differs from measurement for judgement and measurement for research. In one Board meeting, Non-Executive Board Members will often be required to understand data for these three different purposes. It is important to know the different expectations on Board Members for each type of measurement.

Data is commonly gathered from services so that managers and quality assurance and scrutiny organisations can judge the performance of those services against agreed quality thresholds and targets. Data is also commonly collected by research projects that seek to develop knowledge of better ways of delivering services. An example would be data on different medicines to manage blood pressure in patients in the community.

Data for improvement cannot usually be used for comparisons between sites and against thresholds, and more commonly involves tracking processes and outcomes for the same site(s) over time. A typical example is a run chart for a ward showing the number of admissions where a care plan is in place within a particular timescale.

Measurement for improvement informs staff learning as the improvement process develops; data is therefore ‘good enough.’

Rather than waiting for the results of an audit, an improvement approach might use a small sample of case notes used in one morning to see if an action has been taken, and quickly establish if not, then why not. This intelligence is fed into the picture of trying to make the improvement work later that day. For example, if case notes suggest an action did not take place and it is then identified that a new member of staff who did not know about the action was on the rota, then in future the induction for new staff can include reference to this.

At Board level, data for improvement at the local level is usually reported once it has been collected at scale or over a period of time, where there is a cohesive story. A typical point in reporting to the Board is when an improvement has been demonstrated and it then becomes a strategic responsibility to consider how to spread that improvement elsewhere.

Data can be used to understand how well the system is working in meeting the needs of those receiving care and can help the organisation focus energy on the right things. For example, staff might be concerned at the delays in movement of patients through an outpatient clinic; quantitative measures of time and qualitative measures through patient satisfaction surveys would confirm this needs improvement.

Data can be used to prioritise improvements so that those that will bring the biggest change are made first; for example, falls prevention, pressure ulcers and sepsis.

Measurement for improvement should include a small set of measures to test the hypothesis that a particular intervention will bring about an improvement from a variety of angles.

Interpreting data

Board Members will be required to understand data that are reported to them, rather than know about how data might be collected, analysed and presented. Whilst a series of quarterly reports might be enough to establish a trend for some measures, data for improvement needs to show points plotted over units of time that allow for interpretation if a change introduced at one point has had an impact. This is typically shown in a run chart that can be annotated.

Non-Executive Board Members also need to be aware that variation in a process may cause a ‘point in time’ data return to fluctuate between ‘green’ one month and ‘red’ the next if the variation is around the set target level. It is important to understand the variation over time rather than responding to the one data point, and support the Board to minimise these variations.

It is not enough for a Board to simply approve QI data. It is a Board responsibility to see if there are links to other improvements elsewhere in the Board area, ensure the QI work is integrated into a Board-wide intent for QI and an infrastructure to ensure improvements can be sustained.

Board Members are in a position to encourage and support improvement by example, by making links through knowledge of what is going on elsewhere, and by supporting wider changes that could bring about parallel improvements. A Board needs to clear on the purpose of and be alert to the impact on staff if asking for measures.

Board prompts

- What is the data for?
- Is it up to date?
- What does it say?
- Do I know how to look at this presentation of data?
- Do I understand it?
- Do I need to have a short session with someone who can interpret this?
- Do I know how this presentation differs from other data presented in Board papers?

Resources and improvement

Capacity is related to time and ability to spot opportunities

There also needs to be the mental ‘headspace’ to formulate improvements and follow them through. Studies from national QI programmes have shown that middle managers are so busy doing the work that even if they know about QI and are committed to it (are capable of leading QI work), they often don’t have the capacity to support QI in their areas. Often they are responsible for much of the measurement for performance on which the Board is judged and it takes skill and application in order for them to flex and encourage improvement.

A Non-Executive Director can ask what plans there are:

- For developing staff in improvement skills across the NHS Board area;
- For supporting staff to actually use the skills they have learned, including creating the 'headspace' for proactive improvement work; and
- To retain those staff once they have learned the skills.

A lot of disconnected projects, each with their different measures and reporting mechanisms can be very demanding on staff and the system. QI is most likely to be effective if improvement projects are linked and supported at a system-wide level and all are focused on a few key aims for the whole Board area. This ensures good governance and avoids a 'scattergun' approach. There is a tension, of course, between wanting to encourage staff to think of and develop improvements, and ensuring that this enthusiasm and energy is focused on priority areas for the Board and where it will make most difference.

It is a Non-Executive Director's privilege to have an overview of the system and to support the integration of changes so there is intent for, and a consistent approach to QI, and that activity is held together and sustained with an infrastructure. This helps ensure QI becomes part of the culture and is not only activity that is person or situation dependent.

Board prompts

- Do staff in the relevant area have the capacity to take on this improvement?
- Are they capable (i.e. do they have the skills)?
- What is the Board plan for improvement?
- How can I support the development of capacity and capability in my Board area?
- Does my Board have a philosophy or consistent approach to QI?
- Does my Board have a commitment to building up capability and capacity in QI?

4.3.10 Have we set our plans for innovating, testing, implementing and sharing new learning to spread the improvement everywhere it is needed (spread plan)?

Approximately two-thirds of healthcare improvements go on to result in sustainable change that achieves the planned objective (Health Foundation, 2011).

Local improvements, however, need to be acknowledged, celebrated and spread. Spread is “when best practice is disseminated consistently and reliably across a whole system’ and involves the implementation of proven interventions in each applicable care setting”.

Understanding barriers to quality improvement

Non-Executive Directors need to understand that QI involves change and change is often resisted. An understanding of what may hold back change will help in developing QI in the first place and then supporting the spread of that change. Some barriers relate directly to the potential of the Board to support or inhibit improvements, most notably the role of leadership and organisational context and culture. Non-Executive Directors have a powerful role in leading by example.

There are barriers to spreading improvements. In healthcare a third of improvements are never spread beyond the unit where the improvement originated, a further third are embedded in their unit and spread to the organisation and the final third are spread beyond the organisation (UK NHS Institute for Innovation and Improvement, 2010). A common mistake in attempting to spread a success is to task those who have first introduced the change with the responsibility for spreading it. It is not their responsibility; it is a strategic responsibility.

Spread is not as simple as identifying an improvement in an area and telling others to go and do the same. A plan for spreading the change that is supported by Board leadership will be required. The plan needs to make sure that the conditions are created so that those in the next area in the spread plan wish to adopt the change.

The relevant people need to be identified, starting with those who are most likely to adopt the change and the ground prepared. Supporting others to make the change may require a combination of persuasion, marketing and communication skills and change management. On an encouraging note, the history of the NHS is the history of adopting innovations and positive changes. Antibiotics, anaesthetics and the concept of an outpatient department were once innovations. The current challenge is to ensure that innovations and changes that bring an improvement to the way healthcare is delivered are adopted.

Sustainable change

Sustainability is when new ways of working and improved outcomes become the norm. There is evidence that sustainable change is more likely in certain contexts (Health Foundation, 2014). A model that involves patients and staff in co-developing, co-designing and implementing changes is more likely to secure a change than one driven by a 'command and control' or hierarchy model where a change is enforced.

A successful and sustainable spread of change requires understanding of the organisational culture, and knowledge of different units, areas and staff groups. The plan for spread must align with the vision and values of the organisation to ensure the work to spread the improvement is undertaken with conviction in each area. The role of senior leadership is to support alignment of improvements and provide the overview of the system to ensure that improvements are reliably implemented, spread and sustained.

Board prompts

- How can we celebrate this success?
- Do we know where else this improvement is needed?
- What do we need to do as a Board to encourage the spread of this improvement to these areas?
- Is there anything the Board needs to do to unblock a barrier to spread? Or, what can we learn from this failure?
- Am I generous in acknowledging success?
- How do I support the Chief Executive and other leaders?
- How do I approach the failure of an improvement?
- How do I go about challenging or criticising? Am I supportive or do I only discourage?

SECTION 4: (b) Integrated governance

4.4 An overview of integrated governance

4.5 Clinical governance

4.6 Social care governance

4.7 Risk management and effective controls

4.8 Financial stewardship

4.9 Information governance

4.10 Professional regulation and standards

4.4 An overview of integrated governance

Corporate governance was first defined in the Cadbury Report[25, 26] as the "*system by which organisations are directed and controlled"*. This direction and control is essentially concerned with the most senior levels of an organisation and how they seek to achieve their objectives and meet the necessary standards of accountability and probity. For the NHS, corporate governance was defined by the Audit Commission as "*the framework of accountability to users, stakeholders, and the wider community, within which organisations take decisions and lead and control their functions to achieve their objectives".*

In the mid-1990s it was recognised that the NHS saw corporate governance as a series of strands covering clinical, social care, financial and other aspects rather than on more fundamental areas such as the quality of health care and the need for greater emphasis on clinical and social care governance. In 2006 the concept of **integrated governance** emerged and was defined as the "*systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations".*

Key to delivering this is the Trust/ALB integrated governance strategy, accountability and assurance framework.

Clinical governance (see section 4.5) is defined as "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellent care will flourish".

Social care governance (see section 4.6) is defined as "the process by which organisations ensure good service delivery and promote good outcomes for people who uses services".

25 The Report of the Committee on the Financial Aspects of Corporate Governance. December 1992.
26 Human 'Corporate Governance in the NHS', November 2003.

The following parts of the HSC Board Member Handbook form the key elements of clinical and social care governance quality and safety arrangements:

- Serious adverse incidents (SAIs) (section 4.5.1)
- Never event (section 4.5.5)
- Management of HSC complaints (section 4.5.7)
- Early alert (section 4.5.9)
- Clinical standards and guidelines (section 4.5.10)

4.4.1 The need for transition to integrated governance systems

In 2007, the Social Care Institute for Excellence defined social care governance as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[27]

The context for integrated governance in healthcare has its origins in 2004[28] when NHS organisations were urged to: move governance out of individual silos into a coherent and complementary set of challenges, requiring Boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery, require the development of robust assurance and reporting of delegated clinical and operational decision-making in line with well-developed controls and to be supported by Board assurance products, which provide Board Members with a series of prompts with which to challenge their objectives and focus.

The Good Governance Institute's Integrated Governance Handbook recognised that in simple terms there is only one governance and that this is primarily the business of the Board. Apart from clinical practice at the point of care the Board is the key place where all the aspects of governance (clinical, social care, quality, cost, staffing, information etc.), come into play at the same time.[29] Effective governance requires that organisations do not dissipate the composite whole into fragments that never realign.

27 Social Care Institute for Excellence 2007.
28 NHS Confederation Conference Paper by Professor Michael Deighan (and others): 'The development of integrated governance, NHS Confederation', May 2004 as summarised by John Bullivant.
29 Ibid.

In 2006, integrated governance was defined as the "systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations".[30] Key to delivering these systems, processes and behaviours are the Trust's integrated governance arrangements clearly articulated in a strategy or framework which also encapsulates the organisation's accountability and assurance arrangements.

Governance is 'the discussion'

Governance is a way of thinking. It takes account of feelings, intuition, data, information, experience, knowledge, leadership, decision-making, management, risk, risk appetite, risk management.

Information is sometimes based on analysis and interpretation of data, it can come from other sources, for example an announcement about a change in policy or service reconfiguration, new guidance.

It is informed by

Personal knowledge and experience.

Knowledge and experience of the organisation

Knowledge and experience from the wider world within health and social care and beyond, such as the airline industry.

Governance is about

Management – managing people and managing services.

Leadership – setting the tone and the culture and making decisions

Risk – identification and assessment of risk; risk appetite and risk mitigation/management.

It exists at every level of an organisation.

4.5 Clinical governance

Clinical governance is defined as a "system through which NHS organisations are accountable for continuously improving the quality of their services and

30 DoH Integrated Governance Handbook 2006.

safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".[31]

Social care governance is defined as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[32]

The following sub sections are key elements of the clinical and social care governance quality and safety arrangements of HSC Trusts:

- SAIs
- Complaints
- Early alerts
- Never events
- Clinical guidelines
- Lookback review processes and patient recall.

4.5.1 Adverse incidents, including serious adverse incidents

Effective Boards will recognise that HSC organisations that report more adverse events SAIs usually have a better safety culture. The HSC system can't learn and improve if it does not know what the problems are. It is important to know what happened and why it happened. Effective Boards will also want to know about the things that nearly happened (near misses) as well as those that did.

This section should be read in conjunction with the case studies in section 5.

In line with IHRD Recommendation 69 (iii): Trusts should appoint and train Executive Directors with specific responsibility for learning from SAI-related patient deaths.[33] In practice, the six HSC Trusts have an Executive Director/Director lead for SAIs.

31 Scally & Donaldson, BMJ 1998, 317, 61–65.
32 Social Care Institute for Excellence 2007.
33 IHRD Report, Op. Cit. Volume 3 Page 94.

The Board has collective responsibility for promoting effective patient safety and should actively encourage the reporting of adverse incidents (see also section 4.11 Openness and candour). Board Members should check their organisation against the following criteria of what 'good' looks like in relation to the reporting of adverse incidents.

- We understand that high reporting indicates an open and fair culture.
- We encourage and support staff to report things that go wrong.
- We make it easy to do so and we ensure we feedback themes and lessons learned across the organisation and nationally.
- We understand that effective, honest communication and team working supports situational awareness across teams and the organisation, and allows all team members to have a voice, be listened to and responded to.

Various Board prompts have been provided in the case studies in section 5, however the following are frequently asked questions in relation to the management of adverse incidents and in particular the management of SAIs.

What is an adverse incident?

An adverse incident is defined as any "event or circumstances that could have or did lead to harm, loss or damage to people property, environment or reputation"[34] arising during the course of the business of a HSC organisation, Special Agency or commissioned service.

When the potential for harm/loss/damage is detected and the incident is prevented this is considered a 'near miss'[35] and can be used for organisational learning.

Organisations have to create an open and fair culture which facilitates the reporting of incidents (including near misses[30]) and the sharing of learning which results in change and improvements being made. This avoids making similar mistakes repeatedly.

34 DHSSPS, How to Classify Adverse Incidents and Risk 2006. Adverse incidents are reported by staff using electronic incident reporting forms at local level.
35 A near miss is defined as "… an event that might have resulted in harm but the problem did not reach the patient because of timely intervention by **healthcare** providers or the patient or family, or due to good fortune" CMPA Good Practice Guide.

Adverse incidents are reported by staff using electronic incident reporting forms at local level. The HSCB, PHA and HSC Trusts use a commercial software company, Datix Limited (Datix). Datix is a patient safety organisation that produces web-based incident reporting and risk management software for HSC organisations. Incidents are coded in Northern Ireland using **Datix Common Classification System (CCS)** codes. Datix can be used to interrogate adverse incident information at a systems level and can produce incident reports ranging from local directorate reports to Board reports based on a range of variables including patient type (for example inpatient/outpatient), classification code (type of incident, for example medication error or delay in diagnosis) severity, category and location.

The requirement on HSC organisations to routinely report SAIs to the DoH ceased on 1 May 2010 and transferred to the HSCB, working both jointly with the Public Health Agency and collaboratively with the Regulation and Quality Improvement Authority. The regional guidance can be accessed here.

What is a SAI?

The Board should seek assurance that adverse incidents that meet the threshold of being reported as an SAI are being appropriately notified to the relevant agency, for example HSCB/PHA and RQIA where applicable (See also Memorandum of Understanding at section 4.5.4).

The regional guidance provides a list of criteria that will determine whether or not an adverse incident constitutes an SAI. The criteria include the following.

- Serious injury to, or the unexpected/unexplained death of:
    - A service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit);
    - A staff member in the course of their work; or
    - A member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.

- Unexpected or significant threat to provide service and/or maintain business continuity.
- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.
- Serious self-harm or serious assault (including homicide and sexual assaults), on other service users, on staff or on members of the public.
- Incidents involving a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Serious incidents of public interest or concern relating to:
    - Any of the criteria above; and
    - Theft, fraud, information breaches or data losses by member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT THAT MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

What is the aim of the SAI process?

The SAI process aims to:

- Provide a mechanism to effectively share learning in a meaningful way, with a focus on safety and quality, ultimately leading to service improvement for service users;
- Provide a coherent approach to what constitutes an SAI and to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation, Special Agency or commissioned/funded service;
- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;
- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;
- Recognise the responsibilities of individual organisations and support them in ensuring compliance by providing a culture of openness and transparency that encourages the reporting of SAIs;
- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence; and
- Maintain a high quality of information and documentation within a time bound process.

Learning from SAIs

Trust Boards should be aware that the key aim of the regional procedure for reporting SAIs is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following an SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided. Board Members should therefore seek assurance that learning is being shared internally and across the system thorough regular reports to the risk and assurance committee of the Board (or equivalent).

Board prompts

- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How we know if improvement in practice has been embedded?

See sections 4.3 Quality improvement, and 4.7.6 Clinical and social care audit.

When should the HSC organisation report the SAI?

The HSC organisation is required to report the SAI within **72 hours** of the incident being discovered.

Board prompts

- Are we meeting timescales for the notification of SAIs? If not, what is the rationale?

How does the HSC organisation review an SAI and are there timescales for reports to be submitted?

There are three levels of review that may be applied depending on the complexity of the serious adverse incident. The Board should seek an assurance that SAIs are being investigated at the appropriate level and review panels/teams are commissioned in accordance with the procedure and that the timescales for submitting reports is monitored.

4.5.2 Levels of SAI review

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. Most will be subject to a Level 1 review. For some more complex SAIs, reporting organisations may instigate a Level 2 or Level 3 review immediately following the incident occurring.

Level 1 review – significant event audit

Most SAI notifications will enter the review process at this level and a significant event audit or SEA will immediately be undertaken to assess what has happened, why it happened, what went wrong and what went well. The review will assess what has been changed or what change has been agreed and will identify local and regional learning.

The possible outcomes from the review may include:

- Closed – no new learning; or closed – with learning; and
- Requires Level 2 or Level 3 review.

The Trust is required to submit a learning summary to the HSCB within eight weeks of the SAI being notified.

Level 2 review – root cause analysis

Some SAIs will enter at Level 2 review following an SEA. When a Level 2 or 3 review is instigated immediately following notification of an SAI, the reporting organisation is required to inform the HSCB, within four weeks, of the terms of reference and membership of the review team for consideration by the HSCB/PHA designated review officer.

A Level 2 review must be conducted to a high level of detail and should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. Level 2 root case analysis or RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report.

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 review – independent reviews

Level 3 reviews will be considered for SAIs that are particularly complex, involving multiple organisations, having a degree of technical complexity that requires independent expert advice or which are very high profile and attracting a high level of both public and media attention. In some instances the whole team may be independent to the organisation/s where the incident/s occurred.

The HSCB/PHA Designated Review Officer sets timescales for the Trust to report the proposed Chair and membership of the review team at the onset for approval.

The timescale for the completion of the Level 3 review and comprehensive action plan will also be agreed between the Trust and the HSCB/PHA as soon as it is determined that a Level 3 review is required.

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident. Appendix 14 of the Protocol for Responding to SAIs in the Event of a Homicide should be followed and can be found here.

4.5.3 Involvement of service users/family/carers in reviews

Board Members should seek assurance that the organisation has fully engaged with service users/family and carers in SAI reviews. The level of engagement will depend on the wishes of the service user/family or carer and can change over time.

This section should be read in conjunction with 'Being Open' and the Department of Health policy directive on a Statement of What You Should Expect If You are Involved in a Serious Adverse Incident for service users, carers and families which sets out the arrangements for families to respond to the findings/conclusions of a serious adverse incident review report and to receive written answers from the healthcare organisation.

Following an SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user/family engagement across the region. The Trust is required to complete a pro forma: Checklist for Engagement/Communication with the Service User/Family/Carers following an SAI. This must be completed for each SAI to ensure appropriate engagement regardless of the review level which is submitted to the HSCB/PHA. The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroner's office and that this is also communicated to the family/carer.

Detailed guidance for Trusts on engaging with service users/family/carers following an SAI is provided in A Guide for Health and Social Care Staff – Engagement/Communication with Service User/Family/Cares.

Board prompts

- Are we actively encouraging the reporting of adverse incidents?
- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How do we know if improvement in practice has been embedded?
- Do we (ALB Boards) get the right information in relation to adverse incident trends and themes?
- Do we get the right information in relation to SAIs?
- Are we engaging with service users? And how do we know the engagement with service users is effective?
- Are we always open when things go wrong?
- Are the teams reviewing Level 2 and Level 3 SAIs independent enough?
- Are we meeting timescales for reporting and follow-up?

4.5.4 Memorandum of Understanding

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding (MOU) − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU on investigating patient or client safety incidents. It can be found on the Department's website here.

The MOU has been agreed between the DoH, on behalf of the HSC, the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for Northern Ireland) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided, for example it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSC.

It sets out the general principles for the HSC, PSNI, Coroners Service for Northern Ireland and the HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for Northern Ireland or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body;
- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these;
- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high-level decisions are taken; and

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC organisations should note that the MOU does not preclude simultaneous investigations or reviews by the HSC and other organisations, for example root cause analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, a strategic communication and decision group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede an SAI review and subsequently delay the dissemination of regional learning.

4.5.5 What is a 'never event'?

Never events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

It is important, in the spirit of honesty and openness, that when staff are engaging with service users, families or carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a never event. However it will be for HSC organisations to determine when to communicate this information to service users, families and carers.

All categories included in the current NHS never events list (see associated DoH link below) should be identified to the HSCB when notifying an SAI. HSC

organisations are required to complete a separate section within the SAI notification form. The SAI will continue to be reviewed in line with the current SAI procedure.

4.5.6 What is a 'near miss' event?

A near miss: an unsafe situation that is indistinguishable from a preventable adverse incident except for the outcome. A near miss in healthcare is an incident that might have resulted in harm but the problem did not reach the patient/client because of timely intervention by healthcare providers or the patient/client or family, or due to good fortune. Near misses may also be referred to as 'close calls' or 'good catches.'

In a culture of safety, near misses are seen as 'free lessons'.

Near misses may occur many times before an actual harmful incident. Many avoidable deaths have a history of related near misses preceding them.

'High reliability' organisations view near misses as learning and improvement opportunities. Such organisations ask: 'How will the next patient/client be put at risk or harmed?' They value and acknowledge input, and make appropriate improvements.

Conversely, '**low reliability**' organisations are falsely reassured because no harm occurs and they mistakenly conclude the system of care is safe. They wait for harm to occur.

System failures or provider performance issues including provider error, or both, may lead to a near miss.

Why are near misses important?

- They represent 'error prone situations' and 'error traps' waiting to catch other patients and providers.

- There is less anxiety about blame as there are no liability concerns (because no one has been harmed).

Why should near misses be reported?

Reporting near misses helps to:

- Reduce risks for all patients by not waiting for harm to occur;
- Trigger improvements in weak spots in the processes of care;
- Alert other providers to possible vulnerabilities and gaps in training; and
- Contribute to planning, recovery testing, and harm mitigation strategies following events that do result in harm.

Examples of near misses

Sometimes a medication is prescribed without considering the patient's allergies or potential for significant drug interactions. In many, but not all, situations the patient or pharmacist recognises the risk in time.

4.5.7 Management of HSC complaints

Complaints within the HSC are managed in line with regional guidance. 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning', was published by the DoH on 1 April 2009 (and updated **in October 2013).**

What is a complaint?

The regional guidance defines a complaint as 'an expression of dissatisfaction that requires a response'. Complainants may not always use the word 'complaint'. They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

Who can complain?

Any person can complain about care or treatment, or issues relating to the provision of health and social care.

Complaints may be made by:

- A patient or client;
- Former patients, clients or visitors using HSC services and facilities;
- Someone acting on behalf of existing or former patients or clients. As long as they have obtained the patient's or client's consent;
- Parents (or persons with parental responsibility on behalf of a child); and
- Any appropriate person, for example the next of kin, in respect of a patient or client unable by any reason of physical or mental capacity to make the complaint themselves or who has died.

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

What happens if a complaint is made by a third party?

Confidentiality must be respected at all times and complaints made by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complainant the HSC organisations will seek consent from the patient/client concerned or their next of kin where necessary.

There will be occasions where it is not possible to obtain consent, such as:

- Where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- Where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by a disability, mental illness, brain injury or serious communication problems); and
- Where the subject of the complaint is deceased.

Is there support for complainants?

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are available in Northern Ireland and are an important way to enable people to make informed choices. These services help

people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

What issues does the regional complaints guidance not cover?

The regional guidance does not deal with complaints about private care and treatment or services including dental care or privately supplied spectacles, or services not provided or funded by the HSC Trusts (for example, provision of private medical reports).

The guidance does not cover complaints raised within the HSC organisation, for example issues of staff grievances, investigations under disciplinary procedures or issues raised under speaking out or whistleblowing procedures.

There are separate procedures in place for issues that occur under the following that are also not covered by the complaints procedure:

- A request for information under freedom of information;
- Access to records under the Data Protection Act 1998;
- An independent inquiry;
- A criminal investigation;
- The Children Order representatives and complaints procedures;
- Protection of vulnerable adults;
- Child protection procedures;
- Coroner's cases; and
- Legal action.

Complaints received by the Trusts in relation to GP practices and services will be passed onto the HSCB.

Does the Trust deal with complaints about regulated establishments/agencies and/or independent service providers?

HSC Trusts may make use of regulated establishments/agencies and independent service providers, for example residential homes and domiciliary care providers, to

provide services for patients and clients. This form of treatment and/or care is subcontracted to the relevant organisation and funded by the HSC Trust.

These organisations are contractually obliged to have in place governance arrangements for the effective handling of, management and monitoring of complaints. On commissioning of the service it is accepted good practice for the commissioner, i.e. Trust staff, to inform the patient/client and relatives/carers that the regulated establishment/agency or independent service provider will have a complaints procedure in place.

If a patient/client or relative/carer has a complaint relating to the contracted services they should raise the complaint with the provider of care in the first place. However, if the complaint is raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the independent service provider for investigation or it may decide to investigate the complaint itself where the complaint raises serious concerns or where it is in the best interests of the public to do so.

How can complaints be made?

Complaints can be made to a member of a HSC organisation staff at the point of service delivery.

HSC organisations should work closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation. Trust staff should be trained and supported to respond sensitively to the comments and concerns raised by service users.

Formal letters of complaint received at point of service delivery

If a formal letter of complaint is received at the point of service delivery it will be forwarded to the HSC organisation's complaints officer/Department.

Formal complaints made to the corporate complaints officer/team

Complaints may be made verbally, in writing, via telephone (including voicemail) or electronically (via e-mail).

What information should be included in a complaint?

Complaints officers will require relevant contact details, who or what is being complained about, when the events of the complaint happened and where possible what remedy is being sought.

What are the timescales for making a complaint?

The regional guidance indicates that a complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within six months of their becoming aware of the cause for complaint, or within 12 months of the date of the event, whichever is earlier.

In any case, where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request that the Northern Ireland Public Services Ombudsman (NIPSO) consider it.[36]

HSC organisations will normally consider the content of the complaints that fall outside of the time limit in order to identify any potential risk to public or patient safety and, where appropriate investigate the matter.

What is the process for formal complaints?

An acknowledgement of receipt of the complaint should be made within two working days and the acknowledgement will normally express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the organisation. The acknowledgement should contain a copy of the regional HSC '*What happens next'* leaflet.

Complaints should be graded for severity.[37] The issues raised by the complainant may be of a serious nature and may constitute an SAI and the patient/client or

36 Northern Ireland Public Services Ombudsman at www.nipso.org.uk

family/carer advised. If that is the case, then the SAI process outlined in section 4.5.1will apply.

The complaint will be investigated within the service area that the complaint arose. In the case of a complaint across two or more service areas/or directorates the HSC organisation will normally nominate a lead directorate who will seek input from the other service areas. Within HSC organisations the Chief Executive may delegate the signing of the final response to the lead service director. The complainant should receive a full response within 20 working days of the receipt of the formal complaint. If the complaint has been notified as an SAI then the SAI timescales will apply. Engagement with the client/service user in these circumstances is crucial (section 4.5.3).

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the organisation will be unable to meet the 20 working days timescale.

What happens if the complainant is dissatisfied with the response?

The complainant will be advised in the first response that they should contact the organisation within three months of the Trust's response if they are dissatisfied with the response or require further clarity. Discretion for extension of this timescales rests with the HSC organisation.

The first step of local resolution should then be that of an offer of further response to the complainant. This may be in the form of a further written response signed off by the lead director(s). This response should be issued **within 20 days** of the complaint being re-opened.

37 Regional Risk Matrix, Appendix 16 HSCB Regional SAI Reporting Procedure. Available at: www.hscboard.hscni.net

Does the HSC organisation meet with the complainant?

An offer of facilitation of a meeting with the relevant staff will be offered. This will normally be taken forward by the existing investigation team and chaired by someone at head of service level or above. The notes of the meeting should be agreed by all that were present.

What happens if the complainant remains dissatisfied with the response?

Complainants may wish to include the involvement of the Patient and Client Council.

Other options should be considered:

- Local resolution by a second investigation team;
- Conciliation;
- Involvement of lay persons;
- Involvement of independent experts; and
- Review by an independent panel.

4.5.8 What is the role of the Ombudsman?

The role of NIPSO is to provide a free, independent, and impartial service for handling complaints about public services in Northern Ireland. NIPSO will make a decision on each case by taking into account all the available facts and evidence. Its role is to carefully consider the views and opinions of both the person making the complaint and whoever is being complained about. Their aim is to help public services improve through investigations and reports.

NIPSO is not an advocacy agency (an agency that acts in favour of a particular cause, idea or policy), but their role is to sure that the rights of people who complain are respected.

The Ombudsman's legal authority to investigate complaints and make recommendations, as appropriate, is set out in the Public Services Ombudsman Act (Northern Ireland) 2016.

The Act provides the Ombudsman with significant powers to obtain information from public service providers and their employees.

Investigations are conducted in private, though the Ombudsman has the power to publish reports considered to be in the public interest. Before publishing reports NIPSO will take appropriate steps to protect the identity of the complainant.

Section 1: Ombudsman Principles

Principles of Good Administration

Principles of Good Complaint Handling

Principles for Remedy

Section 2: Guidance

Good Administration and Good Records Management

Guidance on Issuing an Apology

Information promise

Human Rights Manual

Section 3: Leaflets

NIPSO Information Leaflet

Signposting to the Ombudsman

Board prompts

- What are we doing to resolve complaints at the point of service?
- Are we always open when dealing with complaints?
- Are we engaging with service users? How we know that service users are satisfied with the responses they receive to their complaints?
- How many complaints are re-opened? How many are referred to NIPSO?
- How is learning from complaints fed into local programmes of care?
- How do we know if improvement in practice is embedded?
- Does the HSC organisation get the right information in respect of themes and trends emerging from the management of complaints? What does it tell us about the quality of our services?
- Are we meeting timescales for acknowledging and responding to complaints?

4.5.9 Early alert system

Notification of emerging issues by HSC Trusts – early alert notifications

The early alert system is the established communications protocol between the DoH and HSC organisations. It is based on the principles of 'no surprises' and an integrated approach to communications. Accordingly, HSC organisations should notify the Department (copied to the HSCB) promptly, and within 48 hours of the event in question, of any emerging issues (events) that have occurred within the services provided or commissioned by their organisation, or relating to family practitioner services.

Events should meet one or more of the following criteria:

- Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;
- The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

- The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client; and
- The event may attract media attention.

The early alert system guidance states “that it is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at director level or higher) communicates with a senior member of the staff in the Department (i.e. the Permanent Secretary, Deputy Permanent Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event”.

The guidance states “that the next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties”. In all cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the appropriate pro forma and forwarded, within 24 hours of notification of the event, to the Department and the HSCB.

Board prompts

- Are we actively encouraging the reporting of early alerts?
- Are we meeting the timescales for reporting and follow-up?
- How can we be assured that the information provided in the early alert is accurate, or as accurate as possible given that facts about the even may still be emerging?

4.5.10 Clinical standards and guidelines

Since the introduction of clinical and social care governance, clinical guidelines have increasingly become a familiar part of clinical practice. Every day, clinical decisions at the bedside, rules of operation at hospitals and clinics, and health spending by governments are being influenced by guidelines. As defined by the Institute of Medicine, clinical guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific

clinical circumstances".[38] They may offer concise instructions on which diagnostic or screening tests to order, how to provide medical or surgical services, how long patients should stay in hospital, or other details of clinical practice.

The principal benefit of guidelines is to improve the quality of care received by patients. For service users the greatest benefit that could be achieved by guidelines is to **improve health outcomes**. Guidelines that promote interventions of proved benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life, at least for some conditions.

Guidelines can also **improve the consistency of care**; studies around the world show that the frequency with which procedures are performed varies dramatically among doctors, specialties, and geographical regions, even after case mix is controlled for.[9] There is a potential that patients/clients with identical clinical problems may receive different care depending on their clinician, hospital, or location. Clinical guidelines offer a remedy, making it more likely that patients will be cared for in the same manner regardless of where or by whom they are treated.

Clinical guidelines are published by a professional body or national organisation with acknowledged expertise in the relevant clinical field. Sources of professional guidance include organisations or reports that are specific to Northern Ireland (for example safety and quality alerts), wider UK bodies (for example NICE, the National Institute for Health and Care Excellence), European societies and international societies. Typically, guidance produced by such organisations is published and freely available on the internet.

Social care guidance is included in the current NICE service level agreement, however, the DoH (NI) Social Care Group undertook to develop a pilot process for the endorsement of these guidelines but have yet to implement NICE social care guidance.

38 Steven H Woolf, Professor of Family Medicine; Richard Grol, Director; Allen Hutchinson, Professor of Public Health; Martin Eccles, Professor of Clinical Effectiveness; and Jeremy Grimshaw, Professor of Public Health. 'Potential benefits, limitations, and harms of clinical guidelines', 1999.

NICE was established in an attempt to end variation in healthcare standards (the so-called ‘postcode lottery’ of healthcare) in England and Wales, where treatments that were available depended upon the NHS health authority area in which the patient happened to live, but it has since acquired a high reputation internationally as a role model for the development of clinical guidelines. NICE is a Non-Departmental Public Body tasked with producing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance to promote clinical excellence and the effective use of resources for people using the NHS is designed for use in England and, as such, does not automatically apply in Northern Ireland.

The Department established formal links with NICE on 1 July 2006, whereby guidance published by the Institute from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in the HSC. This link has ensured that Northern Ireland has access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions. NICE provides national guidance and advice to improve health and social care and publishes guidelines in the following areas.

- **Technology appraisals,** where NICE determines whether or not a drug, medical device or surgical procedure should be funded by the NHS, based on its evaluations of efficacy and its cost-effectiveness.

- Clinical guidelines on the **management of specific diseases** and groups of patients.

- Public health guidance, covering the **promotion of good health** and the prevention of ill health.

- Interventional procedures programme, assessing **the safety and efficacy of new interventional procedures**. England, Wales, Scotland and Northern Ireland are full participants in this programme and fund NICE accordingly.

- **Social care guidance** – NICE works with the adult and children's care sectors to develop independent recommendations for social care.

- **Antimicrobial prescribing guidance** – evidence-based guidelines for managing common infections in the context of tackling antimicrobial resistance, specifically in relation to bacterial infection and antibiotic use.

- **Highly specialised technologies** – the NICE HST programme only considers drugs in development for very rare conditions which by virtue of the small patient population can be significantly more expensive than routinely commissioned medicines.

In the DoH (NI) service level agreement with NICE it was agreed that the Department may add caveats to guidelines to cover legal or policy differences applicable to Northern Ireland, the Department is not permitted to make material changes to the content of the guidelines. The **guidance must be endorsed as a whole** – particular recommendations may not be 'cherry picked' for inclusion or exclusion. NICE guidance is developed for the English HSC system and caveats might include references, for example, in respect of mental capacity legislation or circumstances surrounding the legal circumstances for termination of pregnancy. Whilst there is a process to check the guidance for legal and policy applicability here, there is no reassessment of the clinical or cost evidence used by NICE in coming to its decisions and forming its advice.

The guidance from NICE does not override or replace the individual responsibility of health professionals.

Whilst NICE guidelines are the only source of guidelines with a departmental policy for implementation, they are not the only clinical standards and guidelines which inform clinical practice. Clinical teams typically keep abreast of a full spectrum of clinical guidance. This can be extremely challenging. For example, in 2018/19 a BSO Internal Audit identified approximately 350 guidelines, confidential inquiries

and safety alerts that had been issued to be actioned by HSC Trusts over an 18-month period.

Assurance and monitoring arrangements

It is the responsibility of HSC organisations, under the statutory duty of quality as specified in Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, to put in place the necessary systems, which should include adequate and comprehensive dissemination, as part of their clinical and social care governance arrangements, for implementing NICE guidance.

The HSC Board is responsible for monitoring implementation of NICE guidance within the HSC system.

The HSC Board holds director-level meetings with the HSC Trusts where the implementation of NICE guidelines is a standing item on the agenda. **All HSC Trusts are required to provide positive assurance that the initial required actions of targeted dissemination, identification of a clinical/management lead and implementation planning have taken place.** This is in addition to the positive assurance that will be sought on implementation.

Clinical audit is a very widely used technique across the HSC, whereby existing practice is compared against an existing quality standard.

Board prompts

- What are our policies and procedures for the management of clinical and social care standards and guidelines?
- What assurances do we have that clinical and social care standards and guidelines are effectively received and disseminated throughout the organisation?
- What assurances do we have that clinical and social care standards and guidelines are implemented (see also section 4.7.6 Clinical and social care audit)?
- How are we using the internal audit function to obtain assurance on internal controls on the management of clinical and social care standards and guidelines? Is the scope and level of investment in internal audit appropriate? How are we maximising the assurances we can gain from internal audit and do internal audit staff have the right skills and experience? Are we making best use of other independent forms of assurance?
- Do we need to establish or increase investment in a separate compliance function to ensure operations comply with clinical and social care guidelines and our policies?
- To what extent do we use the clinical audit function appropriately? Is it systematic and focused on our own risks as well as on nationally identified issues? Are the results regularly reported to the Board through the assurance framework? Does it give us a comprehensive view of the quality of clinical services across the Trust's portfolio?
- What are our potential sources of assurance? Do we use these appropriately, balancing them across the risk profile of the Trust? How have we satisfied ourselves that they are not skewed towards big and topical projects and that we keep our eye on the ball more widely? How do we systematically test and evaluate the sources of assurance?

4.5.11 Lookback review processes including patient recall

A lookback review process is implemented as a matter of urgency where a number of people have potentially been exposed to a specific hazard, in order to identify if

any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm as well as to prevent further potential occurrences of harm.[39]

A lookback review is a process consisting of the following four stages.

1. Immediate action including a **preliminary investigation** and **risk assessment** to establish the extent, nature and complexity of the issue(s).
2. Identification of the **service user cohort** to identify those potentially affected.
3. **Recall** of affected service users.
4. Closing and **evaluating** the lookback review process and the provision of a **report** including any recommendations for improvement.

The decision that a lookback review is required often occurs after a service user, staff member or third party such as a supplier has reported concerns about the death or harm to a service user, or the potential for death or harm, the performance or health of healthcare staff, the systems and processes applied, or the equipment used. The triggers for consideration of a lookback review may include, but are not limited to the following:

- Equipment found to be faulty or contaminated and there is the potential that people may have been placed at risk of harm;
- Concern about missed, delayed or incorrect diagnoses related to diagnostic services such as screening, radiology or pathology services;
- Concerns about incorrect procedures being followed or evidence of non-compliance with extant guidance;
- Concerns raised regarding the competence of practitioner(s) or out-dated practices;
- A service review or audit of practice shows that the results delivered by either a service or an individual were not in line with best practice standards and there is a concern that there was potential harm caused to a cohort of service users as a result;

39 Health Service Executive (HSE) 'Guideline for the Implementation of a Look-back Review Process in the HSE', HSE National Incident Management and Learning Team, 2015. Section 1 page 4.

- Identification of a staff member who carries a transmissible infection such as Hepatitis B and who has been involved in exposure-prone procedures which have placed service users at risk; or as a
- Result of the findings from a preceding SAI or a thematic review by the HSCB/ PHA or RQIA.

HSC organisations are required to implement The Regional Guidance for the Implementation of a Lookback Review Process. A draft policy to replace HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer on 8 March 2007 is currently out for consultation and it is envisaged that this will be issued in Spring 2021. The draft policy details the roles and responsibilities of all stakeholders including HSC Boards, Chief Executives, the PHA/HSCB and the DoH. It documents the steps, including the service user and staff support and communication plans that are to be undertaken by HSC organisations when a lookback review process is initiated. HSC organisations should develop their own local policies and procedures, consistent with the policy and regional guidance when issued during 2021, to address any potential lookback review process.

The purpose of the draft policy and regional guidance is to ensure a consistent, co-ordinated and timely approach for the notification and management of potentially/affected service users carried out in line with the principles of 'Being Open'[40] whilst taking account of the requirements of patient confidentiality and data protection.[41, 42]

The objectives of the policy are to:

1. Assist HSC organisations in adopting a risk-based approach and ensure the timely management of appropriate and relevant care for affected groups of service users.

40 National Patient Safety Agency, 'Being open – communicating patient safety incidents with patients and their carers'. September 2005. Archived on 18 February 2009 at webarchive.nationalarchives.gov.uk.
41 European Union, 'General Data Protection Regulations (GDPR)'. 25 May 2018 at https://eugdpr.org.
42 Data Protection Act 2018, www.legislation.gov.uk

2. Establish a standard approach to notification of service users, families/carers, healthcare managers and the public of clinical incidents involving potential injury, loss or other harm to groups of service users.

3. Ensure that communication with, and support for, all affected and potentially affected service users, their families and/or carers and also staff occurs as soon as reasonably practicable, and in as open a manner as possible..

4. Ensure that the HSC organisation adopts appropriate support mechanisms for the health and well-being of staff involved.

5. Ensure that communication with the DoH, HSCB, PHA and the public occurs in a consistent and timely manner.

6. Ensure that HSC organisations' services have established and consistent processes in place when a lookback review is undertaken, and that they also maintain the business continuity of existing services and public confidence.[43]

7. Ensure that HSC organisations appropriately reflect upon the issues which prompted the review and any learning from the outcomes of a lookback review within their systems of governance.

43 South Australia Health, Lookback Review Policy Directive, Safety & Quality, System Performance & Service Delivery, July 2016. Section 1 page 4.

Board prompts

- Can we be assured that immediate steps have been taken to prevent any further harm?
- Has a risk assessment of the situation been carried out?
- What is the level of harm to service users?
- How many service users could this potentially impact?
- Does this affect any other Trust or healthcare provider?
- Has an early alert been submitted?
- Does this constitute an SAI?
- Have we informed the potentially affected service users?
- What is our communication plan including service users, general public and the media?
- How can we reassure service users and the public that the services provided by the Trust are safe?

4.6 Social care governance

HSC Trusts as corporate entities are responsible in law for the discharge of statutory functions delegated by the HSCB. The scheme for the delegation of statutory functions specifies the control and assurance processes informing the organisation's discharge of its statutory functions. The nature and scope of these functions and related services give rise to enhanced levels of public scrutiny. These include:

- Interventions in respect of personal liberty;
- The protection of children and vulnerable adults;
- Corporate parenting responsibilities;
- Provision of vital services; and
- Exercise of regulatory functions.

Their effective discharge is central to organisation integrity. As a consequence, they have heightened organisation and corporate significance and assurance profile. The Trust is required to have in place systems that are capable of balancing appropriately the complex issues of protection and care.

Statutory responsibilities of HSC Trusts

The Health & Personal Social Services (NI) Order 1994 permits the Regional Health & Social Services Board to delegate responsibility for the discharge of relevant personal social services statutory functions to HSC Trusts. Specific duties and powers have been delegated to each Trust under the following legislation:

- The Children (Northern Ireland) Order 1995;
- The Adoption (Northern Ireland) Order 1987;
- The Children (Leaving Care) Act (Northern Ireland) 2002;
- The Mental Health (Northern Ireland) Order 1986;
- The Disabled Persons (Northern Ireland) Act 1989;
- The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978;
- The Carers and Direct Payments (Northern Ireland) Act 2002; and
- The Health and Personal Social Services (Northern Ireland) Order 1972.

The Executive Director of Social Work

The Executive Director of Social Work must be a registered social worker and holds delegated responsibility for personal social services delegated functions. The Executive Director of Social Work is a member of the Trust Board and is accountable to the Chief Executive for compliance with legislative requirements and for ensuring that systems, processes and procedures are in place to effectively discharge statutory functions in respect of child care, mental health, disability and community care and in relation to the social work and social care workforce. The Executive Director of Social Work has a dual responsibility – operational responsibility for the delivery of children's services and executive responsibility for social work in adult services – and provides a direct line of professional accountability from social work practitioners in all programmes of care to the Chief Social Worker, Department of Health.

The HSC Trust as a corporate parent

When a child comes into care ('looked after'), the HSC Trust becomes the corporate parent. The term 'corporate parent' means the collective responsibility of the Trust Board, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are 'looked after'.

A child in the care of the Trust depends on the Trust Board to be the best parent it can be. Every Trust Board Member and employee of the Trust has the statutory responsibility to act for that child in the same way that a good parent would act for their own child.

Corporate parenting principles

- To act in the best interests, and promote the physical and mental health and well-being, of children and young people who are 'looked after';
- To encourage those children and young people to express their views, wishes and feelings;
- To take into account the views, wishes and feelings of those children and young people;
- To help those children and young people gain access to, and make the best use of, services provided by the HSC Trust and its relevant partners;
- To promote high aspirations, and seek to secure the best outcomes, for those children and young people.;
- For those children and young people to be safe, and for stability in their home lives, relationships and education or work; and
- To prepare those children and young people for adulthood and independent living.

Child protection

Those who work with children, young people or families, in whatever capacity, have a particular responsibility to promote their welfare and ensure they are safe. All organisations and agencies working with children and young people must discharge their functions with regard to the need to safeguard children and young people, must have procedures in place for safeguarding, and ensure these are adhered to.

There will unfortunately be occasions where early intervention and support is not sufficient and a child is identified as being 'at risk of significant harm'. In such cases statutory intervention to protect the child or young person will be required. This may include the child being the subject of a child protection plan, the child's name being

placed on the child protection register, and/or the child becoming 'looked after' by the HSC Trust.

Adult safeguarding

Adult Safeguarding: Protection and Prevention in Partnership (DHSS&PS and DoJ, 2015) is the Government's adult safeguarding policy developed by the Department of Health and the Department of Justice on behalf of the Northern Ireland Executive.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect.

The policy states that adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe.

Adult safeguarding extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

The following definitions are intended to provide guidance as to when an adult may be at risk of harm and in need of protection.

1. An **'adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal circumstances – which may for example include but may not be limited to age, disability, special educational needs, mental or physical frailty, or life circumstances such as isolation, socioeconomic factors and living conditions.

2. An '**adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased if unable to protect

for example their own well-being, property, assets and where the action or inaction of another is causing or likely to cause harm.

The rights of vulnerable adults to live a life free from neglect, exploitation and abuse are protected by the Human Rights Act 1998.

Social care governance framework

The Social Care Institute for Excellence publication, Social Care Governance: A Practice Workbook (NI) (2nd edition) (2013) defines social care governance is defined as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.

The publication sets out many of the key factors that are associated with organisations which are well managed, high-performing and successful.

This publication provides a social care governance framework which supports Trust Boards to review the quality, safety and effectiveness of current practice, and to identify the actions necessary to improve and develop. Non-Executive Directors are encouraged to review this comprehensive framework and use it as an aid to supporting them in the discharge of their corporate social care governance responsibilities.

The framework includes four key areas of social care governance:

- Leadership and accountability;
- Safe and effective practice;
- Accessible and flexible service responses; and
- Effective communication and information.

Board prompts

Leadership and accountability

- Are the systems in place to support the discharge, monitoring and reporting of statutory functions sufficiently robust and offer you the necessary assurance?
- Do you receive a corporate parenting report every six months with sufficient information to provide you with assurance about your corporate parenting responsibilities? (DHSS-PSNI Corporate Parenting Circular CC3/02)
- What social care governance structures and arrangements are in place and do they support you in discharging your corporate responsibilities? Are the social care governance strategic audit plans aligned to the risk and assurance framework to drive quality and safety?
- Does the culture of the organisation support and contribute to organisational learning and improvement; effective partnerships with other organisations; and meaningful collaboration with people who use social services and carers?
- How are resources planned and invested in social services functions to ensure optimal outcomes are being delivered? What gaps exist in human and financial resources within social services and how are these being addressed?
- How is unmet need identified and what system is in place to record and use the information?

Safe and effective practice

- How is risk assessed and managed? Is there evidence of service user and carer involvement in risk management and decision-making?
- What system is in place for the notification, management and reporting of adverse incidents in social care and near misses in the organisation and are they sufficiently robust?
- Does the organisation have effective commissioning arrangements in place which deliver safe, quality social services through third parties?

- Is quality improvement methodology proactively used in social services to improve quality and safety?
- Does the organisation proactively support research activities and evidence-based practice in social work and social care to shape service development?

Accessible and flexible service responses

- What systems are in place to gain direct feedback about the quality of services provided?
- Does the organisation have appropriate systems in place to promote and support the involvement of people who use social services, and carers, in all aspects of service planning, delivery, evaluation and review?
- How does the organisation support integrated and partnership working with other key and related organisations to deliver quality social care services to adults and children?
- How is the equality and human rights duty upheld in the discharge of social services?

Effective communications and engagement

- How is social care governance information shared across your organisation at team, directorate and corporate level to support service improvement? How is learning and service improvement evidenced?
- How does the organisation promote and support the use of quality standards across all programmes of social care and how are they reported on?
- How effective are the data systems for statutory duty reporting?
- How is information and data captured, including emerging trends, analysed and communicated to support future planning, commissioning, and unmet need?

4.7 Risk management and effective controls

4.7.1 Corporate governance

The Board should ensure that there are effective arrangements for governance, risk management and internal controls in place throughout the organisation and be able to assess and demonstrate those arrangements through a number of key documents, including the **assurance framework** and the **governance statement.**

Traditionally, responsibility for governance has been discharged through a number of separate controls or disciplines such as finance or clinical and social care governance. But risk crosses boundaries and the systems and controls put in place to manage it must be comprehensive and flexible. The **assurance framework** is designed to help Boards address this by providing a clear, concise structure for reporting key information to Boards.

The assurance framework identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls, or where the organisation has insufficient assurance about them. It should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. As well as establishing a basis for the spread of good practice, it allows the Board to determine where to make the most efficient and effective use of their resources. A robust assurance framework provides a strong basis for effective challenge and better-informed decision-making in the boardroom. It will also be of direct relevance to senior Executives, risk and governance managers, and clinical and social care professionals.

The **governance statement** sets out an organisation's system of internal controls and is signed by the Chief Executive, for inclusion in the annual report and annual accounts. The statement will cover the organisation's capacity to handle risk, its risk and control framework, as well as a review of the effectiveness of its internal control. These areas are examined in more detail below.

4.7.2 Risk management

Organisations face a wide range of uncertainties and factors that may affect the achievement of their objectives. This can create a positive risk (opportunities) or a negative risk (threats).

Risk management focuses on identifying threats and opportunities, while **internal control** helps counter threats and take advantage of opportunities.

Proper risk management should help organisations make informed decisions about the level of risk that they want to take and implement appropriate internal controls that allow them to pursue their objectives.

Risk management is not the same as minimising risk. It is important to remember that being excessively cautious can be as damaging as taking unnecessary risks. Risk taking is the basis of progress. Without it, you cannot have innovation and the benefits that come from developing new procedures and interventions or changing business practices. Boards have to carefully consider whether or not potential long-term rewards will be greater than short-term losses.

It is the role of the Board to decide which risks they need to reduce, which they are prepared to accept and what their tolerances are for those risks they are willing to accept. This is known as **risk appetite.**

The Board must make a considered choice about its risk appetite, taking account of its legal obligations, business objectives, and public expectations. This means that different organisations will have different approaches to the same risks and these may change over time, depending on the circumstances. Figure 16 sets out these concepts in more detail.

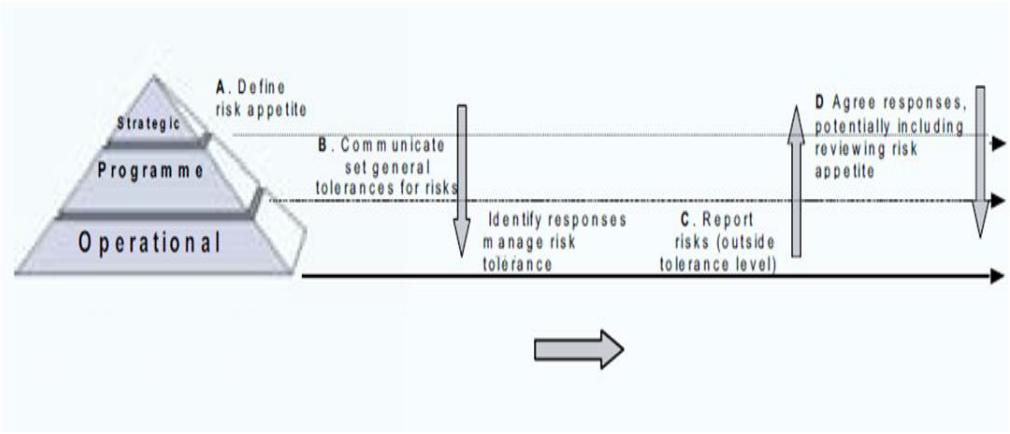


Figure 16: Risk management (HM Treasury, Thinking About Your Risk: Managing Your Risk Appetite, A Practitioner's Guide, November 2006)

A key part of determining risk appetite is the analysis and assessment of each risk. This needs to be done against a common set of metrics. More detail on this can be found here.

Once risk appetite has been established the Board can make decisions about how to respond to different risks. Examples of risk response and when they might be used are set out in Table 2.

Response	When to use
Take opportunities	For circumstances where the potential gain seems likely to outweigh the potential downside.
Tolerate	For unavoidable risks, or those so mild or remote as to make avoidance action disproportionate or unattractive.
Treat	For risks that can be reduced or eliminated by prevention or other control action.
Transfer	Where another party can take on some or all of the risk more economically or more effectively, for example through insurance, sharing risk with a contractor, or management techniques such as public-private partnership.
Terminate	For intolerable risks, but only where it is possible for the organisation to exit (note that some risks can only be assumed by the public sector).

Table 2: Risk responses (Managing Public Money NI)

The Board should make its position on risk clear to both employees and the public through formal annual risk appetite statements so that everyone understands why and how decisions have been taken and as an assurance that the organisation is taking a proportionate response to a risk.

While it is the executive team who will manage the risk, the Board's primary function centres around the organisation's overall control and direction, supported by an audit and risk assurance committee (chaired by a suitably experienced Non-Executive Board Member) and internal audit. More information on this is available in sections 4.7.3 and 4.7.4.

The Board itself should not expect to have more than a dozen or so risks before it and, of those, there should be two or three which pose an immediate threat to organisational stability. Instead, managers will be dealing with the other ongoing corporate and lower-level risks. The assurance framework is designed to allow the

Board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to principal objectives.

It is essential, therefore, that Boards assure themselves that organisations have robust systems in place to deal with a wide range of risks and these systems should be reviewed routinely. As risks (and the appropriate response) can change over time and depending on circumstances, the systems should include the routine monitoring of risks and procedures to raise concerns with the Board as quickly as possible and in line with their risk tolerances. Regular risk assessments should be carried out and information provided on 'close calls' and 'near misses' to enable the Board to evaluate the strength of the risk management procedures.

Figure 17 sets out the process of risk assessment, treatment and review.

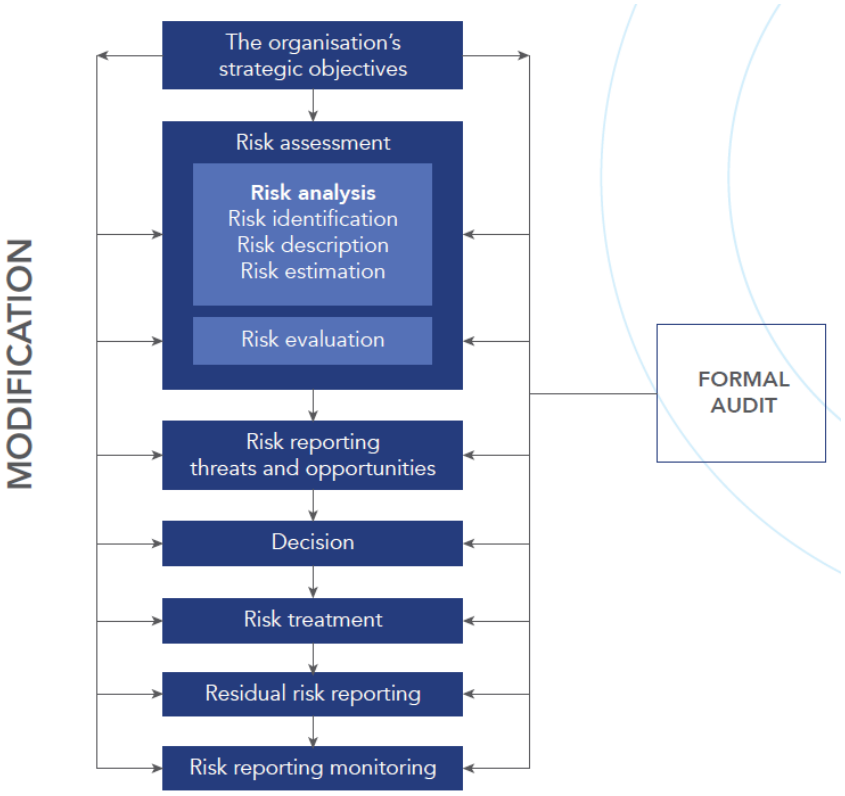


Figure 17: A simple guide to risk for members of Boards and governing bodies (The Good Governance Institute)

Effective governance structures and processes should integrate performance-focused risk management and internal control across all aspects of organisations. The Board should take the lead on, and oversee the preparation of, the organisation's governance statement for publication with its resource accounts each year.

Board prompts

- What level of risk taking we view to be acceptable?
- Have we considered the risk in the context of other risks?
- Have we communicated our risk appetite?
- Have we identified the limits of our risk appetite so that we know when decisions need to be escalated?
- Are risks and opportunities being managed so that the right balance is struck between the organisation's aims and its risk appetite?
- Are risks appraised frequently and systematically?
- Are changes to risks tracked?
- Are adjustments made in response?
- Have the costs been considered?
- How likely is the risk?
- What is the potential impact?
- Have we taken the risk appetite of our partners and suppliers into account?

4.7.3 The remit and membership of the audit committee

The audit committee is responsible for **audit, risk and internal control**, and will report to the Board as appropriate. The Board may decide to have a separate risk committee if it has feels the audit committee has sufficient time or suitable membership to deal with both issues.

The Board should establish an audit committee of independent Non-Executive Directors, with a minimum membership of three (or in the case of smaller organisations, two). The Chair of the Board should not be a member. At least one member should have recent and relevant financial experience.

The main roles and responsibilities of the audit committee include:

- Monitoring the integrity of the organisation's financial statements and publications, including reviewing any significant financial reporting judgements contained in them;
- Providing advice to the Board on the annual report and accounts, particularly whether they are fair, balanced and understandable and if they provide sufficient information to assess the organisation's position and performance;
- Reviewing the organisation's internal financial controls and internal control and risk management systems;
- Annually assessing the need for an internal audit function, monitoring and reviewing the effectiveness of any existing internal audit function and making recommendations to the Board;
- Conducting the tender process for external audit and approving the remuneration and terms of engagement. Making recommendations to the Board about the appointment, reappointment and removal of the external auditor;
- Reviewing and monitoring the external auditor's independence, objectivity and the effectiveness of the external audit process, in line with relevant UK professional and regulatory requirements; and
- Reporting to the Board on how it has discharged its responsibilities.

It is important to note that the audit committee should not limit its focus to internal financial control matters. It has a central role in providing the Board with assurances about all of the organisation's activities and how it is delivering against its objectives, and, the audit committee should review the governance statement before submitting it to the Board for approval and sign-off. More information on clinical (and non-clinical) and social care governance can be found at sections 4.5 and 4.6.

DoH ALBs are required to complete the National Audit Office Audit Committee Checklist, on an annual basis as recommended as best practice by the National Audit Office. Audit committees can assess their performance against best practice using the checklist.

4.7.4 Internal and external audit

Regular internal audits are carried out by auditors to provide an independent, objective assurance about an organisation's risk management, controls, reporting and governance processes. The main purpose of an internal audit is to provide accounting officers with an evaluation of the overall adequacy and effectiveness of these processes. The Accounting Officer will use the Head of Internal Audit's opinion as a key assurance element when completing the annual governance statement. It is one of the key elements of good governance and should add value and improve an organisation's operations.

BSO Internal Audit Unit provides internal audit services to all 16 HSC organisations in Northern Ireland and the NI Fire and Rescue Service.

There should be direct interaction between the Board and internal audit. The Chief Audit Executive must report to the Board and have free access to the Chief Executive and the Chair of the audit committee.

While internal auditors can be used to provide advice and other consulting assistance to employees, external audit do not typically providing close support to the organisations they are examining. This is because external audit are not responsible to management or the organisation; their primary responsibility lies with providing assurances to the public that public resources have been safeguarded appropriately.

Boards should consider evidence from internal and external audit when making decisions about how to manage and control opportunity and risk.

4.7.5 Internal controls

Internal controls are a key part of corporate governance, providing **clear lines of accountability** throughout the organisation. Examples of internal controls include:

- Monitoring by the Board (corporate strategies, action plans, risk policies, annual budgets and business plans, corporate performance, and governance structures and procedures);
- Internal audits and robust policies;
- Proper balance of power (including selection and succession planning of Executives);
- Performance based remuneration; and
- Monitoring by other stakeholders.

In addition to the governance statement, organisations must complete a mid-year assurance statement, to be signed by the Chief Executive and submitted to the Department of Health by the end of October each year. The mid-year assurance statement enables the Accounting Officer to attest to the continuing robustness of their organisation's system of internal control at the mid-year position and, therefore, covers the same areas as the governance statement at the end of the year. Organisations must also develop an assurance framework to strengthen Board-level control and assurance in general, a statement on internal control and the mid-year assurance statement. More information on these documents can be found at Appendix 5 (ii).

Board prompts

- What safeguards are in place to ensure that performance targets are met, to prevent misuse of resources and counter fraud?
- What records are used to track performance and the use of resources?
- What audit arrangements are in place?
- What information does the organisation publish about its resource and activities?
- How often is this information reviewed?
- How and when are policies and projects evaluated?

4.7.6 Clinical and social care audit

Clinical and social care audits have been endorsed by the Department of Health in successive strategic documents as a significant way in which the quality of clinical care can be measured and improved. Originally, clinical and social care audits were developed as a process by which professionals reviewed their own practice. However, clinical and social care audits are now recognised as an effective mechanism for improving the quality of care that patients and clients receive as a whole. It offers a crucial component of the drive to improve quality.

Boards have not always done enough in the past to measure quality; now they must do so, and a clinical and social care audit provides a mechanism for this. There are a variety of related processes which also have a role in measuring and improving quality, such as confidential, serious adverse incident reviews, patient surveys, research, peer review, internal audit and so on. None of these replace clinical and social care audits and a systematic clinical and social care audit is the main way of assessing compliance of ongoing clinical and social care against evidence-based standards.

A clinical and social care audit needs to be a strategic priority for Boards as part of their clinical and social care governance function. A clinical and social care audit is effectively the review of professional performance against agreed standards, and the refining of professional practice as a result. It is one of the key compliance tools at a Board's disposal and has an important role within the assurance framework.

The clinical and social care audit needs to be carefully compared with, and is complementary to, an internal audit; however they are different processes. It is rare for internal audit providers to have access to specialist clinical knowledge, whereas, for example, an insurance company's internal audit function would almost certainly employ, or have access to, an actuary. Trusts need to consider how they can best gain assurance over clinical and social care risk management and their Boards have a role in driving quality assurance, compliance, internal audits and 'closing the loop.' They need to ensure that the recommendations of reviews and clinical and social care audits are actioned by seeking assurance that improvements in care

have been made. Ideally this should be part of an overall quality framework and should be reported in the Trust's publicly reported annual quality improvement report, or equivalent.

Boards will want assurance that there is a clinical and social care audit strategy in place that meets their strategic priorities, and that:

Meets national commitments and expectations;

Prioritises local concerns;

Integrates financial and clinical and social care audits;

Delivers a return on investment; and

Ensures improvements are implemented and sustained.

Boards should use clinical and social care audits to confirm that current practice compares favourably with evidence of good practice and to ensure that where this is not the case that changes are made that improve the delivery of care. Clinical and social care audits can:

- Provide evidence of current practice against national guidelines or HSC standards;
- Provide information about the structures and processes of a healthcare service and patient outcomes;
- Assess how closely local practice resembles recommended practice;
- Check 'Are we actually doing what we think we are doing?'; and
- Provide evidence about the quality of care in a service to establish confidence amongst all of its stakeholders – staff, patients, carers, managers and the public.

Boards will want to be assured that clinical and social care audits are:

- **Material** – i.e. that they are prioritised to focus on key issues and that the value outweighs the cost;
- **Professionally undertaken and completed** – i.e. clinical and social care audits are undertaken and completed to professional standards including the quality of data being analysed;

- **Producing results** that are shared and acted upon; and
- **Followed by improvements** that are made and sustained.

Boards have clear questions they should ask about any clinical and social care audit programme in their Trust. To advance clinical and social care audits, roles and responsibilities need to be clearly established. The Board's role is to ensure that a clinical and social care audit is strategic, happens regularly, is clinically and cost effective and is linked to the safety and quality agenda.

10 simple rules for HSC Boards

1 Use clinical and social care audits as a **tool in strategic management**; ensure the clinical and social care audit strategy is allied to broader interests and targets that the Board needs to address.

2 Develop a **programme of work which gives direction and focus** on how and which clinical and social care audit activity will be supported in the organisation.

3 Develop **appropriate processes** for instigating a clinical and social care audit as a direct result of adverse clinical events, critical incidents and breaches in patient safety.

4 Check the clinical and social care audit programme for **relevance to Board strategic interests** and concerns. Ensure that results are turned into action plans, followed through and re-audit completed.

5 Ensure there is a **lead clinician who manages** the clinical and social care audit within the Trust, with partners/suppliers outside, and who is clearly accountable at Board level.

6 Ensure **service user and carer involvement** is considered in all elements of a clinical and social care audit, including priority setting, means of engagement, sharing of results and plans for sustainable improvement.

7 Build clinical and social care audits into **planning, performance management and reporting.**

8 Ensure with others that clinical and social care audits cross care boundaries and encompasses the **whole service user pathway.**

9 Agree the **criteria of prioritisation** of clinical and social care audits, balancing national and local interests, and the need to address specific local risks, strategic interests and concerns.

10 Check if the clinical and social care audit **results in evidence of complaints** and if so, develop a system whereby complaints act as a stimulus to review and improvement.

Key points

- The aim of a clinical and social care audit has always been quality improvement.
- A clinical and social care audit is a team endeavour.
- The Department of Health has consistently supported clinical and social care audits.
- Clinical and social care audits are now also a mainstream accountability and not solely clinician owned. They are a quality management and governance activity alongside being a professional development activity.
- Board involvement in clinical and social care audits is very recent and has been minimal to date.
- A requirement to demonstrate active engagement in local and national clinical and social care audits is now becoming more clearly a statutory requirement for HSC Trusts.

HSC Boards are the first line of regulation. While they have accountability for strategic decision-taking for the Trust, they must also represent their stakeholders; the public, patients and funders. This is a difficult balancing act and requires great skill and expertise to reflect national and local priorities, and to ensure safe, cost effective and integrated care that is constantly striving for improvement, whatever the financial climate.

There is scope to maximise the assurance provided by the clinical and social care audit function through considering how programmes can be better aligned to the Trust's individual risks as well as taking account of national priorities. For example, if local serious adverse incident reviews, complaints or surveys illustrate specific,

persistent and/or local concerns, then the clinical and social care audit programme can be designed to include the monitoring of standards related to those concerns.

Board prompts

- Is the approach systematic and focused on locally identified risks as well as on national issues?
- Are the results regularly reported to the Board and used as evidence in the assurance framework?
- Does the clinical and social care audit give a comprehensive view of the quality of clinical services across the Trust's portfolio?

Roles and responsibilities in a clinical and social care audit

There is no prescriptive structure for an effective clinical and social care audit but it is likely that your organisation will have a set of governance roles and committees and a set of management/clinical functions and groupings. The role of the Board is in gaining assurance that strategic objectives are achieved and that services commissioned or provided are safe and cost effective. In respect of the clinical and social care audit (as above), Boards will want to be assured that clinical and social care audits are: material, professionally undertaken and completed, produce results that are shared and acted upon and followed by improvement.

HSC Trusts make a substantial, but often unquantified, commitment to clinical and social care audits. Over and above the costs of any central clinical and social care audit team, there is also a significant hidden cost to Trusts arising from the 'supporting professional activity sessions' within the (medical) consultant contract. These comprise a significant part of the contract and are typically used for clinical and social care audit work, continuing professional development, and additional managerial responsibilities.

The issue of cost-effectiveness is crucial in the current financial climate and the importance of the patient/client quality and safety. Clinical and social care audits do have costs, particularly in staff time. The recommendations they make may require

changes in the organisation or delivery of clinical services, training and additional capacity that will require additional costs. However this needs to be balanced against the finding that efficient and effective care can be cheaper. A clinical and social care audit can be useful in identifying processes that are inefficient or ineffective. They can lead to changes in practice that are not only cheaper but are also preventative. Boards will need to consider these factors.

A clinical and social care audit should be able to demonstrate its value in having a **direct impact on care,** rather than simply measuring care standards, if it is to be justifiable in the quality and safety agenda. Boards will need to be assured that:

- Clinical and social care audits are not just measurement activities but have a quality improvement element;
- Those conducting clinical and social care audits and making recommendations for actions do these with a view to efficiency, productivity and demonstrable impact;
- Clinical and social care audits are not simply conducted for the requirements of professional purposes (such as revalidation, professional membership etc.) but also have an equal secondary purpose of improving services;
- Clinical and social care audits involve patients and the public wherever possible and all results and recommendations are made publicly available;
- Clinical and social care audit recommendations are realistic and practical;
- There are clear timescales and plans for when the clinical and social care audit will be conducted and results acted upon – Boards can ensure action does not 'slide'; and
- Clinical and social care audit actions have led to sustained improvements and clinical practice or service delivery has not 'reverted'.

Selection of clinical and social care audit topics

The Board should have a key role in selecting clinical and social care audit topics. Many of these will be dictated by national clinical and social care audit programmes required by the Department of Health and regulators, but there should be room for the Board to determine topics that reflect the Trust's strategic priorities, concerns or gaps in independent assurance.

The Trust's audit committee (not the clinical and social care audit committee) should ensure the processes are robust to ensure the governance structures are fit for purpose. The focus is one of process rather than content but audit committees should also be looking to ensure that audits are integrated across quality, finance and resources. The line of accountability and responsibility to the Board needs to be clear. These groups do not usually have routine responsibility for clinical and social care audit committees but will focus attention on clinical and social care audit work for specific reasons.

Board prompts

- Do we have a clinical and social care audit strategy based on national and local priorities?
- Do we have a relevance test to approve commitment of resources?
- Does our focus on national clinical and social care audits mean we have no resource to advise on local priorities?
- What proportion of approved clinical and social care audits has been completed to time and budget?
- Has the Board agreed what constitutes materiality, unacceptable variation in clinical and social care audit results a) standards and b) comparisons with others?
- For all clinical and social care audits that identify unacceptable variation is there an action plan?
- Is our Board assurance framework supported by clinical and social care audit as assurance?
- Have we assurance that clinical and social care audits have led to improved service delivery?
- Do we share our clinical and social care audit results with others?
- Do our contracts with suppliers/providers require co-operation in clinical and social care audits, for example in the CQUIN regime?
- Are we using clinical and social care audits for quality assurance usage, and do they fit with our Trust's agreed quality process?
- Are areas such as mental health, primary care neglected in local clinical and social care audit programmes?

4.8 Financial stewardship

Organisations must operate with propriety and regulatory compliance in all that they do under a **statutory duty of financial control and requirement to break even.**

They must use resources efficiently, economically and effectively, ensuring value for money and quality of delivery. Achieving value for money is a core principle when using public funds and organisations must find the right balance of quality,

effectiveness and cost. This means ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed. They must have robust internal controls to safeguard public resources and be able to give timely, transparent and realistic accounts of their business to provide assurances to the public

4.8.1 Roles in HSC organisations

The Board, Chief Executive and senior management team all have a role to play in demonstrating effective financial stewardship of public funds through scrutiny and challenge. Board Members should be provided with copies of the organisation's annual report and accounts.

Board prompts

- Is procurement carried out objectively and fairly to achieve value for money?
- Are projects appraised and approved in line with guidance?
- Budget profiles and adjustments
- Do partnerships with other organisations have agreed documented arrangements in place?
- Has expenditure outside the normal delegated limits been approved by the appropriate person/body?
- Has expenditure outside the normal delegated limits been disclosed on the resource accounts?
- Do the accounts give an accurate picture of the organisation's financial position and transactions?
- Is the organisation's published financial information transparent and up to date?
- Does the organisation publish information about its plans and performance?
- Does the organisation have appropriate internal delegations?
- Is the Board provided with regular and meaningful information on costs, efficiency, quality and performance?
- Is there periodic assessment of whether decisions taken remain appropriate, including feedback from internal and external audit and elsewhere
- Are projects and policies evaluated during and after, to inform decisions about whether to continue, adjust or end the activity?
- How will lessons be learned?
- How will proposals be financed?
- Is there budget and estimate cover?

4.8.2 The role of the Chief Executive as Accounting Officer

Each NDPB or ALB must have an Accounting Officer and this is usually the most senior official in the organisation. They are accountable for the use of resources within the organisation and should ensure that the organisation operates effectively

and to a high standard of probity. They are supported in this role by the Board. The Accounting Officer must personally sign the organisation's accounts, the annual report and the governance statement.

Board Members should familiarise themselves with the obligations under managing public money – a helpful resource can be found here.

Board prompts

- Are resources being used in line with legislation and procedures?
- What are the delegated limits for the organisation?
- Are resources being used to deliver value for money?
- Are resources being used in line with the organisation's strategic aims and objectives?
- Do the governance arrangements enable decisions to be shared, delegated and implemented?
- What internal controls are in place to ensure that resources are used as intended?
- Does the organisation give timely, transparent and realistic accounts of its business, underpinning public confidence?

4.9 Information governance

The storage and use of large amounts of clinical and other sensitive data needed for effective health and care services brings a significant level of risk. The provision of effective management and good quality education and training in information governance is an important method of managing this risk. It also assists HSC organisations in meeting their statutory responsibilities and policy obligations in the areas of data protection, confidentiality, freedom of information and IT security.

Information governance is a key issue for all HSC organisations and contracting organisations and is fundamental to the effective delivery of HSC services, particularly as services move towards the introduction of an electronic health record. Without effective and trusted arrangements for handling service user-identifying

information and other sensitive data, the ability of HSC organisations in Northern Ireland to provide high-quality services could be severely compromised. An information management assurance checklist is set out in Appendix 6.

The fundamental objectives of information governance are to:

- Support high-quality care by promoting the safe, effective and appropriate use of information in Northern Ireland;
- Encourage closer working within HSC services and contracting organisations to prevent duplication of effort and enable a more efficient use of resources;
- Allow staff to discharge their responsibilities to consistently high standards, and
- Comply with legislation and professional codes of ethics by developing support arrangements and providing appropriate tools.

4.9.1 Information governance and regulation

Information governance should include the following.

General Data Protection Regulation (2016) (GDPR): EU law on data protection and privacy for all individuals within the European Union and the European Economic Area.

UK Data Protection (2018): Introduces four distinct data protection regimes into UK Data Protection Law.

GDPR and UK Data Protection 2018 relate to personal information (data). Personal data is information relating to a natural person who can be identified or who are identifiable, directly from the information, or who can be indirectly identified from that information in combination with other information.

Personal data could be something as simple as a name, address or a staff/customer number, or could be other types of identifiers such as an IP address.

It may also include special categories of personal data such as race, ethnicity, political opinions, health data, or sexual orientation.

4.9.2 Freedom of Information Act 2000

The Freedom of Information Act provides public access to information held by public authorities. It does this in two ways:

- Public authorities are obliged to publish certain information about their activities; and
- Members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland. This includes HSC ALBs and other ALBs in Northern Ireland.

Recorded information includes printed documents, computer files, letters, emails, photographs and sound or video recordings (this will include communications with and by Non-Executives on personal platforms – email, social media, written form, etc).

4.9.3 Cyber security

Cyber resilience is being able to prepare for, withstand, rapidly recover and learn from deliberate attacks or accidental events in the online world. Cyber security is a key element of being resilient, but cyber resilient people and organisations recognise that being safe online goes far beyond just technical measures.

By building an understanding of cyber risks and threats, individuals and organisations are able to take the appropriate measures to stay safe. This should include IT security, more generally. Depending on the organisation, this is likely to be a key component in the corporate risk register of a HSC ALB.

4.9.4 Principles (in relation to service user information)

The Caldicott Principles were developed in 1997 following a review of how service user information was handled across public HSC services. The review panel was chaired by Dame Fiona Caldicott and it set out six principles that organisations should follow to ensure that information that can identify a service user is protected and only used when it is appropriate to do so.

Since then, when deciding whether it needs to use information that would identify an individual, an organisation should use the principles as a test. The principles were extended to adult social care records in 2000.

The Caldicott Principles (as revised in 2013)

Principle 1. Justify the purpose(s) for using confidential information
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2 . Don't use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

In April 2013, Dame Fiona Caldicott reported on her second review of information governance. Her report Information: To Share Or Not To Share? The Information Governance Review, informally known as the Caldicott2 Review, introduced a new seventh Caldicott Principle.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

HSC professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

4.9.5 Information sharing

Information sharing is a complex, but necessary element in the provision of safe, secure and effective health and care services, but this brings with it risks and challenges.

The Department developed a protocol for sharing service user information in 2011 that should be used to support the safe management of personal information between the health and care services.

In addition, the Scottish Government recently produced a toolkit, the Information Sharing Toolkit, which may aid Board Members further in this regard and in light of the requirements of GDPR.

4.9.6 What does this mean for Board Members?

Boards have a role to play in the oversight of information governance within the ALB. Board Members must be assured that the organisation:

- Complies with the legislation; and
- Has appropriate technical and organisational measures to meet the requirements of accountability, including the annual statement of compliance.

From 2018–19 the Department has sought an annual assurance from individual chief executives in relation to their organisation's compliance with information management requirements. HSC organisations are required to maintain the best practice standards set out in this guidance document in order to be able to both provide assurance to the Department and for BSO Internal Audit purposes. BSO Internal Audit will continue to audit HSC organisations' information management compliance on a periodic basis, as is currently the case.

The DoH guidance should be used as a reference document to aid completion of the information management assurance checklist document (set out in Appendix 6) which the Chief Executive in collaboration with the organisation's senior information risk owner (SIRO) and its personal data guardian will be required to complete annually.

The organisation exercising ongoing diligence must review, and where necessary update the measures the ALB has put in place.

It is not for Board Members to do the work or manage information, but to ensure that things are done in respect of all of the above areas and that the policies, procedures and effective management are in place. Consequently, Board Members should be aware of the requirements in respect of all of these areas, without needing to have a detailed understanding.

It is expected that each ALB will have an (operational) information governance committee, together with robust policies and procedures covering all of the areas in respect of information governance. The information governance policy should have been agreed at Board level and should be regularly updated. An information governance report should be brought to the Board annually by a designated member of the executive team.

An overview of all areas of information governance will be included in the induction of all new Board Members and it is good practice to make Board Members aware of changes in legislation and strategy through development sessions and discussions at Board meetings.

The Information Commissioner's Office provides access to the legislation in respect of data protection and freedom of information and this can be used by Board Members as a helpful resource, with guides and toolkits, which will provide gain a wider understanding.

The NHS in England provides a useful Data Security and Protection Toolkit which Board Members may wish to access to assist in their understanding of the issued in respect of information governance.

The Department of Health has issued amended guidance[44] which sets out the expectations for organisation in assuring the Department that:

- They have an information governance management framework in place which is supported by policies, strategies and improvement plans;

44 Appendix 7.

- Mandatory information governance awareness and training procedures are in place and staff are appropriately trained;
- Information governance is supported by adequate information quality and records management skills, knowledge and experience;
- The SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy; and
- Documented and agreed procedures are in place to ensure compliance with the requirements of GDPR.

4.10 Professional regulation and standards

4.10.1 Professional regulation

Staff in specific clinical and social care posts should be registered with a relevant professional regulatory body, as a requirement of their appointment to HSC organisations, as set out in section 4.10.3 below.

Under current statutory healthcare regulation, there are 32 regulated occupations ranging from doctors, dentists and nurses to pharmacists, opticians and osteopaths. To work in any of these 32 professions, professionals must be registered with the appropriate regulator both at the time of appointment and on a continuous basis throughout their time of employment in HSC organisations. The Government is responsible for deciding which occupations are regulated. It is recognised that there are other posts for which registration is voluntary or where the professions are working towards statutory registration, as set out in section 4.10.4 below.

Regulatory bodies have three principle aims:

- Protecting the public;
- Maintaining public confidence in the profession; and/or
- Declaring and upholding professional standards.

Regulation is simply a way to make sure that healthcare professionals are safe to practise and remain so throughout their career, but it is far from simple itself. Regulation is designed to protect the population by limiting the risks that may be

faced when receiving treatment. In UK healthcare, regulation does not just apply to people but also touches many areas, from hospitals to equipment to medicines.

Individual registrants must meet minimum training requirements, pay a registration fee, submit evidence of continuous professional development and subscribe to a defined code of conduct. Individual registrants can be referred to their relevant professional registrant body where issues of professional standards or behaviour are at issue.

The individual regulators have four main functions to ensure that those they register are fit to treat us. They do this by:

- Setting standards of competence and conduct which health and care professionals must meet in order to register and practise, this includes updating and/or producing new guidance (for example, 10 years ago professional behaviour on social media would not have been something regulators would need to cover);
- Checking the quality of education and training courses to make sure they give students the skills and knowledge to practise safely and competently;
- Maintaining a register of professionals which everyone (including the public) can search, but also making sure that the professionals on their registers remain fit to practise. After all a doctor or dentist could pass their exams, start practising and never look at another textbook again. However, regulators are there to make sure that this does not happen. They have various systems in place to gather evidence that their registrants continue to develop professionally and keep up-to-date with developments in their chosen field; and
- Investigate complaints about people on their register and decide if they should be:
    - Allowed to continue to practise (also known as being fit to practise);
    - Allowed to continue to practise but with conditions on how they should work (for example, attending a training course);
    - Suspended from practising; or

- Struck off the register (also known as ‘erasure’), either because of problems with their conduct or their competence.

This process is commonly known as fitness to practise.

In addition to these functions, some regulators will have other responsibilities. For example, the General Pharmaceutical Council also registers and inspects pharmacies.

4.10.2 The Professional Standards Authority

The **Professional Standards Authority for Health and Social Care** (**PSA**) oversees the nine statutory bodies that regulate health professionals in the United Kingdom and social care in England. Where occupations are not subject to statutory regulation, it sets standards for those organisations that hold voluntary registers and accredits those that meet them.

Until 30 November 2012 it was known as the Council for Healthcare Regulatory Excellence. It is an independent body, which is accountable to the Parliament of the United Kingdom. It assesses the performance of each regulator, conducts audits, scrutinises their decisions and reports to Parliament. It seeks to achieve balance in the oversight of regulation through the application of the concept of right-touch regulation.

4.10.3 Oversight of statutory regulators

The PSA covers the nine statutory bodies that regulate health professionals in the UK and social workers in England:

General Chiropractic Council

General Dental Council

General Medical Council

General Optical Council

General Osteopathic Council

Health and Care Professions Council

Nursing and Midwifery Council
Pharmaceutical Society of Northern Ireland
General Pharmaceutical Council

There are similarities and differences but all have the same basic core functions and they are all directly accountable to the Parliaments and Assemblies that hold their legislation. However, the number of registrants each regulator is responsible for varies greatly. For example, the Nursing and Midwifery Council has the largest register with over 690,000 nurses and midwives, whilst the Pharmaceutical Society of Northern Ireland registers 2,470 pharmacists and 548 pharmacies.

Some regulators like the General Chiropractic Council regulate one profession each, whilst the Health and Care Professions Council registers 16 different professions. There are also differences between regulators in their registration fees and fitness to practise processes. Meanwhile, the General Optical Council is the only regulator to register students. These are just a few of the differences. Many differences between regulators are caused by their disjointed legislation, whilst others may be rooted in the different environments in which the professionals work.

4.10.4 Voluntarily accredited associations

In addition several organisations offer a voluntary accredited scheme for practitioners:
Alliance of Private Sector Practitioners (foot health)
Association of Child Psychotherapists
British Acupuncture Council
British Association for Counselling and Psychotherapy
British Association of Sport Rehabilitators and Trainers
British Psychoanalytic Council
Complementary and Natural Healthcare Council
COSCA (Counselling & Psychotherapy in Scotland)
Federation of Holistic Therapists
National Counselling Society
National Hypnotherapy Society

Play Therapy UK

Society of Homeopaths

UK Public Health Register

United Kingdom Council for Psychotherapy

JCCP Practitioner Register

SECTION 4: (c) Culture

4.11 Openness and candour

4.12 Raising concerns

4.13 Internal and external engagement

4.11 Openness and candour

In his Inquiry into Hyponatraemia Related Deaths (IHRD), alongside recommendations focusing on specific clinical practices, Judge O'Hara made recommendations concerning openness and candour. This included a recommendation for legal duty of candour, for HSC organisations and staff, as well as support and protections to enable staff to fulfil that duty. In addition, Justice O'Hara recommended that HSC Trusts should appoint and train Executive Directors with specific responsibility for issues of candour.

Work is underway to introduce the necessary legislation and policies to implement these recommendations. Once they have been implemented, this section of the HSC Board Member Handbook will be updated to provide specific guidance about the legal duty of candour for HSC Boards and Executive Directors.

In the interim, HSC Trusts have put in place policies for openness so that service users, carers, families and staff can have a clear understanding of the standards expected; examples of these are given in Appendix 12.

4.12 Raising concerns

The safety of service users is the concern of everyone working in HSC services and accordingly it must be the duty of everyone to raise patient safety concerns.

However, because it has been found necessary to encourage whistleblowers, the Department has directed that HSC Trusts develop policies enabling staff to raise concerns about questionable practice.

The RQIA issued guidance for whistleblowers and published its Review of the Operation of Health and Social Care Whistleblowing Arrangements in September 2016.

It made 11 recommendations, seven of which the Department maintains "are either fully implemented or on target to be implemented" as at November 2017. This

impetus should be maintained. In every hospital there should be real or virtual individuals to whom concerns can be taken easily and without formality. There should be training and the system should be as responsive as possible.

4.13 Internal and external engagement

4.13.1 Building strong partnerships and engagement

An effective Board will have direct interactions with the organisation's staff, service users and carers as well as with the wider public and key stakeholders such as community and patient representatives, 3rd sector, regulators and the media etc.

Engagement should be routine and the feedback gathered systematically collected and analysed to actively inform the Board's priorities. The Board must demonstrate how it has used this feedback in its decision-making and resource allocation.

HSC organisations have a legislative requirement, as set out in the Health and Social Services (Reform) Northern Ireland Act 2009, to actively and effectively involve service users, carers and the public in HSC services. This is known as personal and public involvement, or PPI (see section 4.14).

Like the engagement itself, the benefits should go both ways. Engaging effectively allows the Board to demonstrate that it is being open, transparent and accountable. Listening to the voices and opinions of others ensures that the Board is putting the user experience at centre stage. Effective engagement should also provide a sense of empowerment and can help shape organisational change as well as drive cultural change. Staff and service professionals are a key element of this and they should be involved in the development of the organisation's strategy that they will be asked to deliver on.

4.13.2 Engagement strategy

The Board should develop an engagement strategy that sets out how and why the organisation intends to engage with staff, service users and carers, community, patient reps, regulators, academics, media, 3rd sector, faith sector etc. The Board

will need to consider how effective the engagement strategy has been and actively seek both qualitative and quantitative feedback.

The Public Health Agency has developed the Engage website as a central resource for involvement in HSC in Northern Ireland. It has a range of resources and tools to support HSC in involving service users, carers and the public. Check out Engage here. Whilst Engage focuses primarily on HSC organisations' responsibilities under the PPI legislation, the resources are useful in developing all forms of engagement.

4.13.3 Effective partnership working

The public sector is a complicated landscape with boundaries that are occasionally blurred and often a source of tension. The system works most effectively when all stakeholders have a shared vision including outcomes and agreement on how they will work together within the system while respecting individual organisational interests and constraints. This can only happen when organisations develop good relationships with regular and ongoing communication.

The basis of any good working relationship is information sharing and a shared sense of purpose but organisations may want to co-ordinate activities through a more formal partnership agreement. Issues to consider include:

- Formulating strategy;
- Ensuring accountability;
- Shaping culture;
- Transparency, particularly around decision-making;
- Outcomes and performance indicators; and
- Service user perspectives.

SECTION 4: (d) Involvement, co-production and partnership

4.14 Duty to involve and consult

4.14.1 Statutory duty to involve and consult

HSC organisations have a statutory duty to involve the public and consult them in relation to their health and social care. PPI is the term used to describe the concept of involving ordinary people and local communities in the planning, commissioning, delivery and evaluation of the HSC services they receive. PPI was first introduced as a concept by the Department in 2007 and it is a central component of the quality agenda.

More recently, there has been an increased focus on embedding a co-production approach to support transformational change and promote the opportunity for all service users and carers to partner with HSC staff in improving health and social care outcomes.

The statutory duty to involve and consult (Sections 19–20 of the Health and Social Care (Reform) Act (2009)) set out a requirement for health and social care to involve and consult service users and their carer's on matters relating to:

- The planning of the provision care;
- The development and consideration of proposals for changes in the way that care is provided; and
- Decisions to be made by that body affecting the provision of that care.

This means that all Board Members are accountable in relation to ensuring that the necessary steps have been taken to involve and consult service users and carers in all major decisions regarding the planning, development and delivery of HSC services.

4.14.2 What is involvement and why is it important?

People have a right to be involved in and consulted on decisions that affect their health and social care. We know that when people are meaningfully involved in decision-making about their health and social well-being, this leads to improved quality, safety, effectiveness and efficiency. Involvement can:

- Ensure responsive and appropriate services;
- Reduce perceived power imbalances;
- Contributes to tackling health inequalities;
- Reduce complaints;
- Reduce adverse incidents;
- Acknowledge rights;
- Increase levels of accountability; and
- Improve dignity and self-worth.

4.14.3 What are the key roles and responsibilities of HSC organisations?

The 2012 DoH policy circular sets out further 'Guidance for HSC organisations on arrangements for implementing effective personal and public involvement in the HSC'. The key roles and responsibilities for each HSC organisation are set out in within the guidance.

All relevant HSC organisations must also have a consultation scheme in place to make it clear how the organisation will involve and consult the Patient Client Council, service users and carers.

4.14.4 Role of the Board in involvement

In 2015, a set of standards for HSC organisations and staff in relation to personal and public involvement were developed and endorsed by the DoH. The five standards set out what is expected from HSC organisations, staff and Boards in relation to involvement:

1. Leadership – HSC organisations will have in place clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.
2. Governance – HSC organisations will have in place clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

3. Opportunities and support for involvement – HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.
4. Knowledge and skills – HSC organisations will provide PPI awareness-raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.
5. Measuring outcomes – HSC organisations will measure the impact and evaluate outcomes.

The Board is required to ensure that all major decisions relating to the planning, development and delivery of HSC services is undertaken with service users and carers. Boards must ensure there is evidence to demonstrate that service users and carers have been meaningfully involved before any major decision is taken.

Alongside organisational governance arrangements, Boards should specifically consider their responsibility in line with the standards for involvement:

Board prompts

- Have in place a named Executive and Non-Executive PPI at Board level with clear role descriptions and objectives in place.
- Ensure that there are appropriate governance and corporate reporting structures in place for involvement.
- Consider how the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Evidence awareness of targets in place for staff training and ensure a mechanism is in place to capture the uptake of PPI training.
- Consider what evidence is available to determine how service users and carers have been involved in all major decisions in relation to planning, developing and implementing services. Approve involvement monitoring reports for submission to PHA for assessment.

Involvement information and guides

The Engage website is the central resource for involvement in HSC and provides further information in relation to guides for involvement, involvement tools and training.

Board prompts

- How does the Board ensure that the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Is there evidence that service users and carers have been involved in all major decisions in relation to planning, implementation and evaluation of services?

4.15 Co-production and partnership working

The Bengoa Report, Systems not Structures[45] and Health and Well-being 2026: Delivering Together[46] placed an increased focus on partnership working and co-production. Delivering Together states:

> *"We must work in partnership – patients, service users, families, staff and politicians – in doing so we can coproduce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system."*

There has been an increased focus on advancing and building on PPI to encourage a move towards co-production and partnership working. Co-production is a highly person-centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. Co-production is a genuine partnership approach which brings people together to find shared solutions. It is regarded as the pinnacle of involvement.

45 DoH, Systems not Structures: Changing Health and Social Care, 2016.
46 DoH, Health and Well-being 2026: Delivering Together, 2017.

What are the key enablers for embedding co-production?

In order to progress the vision set out by Bengoa and within Delivering Together, the DoH published the Co-Production Guide for Northern Ireland – Connecting and Realising Value Through People. Adopting a co-productive approach is at the heart of improving people's experience of care. Co-production, done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

Six principles have been developed to enable the implementation of co-production across all HSC organisations. By working to embed a co-production approach, people will be active participants in co-design and co-delivery of services with measurable and objective improvement in people and staff experience, care outcomes and evidence of increased productivity across all services.

For co-production to be successful it requires Boards to lead and have co-production embedded in the organisation's core business and its culture. Roles and responsibilities for Boards and Executives have been set out against the six principles which are found in the Co-production Guide.

Board prompts

- How does the Board **value people** in creating the strategic and organisational conditions to enhance the role and contribution of people in the planning, development, delivery and evaluation of all the organisations activities and services? This involves leading from the front and valuing people's contribution by progressively sharing decision-making and promoting co-design and co-delivery.
- How is the Board **building representative networks** across all programmes of care? This includes investing time and resources in building relationships with local communities and groups of people who use services. It also involves investing in peer support, expert patient services and progressively creating self-managing teams who are empowered to co-produce with those who use services.

- Does the Board ensure **reciprocal recognition** by ring-fencing funding to enable the development of co-production across the organisation? This includes establishing systems that reward and recognise the contributions people make. It also involves learning from the experience of people who use services and staff who provide care by formally recognising how their contribution has changed the delivery of services.
- Is the Board working to strengthen **cross boundary working** to reach out and invest in multi-agency and community sector partnership to deliver better outcomes?
- Is the Board **enabling and facilitating** change in organisational culture which embeds co-production at the heart of the organisation's strategic planning processes. This involves leaders providing oversight and enabling all those involved in service planning, development and improvement to reflect the principles of co-production in their practice.
- How does the Board ensure that the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Is there evidence that service users and carers have been involved in all major decisions in relation to planning, implementation and evaluation of services?
- Consider if the appropriate mechanisms are in place in the organisation, to oversee the development of involvement, co-production and partnership approaches in the organisation.

4.16 Independent advocacy and the role of the Patient and Client Council

The **Patient and Client Council (PCC)** is responsible for delivering and/or providing access to advocacy and support services as specified by the Department of Health directive and HSCB guidance in supporting families to engage with the revised serious adverse incident processes through a 'hub and spoke' model of service delivery working with other providers of advocacy services. Other independent services will be identified and accessed as required through the PCC,

including the development of a network of available advisory services. Such advocacy services must meet the principles of:

- Independence;
- Confidentiality;
- Person and family led;
- Empowerment;
- Equality and diversity;
- Accessibility;
- Accountability;
- Safeguarding; and
- Supporting advocates.

HSC Trusts are responsible for ensuring that individuals and families are informed at the earliest practicable point of serious adverse events having taken place and for ensuring that they are engaged in setting out the terms of reference for subsequent reviews. As well as the allocation of a Trust liaison office, Trusts must ensure that families are directed to the PCC for independent sources of support and advocacy, including when expert advice is required in complex cases.

4.17 Shared decision-making

What is shared decision-making?

Shared decision-making is a practice in which a person receiving care and a person providing care work jointly to make decisions.

It brings together the expertise and experience of both, enabling each to understand what is important when choosing a course of action. By working together, we make the best treatment and care decisions for each individual.

There are a number of enablers for shared decision-making which include:

- A supportive organisational culture;
- Sharing examples of good practice;
- Communication in plain English and in different formats;
- Professional humility;

- Patient advocacy;
- A culture of learning; and
- Training programmes for professionals, patients and service users and their carers.

Fundamentally, shared decision-making begins and continues as a conversation between two people – a health or social care professional and a patient or service user.

HSC Board Member Handbook

SECTION 5: Case studies

This section is intended to assist HSC Board Members to undertake their role with confidence and rigour. Following on from the information in previous sections, where aspects of governance and assurance have been set out in detail, the case examples given are a useful means of testing and rehearsing the skills of scrutiny and challenge. Each case is based on real experience, changed only sufficiently to ensure anonymity.

Consider each case from the perspective of the timeframes and prioritisation to ensure you are focusing on the right issues at the right time, whether immediate, short term, medium term or long term.

For the information that you have been briefed on, ask:

- What information is relevant?
- What is unnecessary detail and extraneous to your understanding of the issues?
- What information is missing?

Consider perspectives such as:

- Patients/**service users**/carers/families (immediate impact and quality and safety and aftermath of any incidents);
- **Staff**/trade union (including agency/locum staff and staff employed by organisations commissioned to provide services by the Trust – issues may be welfare of staff but also whether or not staff or trained and adhere to standards and regulatory registration issues);
- **Notification** requirements (DoH – early alert, Coroner – death, professional regulators, PSNI, HSE, other regulatory/oversight bodies, for example nuclear);
- Implications for **governance** (internal oversight and accountability and external oversight and accountability of HSC body);
- Financial/**resources;**
- Service **continuity** risk (capacity, viability, waiting lists and waiting times);
- **Reputation** of the organisation; and

- **Openness** and candour.

There are some issues which should be considered when **serious harm** has been suspected or caused.

- What **support** has been put in place for the patient/service user/carer/family including advice and counselling?
- What **support** has been put in place for staff?
- Have service user and families been **engaged** and being given a full and **honest information** about the incident?
- If external agencies are involved – have they been **notified** with **a full and honest explanation of what has happened**? The Board should ask to see copies of notifications to other agencies and also detail of what family has been told – this could be routine as part of the evidence they ask for in Board papers.
- Who in the executive team is the point person (below the Chief Executive) for **overseeing Trusts response** and **updating the Board?**
- For a **serious adverse incident** – has this been properly scoped out and is resourced?

A series of questions is posed after each short case scenario, in most cases asking for what further information is required and the type of questions that could be asked to fulfil the individual responsibilities of HSC Board Members. A number of cases have been included which do not include these questions or prompts. These may be used to further test the skills of scrutiny and challenge.

5.1 Case studies for HSC Board Members

Case study 1. Ensuring an effective clinical and social care governance system – triangulating information

You sit on the Board of a busy HSC Trust responsible for providing a wide range of HSC services. On a regular basis you are provided with a range of performance and governance reports that are presented at the public Board meetings. All reports indicate that things are going well and the executive team is content that all principal risks are being managed. Recently however you/your family member attended for services at the Trust where you were surprised to find that the service was understaffed, morale was low, the service was chaotic and leaderless and you/your relative was dissatisfied with the services you received and observed. Since then you have asked other service users and staff of their experience and hear a similar story. You do not know how to reconcile your direct experience from the assurances on safety and performance that you receive on the Board.

You are wondering how to reconcile your direct experiences with the reports from the Board.

Case study links with:

Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.3 Quality improvement and measurement

What questions do you need to ask?

- How robust are the control measures identified in the Board assurance framework/corporate risk register? Do we have adequate independent assurance that the controls are effective? Is the assurance proportionate to the level of risk?
- How are our risk registers populated? Is there a bottom-up/top-down approach?

- What are our leadership walk-rounds telling us? Can we improve the process?
- Are we engaging with service users? And how do we know the engagement with service users is effective?
- Are we always open when things go wrong?
- Do we have a culture that enables our service users and staff to raise concerns?
- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How do we know if improvement in practice has been embedded?
- Do we, the Trust Board, get the right information in relation to adverse incident trends and themes?
- Do we get the right information in relation to SAIs?

What information do you need to have?

- External reports, for example Royal College reports, RQIA reports.
- Independent assurance information (related internal audit reports).
- Quality improvement information including any dashboards for the area; not high-level directorate data.
- Real time data collection, for example almanac heat maps.
- Clinical audit data.
- Risk registers for the area.
- Customer feedback and patient experience information, for example 10,000 voices.
- Complaints and compliments, themes and trends.
- Clinical outcomes data, for example morbidity and mortality.
- Adverse incident data including serious adverse incidents.
- Legal services data including professional or clinical negligence and employers and occupiers liability claims themes and trends.
- Recruitment and retention data.
- Staff absence information.
- Staff survey.

- Related human resource data, for example any trends in bullying and harassment cases.

Case study 2. Systemic failure – patient recall

The Trust has received a complaint from a GP about a 10 year-old girl with congenital phenylketonuria (PKU). People with PKU can't break down the amino acid phenylalanine, which then builds up in the blood and brain. This can lead to brain damage. The patient was diagnosed at five days old and has been on a low-protein diet that completely avoids high-protein foods and has regular monthly blood tests. Despite this regular monitoring that has indicated that all is well, the girl's behaviour has become difficult and school has been reporting a deterioration in her attainment. On reviewing her blood results from the lab the GP has noticed that her results have been **exactly** the same for the last six months, where there would previously have been a little variation but within the normal range. He had asked the lab to check this and has now received information that the last six months' results may have been incorrect. The GP has also stated that he is concerned about patients with PKU whose blood results were also 'normal', particularly a young woman who is pregnant.

The Trust has started to investigate how this might have happened and are planning to recall a number of patients with PKU whose blood tests were also analysed in the same lab.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 3.2.4 Being an effective Board Member
Section 4.5 SAIs (sections 4.5.1 to 4.5.3),
Never events (section 4.5.5)

Early alerts (section 4.5.9)

Lookback processes including patient recall (section 4.5.11)

Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Can we be assured that immediate steps have been taken to prevent any further harm?
- Has a risk assessment of the situation been carried out?
- What is the level of harm to patients?
- How many patients could this potentially impact?
- Does this affect any other Trusts or healthcare providers?
- Has an early alert been submitted?
- Does this constitute an SAI?
- Have we informed the potentially affected patients?
- What is our communication plan?
- How can you reassure service users and the public that the services provided by the Trust are safe?
- Has the laboratory undertaken a recent UKAS accreditation process and were there any significant findings?

What information do you need to have?

- Level of harm/potential harm to patients.
- Numbers of patients potentially affected.

Case study 3. Systemic failure leading to an avoidable SAI-related death[47]

A 54 year-old female patient was admitted for investigation of heart disease. The patient was first on the afternoon list for cardiac angiography. The catheter was successfully placed through the blood vessels into the heart under X-ray guidance. A small amount of dye/contrast medium was injected through the catheter into her

47 This case study is based on Norfolk and Norwich Health Care Trust, which was prosecuted in May 1996 for breaches of health and safety legislation. The judge found that the Trust did not have safe systems of work and the Trust was fined £38,000 plus £17,000 costs.

heart. Moments after the dye was injected into her veins she collapsed and despite attempts to resuscitate her she died. The post-mortem confirmed that she had suffered a fatal air embolism.

The incident was reported as an SAI and the incident team discovered that at the end of the morning session a radiographer commenced a procedure and fitted an uncharged automated syringe, however the procedure was then cancelled. The empty syringe was left in the machine. A different radiographer was allocated for the afternoon list and had made an assumption that the syringe had been charged and had injected air into her heart instead of contrast medium.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3, and 4.5.6.
- Can be we assured that we have systems in place now to prevent recurrence?
- Was it reported as a never event? Has an early alert been submitted?
- What external agencies will be involved, for example Coroner, PSNI, HSENI, RQIA?
- Have we involved the family?
- Are we supporting the staff?
- Are there guidelines in place to prevent this? Were they audited?

- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Never event trend data (local and national).
- Quality improvement data, if applicable.
- Any relevant audits of practice in the clinical area.
- Safety culture data of the clinical area.

Case study 4. Avoidable SAI and systemic failure – retention of a guide wire[48]

A severely ill patient was admitted to the coronary care unit where their condition deteriorated rapidly. The doctor needed to administer emergency drugs by intravenous infusion. Accessing the patient's veins was difficult so the doctor inserted an emergency central line through a vein in the patient's leg using a technique that required a guide wire. The doctor was under pressure due to the patient's condition and wanted to check immediately that the sheath was in the femoral vein, so they quickly aspirated blood and then flushed the sheath ready for use – forgetting to remove the guide wire. The flush pushed the guide wire into the patient's vein and it travelled around their body and lodged near their heart.

The fact that the guide wire had been retained was not noticed until three weeks later when the patient was transferred for heart surgery. The guide wire was removed successfully by a specialist team after two attempts.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.

48 For learning and key contributory factors see, NHS Improvement Surgical Never Events Learning from 38 cases occurring in English hospitals between April 2016 and March 2017, 12 September 2018 accessed via https://improvement.nhs.uk

Section 4.11 Openness and candour

Section 3.2.12 Scrutiny and challenge

Section 4.5.1 SAIs

Section 4.5.5 Never events

Section 4.5.9 Early alerts

What questions do you need to ask?

- How do we prevent this happening again?
- Have the patient/family been informed that it is an SAI and a never event?
- How are we engaging with the patient?
- Have we implemented the World Health Organization (WHO) surgical safety checklist and the five steps to safer surgery? Have we audited compliance?
- Is this an isolated incident for the individual or team?

What information do you need to have?

- Quality improvement data, i.e. WHO surgical safety data
- Trends for never events for retained objects (Trust and national data).

Case study 5. SAI and systemic failure – wrong site surgery

A 47 year-old patient is admitted to have a lymph node removed in her armpit, as part of her treatment for breast cancer. Surgery was performed on the wrong side. The incident was reported as an SAI. The investigation showed the following sequence of events.

The surgeon wrote down the wrong side for the procedure during a busy multidisciplinary team meeting when the laboratory results for both sides were discussed.

The surgeon's notes, including the error, were typed up by the administrator, put in the medical notes and fed into the operating list schedule.

The patient had a benign lump on the opposite side to where surgery was intended. When the patient was examined before the procedure, the surgeon followed what was written in the patient's notes and felt a lump in the 'wrong' side.

The WHO safe surgery checklist was undertaken pre-procedure but the imaging and histology results were not reviewed; only the patient's records were considered.

The error was found when the results of the test on the node removed came back as 'benign'.

The patient was readmitted and the correct procedure undertaken.

The patient makes a formal complaint when she is discharged from the hospital and is informed that the incident is being investigated as an SAI. She had not been informed that this was the case.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.7 Management of HSC complaints
Section 4.5.5 Never events
Section 4.5.9 Early alerts

What questions do you need to ask?

- Consider the generic Broad prompts as per sections above.
- How do we prevent this happening again?
- Has the patient now been informed that it is an SAI and a never event?
- How are we engaging with the patient?

- Have we audited the WHO surgical safety checklist and the five steps to safer surgery following dissemination?
- What is the safety culture of the clinical area?
- Is this an isolated incident for the individual or team?

What information do you need to have?

- Quality improvement data, i.e. WHO surgical safety data.
- Trends for wrong site surgery (Trust and national data).

Case study 6. Avoidable mental health inpatient suicide

Your Board has been presented with a learning report from an SAI on a young man who took his life shortly after admission to one of the Trust mental health in-patient facilities. The report identifies a known ligature point as one of the issues that could have prevented his death and sets out what now needs to be done to prevent further deaths in such a way.

No others learning points are identified in the report.

You are wondering what other learning could have been identified?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.9 Early alerts
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.3 and 4.5.6.
- Can be we assured that we have systems in place now to prevent recurrence? Not just about ligature points but for the identification of individuals known to be at risk?

- Have we involved the family?
- What level of support and engagement are we offering to the family?
- What feedback has there been from the family?
- Are we supporting the staff?
- Are there guidelines in place to prevent this? Were they audited?
- Are there any trends we should be aware of locally (Trust level) or regionally?

What information do you need to have?

- Never event trend data (local and national).
- Quality improvement data, if applicable.
- Any relevant audits of practice in the clinical area.
- Safety culture data of the clinical situation.
- Feedback on experience from families.

Case study 7. Risk assessment of a service reduction/saving proposal

The Trust has a requirement to make a 2% savings in the current financial year for which the executive team has presented a paper for the reduction in domiciliary care services – both those directly provided and those commissioned by the Trust. The proposal has focused on the financial aspects of the service reduction but not the impact on the individuals affected and the unintended consequences of a reduction of service.

You are wondering how to get assurance that these aspects of risk and service user experience have been considered in the proposal.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.13 Internal and external engagement

Section 4.7 Risk management and effective controls

Section 4.3 Quality improvement and measurement

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Have we undertaken an equality impact assessment?
- Have we undertaken required levels of public consultation/stakeholder surveys?
- Can be we assured that we have undertaken risk assessments on patient and client safety? Is the risk adequately described in the Board assurance framework/corporate risk register?
- Have we listened to staff?
- What systems are in place now to prevent recurrence? Not just about ligature points but for the identification of individuals known to be at risk?

What information do you need to have?

- Business proposals including comprehensive risk assessment including patient/client safety risk assessment.
- Equality impact assessment.
- Risk registers.

Case study 8. Performance issues – governance issues on the management of a waiting list and unexplained reduction

Your Trust has been rocked by revelations in the press of a waiting times scandal. It turns out that Trust staff have been offering treatment at hospitals in the Republic of Ireland to patients on its waiting lists at short notice, recording patients as unavailable if they could not travel (no means of transport or other support were offered to patients before or after treatment).

You were aware that Board reports had indicated that the number of patients on the waiting list had reduced quite significantly in the last year (by 2,000 patients) but it

now turns out that this innovative (and technically legal) method was responsible for the successful outcomes.

It is now evident that there has also been a widespread culture of staff bullying (linked to the pressure to deliver on these targets) over the past six years or so and the Trust is in turmoil.

The Chair has stated publicly that the Board was completely unaware of both the waiting times 'scandal' and the culture of staff bullying.

You are wondering whether and how this could have been prevented?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.8 Financial stewardship
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Has a full investigation been undertaken to establish facts?
- How can we be assured that we have been given candid and accurate performance data in the monthly Board reports? What has the performance reports shown, how is the data presented and could the data be presented better in the future?
- What does our Board assurance framework/principal risk document and corporate risk register say?
- Have we listened to staff? Have we any data from staff surveys?
- Have we completed all the appropriate notification reports, for example has an early alert been completed?

What information do you need to have?

- Service user surveys.

- Staff surveys.
- Complaints data.
- Corporate and directorate risk registers.

Case study 9. Complaints from service users – internal reports versus media coverage

At a recent Board meeting you were presented with a complaints report which showed a low level of reporting and no particular areas of concern. However later at the same meeting the Board received a report on recent media coverage where the Trust was criticised for the placement of older people in same sex wards and for the placement of children and young people in adult wards. The media coverage included direct reports from several patients and their families who stated that they had complained to the Trust but hadn't received a satisfactory response and that they were considering approaching the RQIA and Patient and Client Council to assist them.

You are now concerned that there are opportunities missed in the complaints report to the Board.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.5.7 Management of HSC complaints
Section 4.1 Duty of quality and role of RQIA (section 4.1 and 4.1.1)
Section 4.5 Serious adverse incidents and near miss reporting
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompt questions as per sections above.
- What have service user and staff surveys told us about the clinical area?

What information do you need?

- Any recent thematic reviews by regulators, for example RQIA.
- Service user surveys, for example 10,000 voices campaign.
- Patient safety and quality improvement data including dashboard.
- Risk registers at directorate level.
- Adverse incident reporting data.
- Staff surveys.
- Whistleblowing or raising concerns data.
- Leadership walk-round data.

Case study 10. Whistleblowing by staff

Your Board has a new and inexperienced Chair and a strong Chief Executive. A senior member of staff has highlighted to you that there is significant and serious bullying taking place by the Chief Executive.

You understand that a union-led staff survey is very critical of a bullying culture and that this is being picked up by the press. You have asked for this to be brought to a Board meeting, but this has been refused by the Chief Executive on the grounds that this is an operational matter and not for the Board.

After some discussion the Chair agrees with the Chief Executive, and the staff concerns are not shared with the Board, but many of the concerns are subsequently highlighted by the press.

You and other Board Members ask that this be brought to the Board as a significant and urgent issue, but this is declined. You are now aware that this issue is having a detrimental effect on individual staff and on the performance of the organisation.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.7 Risk management and effective controls

Section 4.7.5 Internal controls – Board assurance framework

What questions do you need to ask?

- How should you deal with this? What options are open to you?
- What are the risks associated with this?
- How would you know when and how to escalate such an issue?
- Where would you get your assurances and evidence and who would you involve?
- What are the outcomes you would wish to see and require from doing something about this?
- How would you determine what is operational and what is open to a Board discussion?
- Who would you aim to protect and how would you ensure this happened?
- What part would effective governance play in resolving this and avoiding any recurrence this in the future?

What information do you need to have?

- Staff surveys.
- Report on issues raised under the organisation's raising concerns or whistleblowing policy.

Case study 11. Concerns about a lone practitioner

Your Board has recently received a report from the Medical Director in respect of the multidisciplinary working of the specialty teams across the Trust and how this safeguards individual practice and improves the diagnoses and treatment of patients. However you also note that there are a number of lone consultant practitioners who are not linked to a relevant team. You are concerned about how

such individuals are able to meet professional standards in light of the experience in your own and other Trusts where such individuals have been practising outside their field of expertise/competency and which has led to large scale reassessments of patients.

At the same Board meeting you have also received a report on an individual (also a lone practitioner) who has been suspended while a review of outcomes for his patient group is undertaken following concerns being raised by another consultant in the Trust.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:
Section 4.11 Openness and candour
Section 3. Roles and responsibilities
Section 3.2.12 Scrutiny and challenge
Section 4.5.11 Lookback processes and patient recall

What questions do you need to ask?

Consider the generic Broad prompts as per the sections above.

- Has a risk assessment been undertaken in respect of lone consultant practitioners who are not aligned to a multidisciplinary team and is this reflected in the directorate or corporate risk register?
- What safeguards or control measures were being implemented in the areas to ensure safe and effective practice? Were any clinical audits undertaken?

In addition, in respect of the clinician who has been suspended the following should also be considered.

- Are there any immediate safety concerns for patients in this potential cohort and what plans are in place to address these?
- Has a risk assessment been completed to determine the size (how many potential patients), complexity and nature of harm/potential harm to patients?

- Do we have a communication plan in place (for patients who are or maybe affected by this, the media and wider public and for staff)?
- What are the business continuity plans for the service area?
- Will this incident necessitate a lookback review process?
- Is the suspension being managed within the parameters of relevant employment law guidance/professional regulation guidance, for example maintaining high professional standards/Trust HR policy and procedure?
- Are staff support mechanisms in place?
- How do we prevent this happening again?

What information do you need to have?

- Clinical coding or other outcomes data for the clinical area.
- Appraisal and revalidation data.
- Complaints and incident data for the area.
- Service user feedback for the area.
- Directorate and corporate risk register.

Case study 12. A case involving cyber security

Board Members have just been briefed about a security issue which has recently emerged.

Some months ago a senior staff member, ‘JB’, received an email telling her about an outstanding invoice. The email contained a very small, illegible thumbnail of the invoice. JB didn't think the invoice was for her but she clicked on the thumbnail to enlarge it, just to check. She didn’t recognise the invoice, but it was similar to others she had received so JB sent the email to the rest of her team to check. A few of JB's team members also clicked on the invoice. It is only six months later that the IT team discover that the email in fact contained malicious software, which was downloaded when JB and the others clicked on the thumbnail. In that time, criminals have been able to steal a large amount of valuable and sensitive information from the Trust, remaining undetected all that time.

By getting JB to click on the thumbnail, the criminals were able to cause significant damage to the organisation through stealing valuable and sensitive data. As a result, the integrity of the whole system has been compromised. Putting this right is likely to be hugely expensive. Phishing emails like this can lead to the loss of business critical information. The story was reported in the media, the organisation suffered reputational damage, and people lost confidence in its ability to protect its assets and the Information Commissioner is likely to take action.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance, and cyber security (4.9.3)
Section 4.7 Risk management and effective controls
Section 4.5.1 Serious adverse incidents and near miss reporting
Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompt questions for the sections above.
- How can we be assured that this could not happen again? Question areas from the SIRO and the data guardian for the organisation.
- What steps had the organisation taken to prevent this? What do we need to do differently?
- What is our communication plan to address the reputational damage?

What information do you need?

- Reports from the SIRO and data guardian and an action plan to prevent recurrence.

Case study 13. Information breach – personal

A 32 year-old female patient is admitted to St Elsewhere HSC Trust for routine surgery. Unfortunately she suffers an unexpected complication that will require prolonged admission for further treatment including antibiotic therapy and further surgery. The prognosis is that she will be left with permanent disability as a result of this incident.

In line with DoH guidance, the Trust reports the incident as a SAI and a team is commissioned to investigate the events using root cause analysis methodology. The team is required to report the findings of the investigation to the Trust Board and the Commissioners within a 12-week period. The lead consultant explains to the patient and her next-of-kin that the incident is being fully investigated and the patient and family agree to be involved in the review and will receive a copy of the investigative report.

The investigation team includes a senior doctor who is required to provide his clinical expertise. Towards the end of the timeframe the doctor becomes ill and will not be able to return to work and participate with the investigation. The Trust is mindful of the potential impact on the family and seek another doctor to assist.

The second doctor is given a copy of the patient's medical records and other relevant documentation including staff rotas, witness statements and policy and procedures. Given the timeframe he takes the information home to examine over the weekend. He stops at a shopping centre on the way home. When he returns to the car the driver's window has been smashed and his briefcase and mobile phone have been stolen. All of the review materials were in this briefcase. He reports the incident to the police and the Trust.

A few hours after the theft a member of the public finds the patient's records and other documentation discarded on a grass verge close to the scene of the crime. She takes the information to the local newspaper and the breach of confidentiality is reported in the press the next day. The local TV station also take-up the story and

the Trust is now required to report this as an additional SAI to the Commissioners and to the Information Governance Commissioner.

In a risk-aware organisation the potential risk of information governance breaches will be considered at service, directorate and corporate levels.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.7 Risk management and effective controls
Section 4.9 Information governance

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Have we informed the family?
- Have we informed the staff who provided witness statements?
- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has an early alert been submitted?
- Are we supporting the staff?
- Are there any control measure in place to prevent this?
- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 14. Information breach – organisational

Your HSC Trust/organisation was involved in a major reorganisation within the last three years that involved the movement of services and transfer of staff, equipment and records.

Following a social media post campaign by an 'urban guerrilla' group, photographs have been posted that show members of the group posing with confidential records which have been stored in a disused Trust building. There is a public outcry, considerable media attention and the Information Commissioner is likely to investigate the matter.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.7 Risk management and effective controls
Section 4.9 Information governance
Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has the incident been reported as an SAI?
- Has an early alert been submitted?
- What is the communication plan for potentially affected patients, service users and wider public?
- What is the communication plan for the media?

- Are there any control measure in place to prevent this, for example a decommissioning policy?
- How can we be assured that other buildings are not also vulnerable?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 15. Corporate parenting

A 12 year-old boy, with a history of violent outbursts, is admitted to a Trust children's home after his parents say they can no longer cope with his behaviour. They decided this after he assaulted one of his siblings. The family's situation had deteriorated after an arrangement to provide them with regular respite in a fostering placement broke down due to the boy's behaviour in the placement. The boy is big for his age and could pass for 15 or 16 years of age.

The Trust Board is advised that the boy attacked a 14 year-old resident of the same children's home, biting him in the face. The boy also attacked a female member of staff who came to the assistance of the 14 year-old. Other staff then restrained the 12 year-old. Subsequently, it was discovered that the 12 year-old had a fracture in a bone in his hand.

The family have alleged that the boy sustained this injury when a member of staff deliberately stood on his hand whilst restraining him. Staff believe he sustained the injury to his hand due to the ferocity of his physical attack on the female staff member whom he punched and kicked several times. The 12 year-old boy has been moved to secure care. The female staff member is absent on sick leave and two male members of staff are on precautionary suspension. Police are investigating the assault on the 14 year-old, the assault on the female staff member and the allegation that the 12 year-old was also assaulted by staff.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.6. Social care governance (corporate parenting principles and child protection)

Section 4.5.1 SAIs

What questions do you need to ask?

- Generic Board prompts for the sections above.
- How do we prevent this happening again?
- Is this an isolated incident for the individual or the team?

What information do you need?

- Trend data from the adverse incident/near miss system/complaints and legal services systems.
- Leadership walk-round data for the area.
- Service user/client data.

Case study 16. Police involvement – staff member and drugs charges

A health visitor employed by the Trust has been arrested by police investigating the sale of illegal drugs.

The police have advised that the health visitor had been retrieving unused medications from the homes of deceased clients and stockpiling them. The police suspected that some of these drugs had been sold to a local drug dealer but also suspected that some of the medications may have been sold or provided to other

Trust clients of the health visitor. The health visitor has been suspended by the Trust and police investigations are ongoing.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.4 Memorandum of Understanding
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Is this an isolated incident?
- How do we prevent this happening again?

What information do you need?

- Updates on internal investigations and related medicines governance action plans.

Case study 17. Unattended fire alarm

The Trust Board are advised of an incident involving a fire alarm going off in one of its hospitals. The alarm continued to sound for 15 minutes.

The incident occurred during visiting hours, and staff, patients and visitors all reported confusion about what to do during the time the alarm was sounding. No evacuation took place and it is reported that staff responded to the alarm by telephoning other wards, porters and management to check if this was a real alarm. The Fire and Rescue Service attended within 10 minutes. A number of staff

communicated to visitors and patients during the incident that they did not know what the Trust's evacuation plan was in the event of a real emergency.

It subsequently emerged that the alarm system had been serviced by a private contractor earlier that day and that the false alarm was as a result of a faulty sensor which had been installed that day.

In a follow-up to the incident the Fire and Rescue Service have advised that it is their assessment that the Trust's preparations and response was inadequate to protect the safety of patients or staff. The Board is now considering this report.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Is this an isolated incident to this part of the Trust?
- How do we prevent this happening again?
- Are there any other issues with this contractor or is this an isolated incident?
- Have we notified all relevant external agencies?

What information do you need?

- Report on fire safety plans and fire risk assessments for the site and other sites/hospitals within the Trust.
- Overview of fire training records.
- Business continuity plans for the site.

Case study 18. A mental health patient absconding and subsequent suicide

The report of a review of a serious adverse incident into a case where a mental health patient had absconded from a mental health unit and shortly after took his life through suicide, reports that only a minority of staff working in the unit and interviewed as part of the review had attended mandatory Trust training on suicide awareness and prevention.

The family allege that their relative had openly told them and Trust staff of his intention to 'get out and kill himself' and that the Trust had not acted on this information.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Can we be assured of compliance with mandatory training?
- Is this an isolated incident to this service area? How do we prevent this happening again?
- Are there any other issues with this contractor or is this an isolated incident?
- What other learning did the SAI review establish and have we disseminated the learning internally? Regionally?

What information do you need?

- Patient/client safety data including risk assessments.
- Clinical and social care audit data for the area and other related units, for example the Emergency Department and Acute Admission units.

- Overview of mandatory training records and any internal or external audit information on this, for example internal audit, RQIA.

Case study 19. Assault of staff in Emergency Department

A male nurse was assaulted in the Trust Emergency Department by two patients who were under the influence of alcohol. The nurse's jaw was fractured and he is now on sick leave after being admitted and treated in the hospital for his injuries. A member of the public who came to the aid of the nurse was also assaulted and suffered cuts and bruises but was able to be released home after treatment.

Staff working in the Emergency Department have complained that porters present in the department at the time of the incident did not come to the assistance of the nurse. Two other Emergency Department staff members present at the time of the assault have gone on sick absence suffering from stress following the incident.

This is the third significant assault on staff in the Emergency Department over the past two years. Trade unions have previously complained at the lack of security in the department and the slow response of police to calls from the Emergency Department when previous incidents have occurred. The two alleged perpetrators were arrested and police investigations are ongoing.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.1 Adverse incidents, and 4.5.6 Near miss reporting

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Have we listened to what staff have told us?
- Do we encourage a culture of incident reporting including near misses?

- Do we operate a zero tolerance policy?
- Are security/management of aggression risk assessments undertaken?
- Is training in the management of aggression provided commensurate with the risk assessment? Attendance rates?

What information do you need?

- Trends and themes for incidences of verbal and physical abuse including severity.
- Risk registers at directorate and corporate level.
- Oversight report on management of aggression policy, risk assessment and training.

Case study 20. Information breach and loss of data by Trust staff

The car of a Trust health visitor which was parked outside the house of a client she was visiting has been broken into. The personal records of a number of other clients have been stolen from the car along with a Trust laptop containing personal information and details of other clients.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance
Section 4.5.1 SAIs
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Have we informed the clients?
- Have we informed the staff who provided witness statements?

- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has an early alert been submitted?
- Are there any control measure in place to prevent this?
- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 21. Allegations of victimisation

A theatre nurse has complained that she is being victimised by a consultant who asked that she should not be scheduled to be in theatre whilst he is operating. He has stated that he has concerns about her professional practice. The nurse states that her problems with the consultant only began after she spoke to him one-to-one about his failure to adhere to the WHO's pre-operative checklist. She now says she has been treated unfairly and that her career and reputation is damaged by this, leading her to feel stressed.

The nurse has subsequently written to the Trust Chair as she further alleges that senior Trust staff have not investigated her concerns because the consultant involved is in a powerful position as he is critical to making certain performance targets and senior managers do not want to upset him.

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from sections as above.

- Do we have a culture where all staff can raise concerns irrespective of their grade/professional background?
- Is this an isolated incident for the nurse and the consultant?
- What is compliance with WHO check list for the area and for the consultant's cases?
- Are there any related patient safety incidents/complaints or claims in the area?

What information do you need?

- Patient/client safety data for the area both outcomes and process compliance rates.
- Staff surveys.
- Leadership walk-round data.

Case study 22. Concerns about a consultant

A nurse has raised concerns through whistleblowing about a consultant who refuses to adhere to hand cleanliness requirements during ward rounds.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Do we have a culture where all staff can raise concerns irrespective of their grade/professional background?
- Is this an isolated incident for the nurse and the consultant?
- What is compliance with WHO check list for the area and for the consultant's cases?
- Are there any related patient safety incidents/complaints or claims in the area?

- Is the alleged incident being managed in line with HR procedures for the investigation of alleged bullying and harassment?

What information do you need?

- Patient/client safety data for the area both outcomes and process compliance rates.
- Staff surveys.
- Leadership walk-round data.

Case study 23. Media concerns about confidentiality

A member of the public has approached the media to report concerns about the confidentiality of information of patients in hospital. The member of the public had been visiting a relative in hospital. The patient in the next bed was a patient who had attempted to commit suicide. During the visit the screening curtain was pulled around the bed of the attempted suicide patient and she was being to spoken to by a doctor. The visitor to the patient in the next bed was able to hear the entire conversation including the detail of the suicide attempt and the factors which led up to the suicide attempt.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Is this an isolated incident? What steps are taken to maintain privacy and dignity in ward areas?
- How can we be assured that this is not happening on a frequent basis?
- What information governance training takes place and does the training apply to all professional staff?

What information do you need to see?

- Information governance risk assessments and action plans.
- Media statement.

Case study 24. Concerns about the individual practice of a consultant gynaecologist

Concerns have been raised by colleagues about the professional practice of a consultant gynaecologist employed by the Trust for the past 12 months. An audit of the records of the diagnosis and treatment of 40 patients seen by the consultant had been undertaken and confirmed that there were concerns. This is the first time information has been shared with the Board.

During the three months of the audit the consultant was under close supervision and following the audit the consultant was now restricted from seeing patients. Consideration is being given to the need for a patient recall.

The consultant had worked in another Northern Ireland Trust for nine months immediately before joining the Trust and had worked as a locum in one other Trust for six months prior to this. The Trust Board is also advised that it they now have information that six years previously, whilst working in England as a senior registrar, concerns had also been raised about his professional practice and an investigation had taken place. The Trust has no information about the outcome of the investigation and the staff member had resigned from that position shortly afterwards.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.10 Professional regulation and standards
Section 4.7.6 Clinical and social care audit
Section 4.5.1 Management of SAIs

Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Have we completed the necessary notifications including informing the other Trusts involved? The early alert should indicate to DoH that the issue involved more than one Trust in the region and in England.
- What is the current level of harm to our patients/clients?
- Have we taken the necessary steps to prevent further harm?
- Has a service review been undertaken to assess the extant and severity of the problem?
- Do we have a Directors oversight group in place to manage the potential lookback?
- How can we be assured that our recruitment process are robust and that we don't have another issue that is undetected to date?
- How can we be assured that professional registration and revalidation requirements are robust?
- Have we any concerns with the professional registration checks by the agency?
- Are we investigating the provision of the reference in line with HR policies?

What information do you need?

- Professional report on professional registration and revalidation processes.
- Risk assessment for patient cohort and level of harm or potential level of harm.
- Communication plan for affected patients, potentially affected patients and general public.
- Media communication plan.

Case study 25. Unregistered staff

A recent investigation in a Trust in Scotland has revealed that a radiologist employed by them for the past year, with references from your Trust staff, is

unqualified and unregistered. They are currently undertaking an exercise to re-report every radiological investigation he was involved in, with early indications that there were serious errors in the reporting of complex investigations such as MRI and CT. The review team have contacted the Trust in respect of his practice with your Trust.

A scoping exercise has revealed that the radiologist was employed through a locum agency for nine months in an outlying department that had been difficult to recruit to.

You are concerned about the potential harm to Trust service users and want to understand how he could have been employed without adequate registration checks.

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.1 Adverse incidents and 4.5.6 Near miss reporting

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Can we be assured that in the short term we have mitigated the risk effectively?
- What is the level of potential harm to our patients in the paediatric wards?
- When was the risk issue added to the directorate risk register?
- Is the issue adequately covered in the directorate and corporate risk register?
- Have we escalated the risk appropriately to DoH and HSCB?
- Are we supporting staff?

What information do you need to see?

- Board assurance framework/corporate risk register with contingency plans.
- Communication plan.

Case study 26. Staffing levels and safe practice

In response to a severe shortage of nursing staff in two paediatric wards (one surgical, one medical) the Trust took steps to call in off duty staff and secure agency staff. However, this was not sufficient and as a consequence three nursing staff without a background or specific training in paediatric nursing were in place. In one of the two wards this was on a supervised basis to undertake a limited risk assessed basis. However in the second ward, it is reported that no such restrictions were applied. Concerns have been raised with the Board by a whistleblower.

The Trust is taking extensive steps to prevent recurrence, including a targeted campaign to recruit more paediatric nurses, and work to look at sickness levels on these wards and improved support and training to ward sisters on both wards.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.10 Professional regulation and standards
Section 4.5.1 Management of SAIs
Section 4.5.9 Early alerts
Section 4.7.6 Clinical and social care audit

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- What is the current level of harm to our patients/clients?
- Have we taken the necessary steps to prevent further harm?
- Has a service review been undertaken to assess the extant and severity of the problem?

- Will this require a patient recall for this Trust?
- How can we be assured that our recruitment process are robust and that we don't have another issue that is undetected to date?
- How can we be assured that professional registration and revalidation requirements are robust?
- Have we any concerns with the professional registration checks by the agency?
- Are we investigating the provision of the reference in line with HR policies?

What information do you need?

- Professional report on professional registration and revalidation processes.
- Local agency checks.
- Risk assessment for patient cohort and level of harm or potential level of harm.
- Communication plan for affected patients, potentially affected patients and general public.
- Media communication plan.

Case study 27. Letter of complaint to Board by family member

The daughter of an 84 year-old woman admitted to hospital from a nursing home suffering from dehydration has complained to the Trust that the nursing home is refusing to allow her mother to return to the home and insisting her mother be moved to another home. She has now written to every Trust Board Member about her treatment by the Trust and the nursing home.

This is the third nursing home the mother has lived in during the past 18 months. The home manager alleges that the daughter has been persistently abusive and threatening to staff in the home and has also been abusive to other residents and their relatives visiting the home. The daughter is also a client of the Trust in receipt of community mental health services.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.5.7 Management of HSC complaints

What questions do you need to ask?

- Have we established the facts for this case?
- Have we an accurate picture of the standards of care being delivered by the nursing home? RQIA reviews? Complaints data?
- How can we effectively manage a safe discharge for this patient?
- Do we have a duty of care for the daughter? What is the correct course of action for her?

Case study 28. Allegations of theft

The family of an elderly man, who, following a stroke, is in receipt of a domiciliary care package, has alleged that a watch valued at several thousand pounds has been stolen from his house.

A number of Trust staff members were in and out of the house on a regular basis including a community nurse, speech and language therapist and physiotherapist. Domiciliary care workers from a private company contracted by the Trust attend the elderly man twice a day.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.6 Safeguarding vulnerable adults

What questions do you need to ask?

- Generic Board prompts as per the sections above.

- Has it been reported to PSNI?
- Is this an isolated incident?
- How do we prevent this happening again?

Case study 29. Never event and candour

As a Non-Executive Director you hear on the news that your Trust has had a recent outbreak of *Clostridium difficile* (Cdiff) infection as a result of which two elderly patients have died.

Relatives have been interviewed on local television and radio and have said that they had a number of concerns about the cleanliness of the ward in which their relatives had been inpatients and one set of family members stated that they had complained about their mother's bed linen, call bell and bedside locker had been stained with faeces on three visits. One other family when interviewed said that they had no idea that their father was being looked after in a side room because of a potential infection and that they had not been informed that they needed to wear personal protective equipment (gowns or masks). Additionally, three families who have had a recent experience in this ward have provided information about the staff attitude in the ward, saying there was a general lack of cleanliness of the area and that they had noted that staff did not always clean their hands before coming into contact with their relatives. Two of the families had complained locally to the ward manager three months prior to the current events and had been advised to put their concerns into writing. At the time of the press statement these families had only had an acknowledgement of their complaints.

You have not had any prior notice of any of these events and at a recent Board meeting the infection prevention and control performance data for the specialty area did not indicate that there were any problems. The press statement provided by the Trust has stated that this incident has been as a result of exceptional circumstances and that there had been no previous indication that there were any problems with infection control in this area.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from the sections as above

Case study 30. Financial governance issues/conflict of interest

You are on the governing body of the Clinical Commissioning Group, or CCG. One of the hospitals in your region where the CCG makes fixed payments under a guaranteed income contract has had a series of outbreaks of infections in recent months. This has caused a significant number of affected patients to stay in the hospital for longer than expected and some patient deaths may have been linked to the infections.

Some wards have had to be closed for periods of time which, together with the need for patients affected by the infections to stay longer in hospital, has slowed the ability of the hospital to take in new patients.

Following media coverage of these events, the local MP is recommending that the public stay away from the hospital until public health regulators confirm that the risk of further outbreaks of infections has been minimised. The MP is seeking an urgent meeting with the CCG to ascertain its role in these recent events.

Meanwhile patients who had been due to attend the affected hospital are mostly being sent to a neighbouring NHS hospital where the CCG has a payment by results contract and therefore pay according to the level of activity. As well as expecting to be paid standard rates for the further patients being sent to this hospital, the Trust has said it will only take in all the additional patients if the CCG also makes a substantial special payment as recompense for the extra temporary

clinical and nursing staff and managerial time it says it will need to deal with the workload.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.7 Risk management and effective controls

What information do you need to have?

- Performance reports on Health Care Association infections.
- Patient/client safety data on Health Care Association infections, both outcomes and process measures.

Case study 31. Ambulance service – assessment process

NIAS received a 999 call for a male patient described as having chronic respiratory condition known as COPD, which, during a flare up, can cause shortness of breath and difficulty with breathing. The call was triaged as a category red call requiring an eight-minute response.

A paramedic-led ambulance was dispatched to the call arriving with the patient in three minutes, however they were not informed of the patient's chronic condition prior to arriving. The ambulance crew began to assess the patient which included obtaining a medical history. During this time asthma had been relayed as part of the medical history by the patient's wife. The paramedic began treating the patient for life-threatening asthma as they believed this was the primary cause of the patient's difficulty in breathing. They administered two doses of intra-muscular adrenaline 1:1000 and subsequently the patient developed pain in their chest. A heart tracing was obtained and it was noted that changes had occurred which indicated the patient was having a heart attack. Following admission to the Emergency Department, blood tests were performed and the results indicated that the male patient was having a heart attack. An angiogram was carried out the next day,

which showed no evidence of previous heart disease. Discussion between the receiving hospital clinical lead and the cardiology team resulted in the impression that the patient had suffered a heart attack due to the blood vessels that supply the heart going in to spasm and reducing the flow of blood to the heart secondary to the administration of adrenaline.

Case study links with:

Section 4.12 Being Open

Section 4.11 Scrutiny and Challenge

Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- What early learning have we identified that should be shared internally and with the wider HSC system?
- Has the patient now been informed that it is an adverse incident?
- How are we engaging with the patient (and their family)?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including trend analysis of incident.
- Any relevant clinical audits.

Case study 32. Ambulance service – response to a fall at a care home

NIAS received a 999 call for an elderly male who had an unwitnessed fall in the residential care home where he resided, and had sustained a facial injury. A paramedic-led crew were tasked and on arrival, the crew were met by two carers

who directed them to the patient who was in bed, alert and looking well. The initial assessment of the patient revealed he had a small graze above the left eyebrow which was not actively bleeding. The ambulance crew undertook a range of diagnostic tests and determined the patient had a fast heart rate, low blood pressure and 'skin tenting' (reduced elasticity). In addition carers advised that the patient had not taken his prescribed medications for two to three days and he had not been drinking fluids, which was supported by the fluid chart which the carers had. Based on their observations and the information provided, the paramedic suspected the patient was dehydrated.

In order to treat the suspected dehydration, the paramedic inserted a cannula in the patient's vein and administered sodium chloride solution. The crew continued to monitor the patient and his blood pressure increased slightly, although his blood pressure was still relatively low, the carers advised that this was normal.

The crew informed the patient of their intent to transport him to hospital, to which he refused. The carers informed the crew that they anticipated that the patient would refuse transport. Although having a history of dementia, the crew determined the patient to have the capacity to make the decision to refuse transport to hospital. Prior to leaving the scene, the crew provided the patient and the carers with advice which included contracting the patient's own GP the following morning for follow-up assessment. The carers contacted the patients GP later the same day which resulted in a home visit. The GP assessed the patient and noted that his condition had deteriorated significantly since the attendance of the ambulance. A further ambulance was called and the patient was transported to the Emergency Department. In the Emergency Department the patient was diagnosed with a perforated bowel, however, no surgical intervention was undertaken due to the patient's poor state of health and subsequent low likelihood of successful outcome.

Case study links with:

Section 4.12 Being Open
Section 4.11 Scrutiny and Challenge
Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Have we notified the relevant external stakeholders in line with organisational and regional policies?
- What early learning have we identified that should be shared internally and with the wider HSC system?
- How are we engaging with the patient (and their family)?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including trend analysis of nature and severity of incident.

Case study 33. Ambulance service – adult male refusing to eat

NIAS received 999 call from a care worker for an adult male refusing to eat and who was described as being weak. The call was deemed suitable for the clinical support desk (CSD) and was passed to this area, which is paramedic-led. CSD paramedics utilise a telephone triage and assessment tool called the Manchester Triage System (MTS) as a clinical guide during their telephone consultations. Within the tool, various 'cards' are used dependent upon the patient's presenting complaint. Using MTS as a guide and prompt for clinical questioning the paramedic will clear all 'red flags' in order to rule out any immediately life-threatening conditions. They then have options for either admission to the Emergency Department, referral to primary care or discharging the patient.

Initial discussion regarding the presenting complaint prompted the CSD paramedic to select the 'unwell adult' card. In the subsequent telephone triage/assessment, the caller was advised to contact the patient's GP and/or social worker. The CSD paramedic then closed the call. Later the same day a further emergency call was

received from the patient's stepfather wanting the patient assessed, as he has not been eating for four weeks. A CSD paramedic again assessed the call. During the course of the call, the patient stated that they did not want an ambulance so the CSD paramedic closed the call. The following day an emergency call was received from a care worker who had entered the patient's home to find him deceased.

Case study links with:

Section 4.12 Being Open

Section 4.11 Scrutiny and Challenge

Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Have we notified the relevant external stakeholders in line with regional policy?
- What early learning have we identified that should be shared internally and with the wider HSC system?
- How are we engaging with the patient's family?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including adverse incident trend analysis including dealing with patient consent.

Case study 34. Media coverage with complex family dynamics

The father of a severely disabled child has approached the media to allege that the Trust has failed to properly assess his son's needs and to provide an adequate care package.

The father is separated from his son's mother. The son is on the Trust child protection register and the Trust is investigating allegations of physical abuse of the boy made by the boy's mother against the father. The father only has supervised access to his son at the present time although this is not part of his complaint to the media.

Case study links with:

Section 4.11 Culture of openness and duty of candour
Section 3.9 Scrutiny and Challenge
Section 4.6.2 Social Care Governance Safe and Effective Practice
Section 4.6.6 Corporate Parenting
Section 4.6.7 Child Protection

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Are there any immediate care management issues that need to be addressed?
- Have we notified the relevant external stakeholders in line with regional policy?
- What is our media communication plan? Does it comply with relevant Data Protection Legislation and organisational information governance policies and procedures?

What information do you need to have?

- Updates on the emerging situation in respect of any child protection and/or corporate parenting issues.

Case study 35. Media allegations against social workers

A journalist has approached the Trust to state that the parents of a child on its child protection register have approached them to make allegations about named social workers in the Trust's child protection team. The family played to the journalist recordings of conversations which they had surreptitiously recorded with Trust staff including a recording of part of a child protection case conference about their child.

The family had previously made allegations on social media about members of Trust staff and had published personal details of two of these staff including the home address and telephone number of one staff member on social media. Following representations by the Trust these details were removed from the social media page and police are investigating. The family have indicated to the Trust that they intend to publish extracts of the recordings on social media. The parents have three other children who are not on the child protection register.

Case study links with:

Section 4.11 Culture of openness and duty of candour
Section 3.9 Scrutiny and Challenge
Section 4.6.2 Social Care Governance Safe and Effective Practice
Section 4.6.6 Corporate Parenting
Section 4.6.7 Child Protection

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Are there any immediate care management issues that need to be addressed?
- Have we notified the relevant external stakeholders in line with regional policy?
- What is our media communication plan?
- What is our social media policy? What are our organisational information governance policies and procedures?
- What support has been put in place for the staff members?

What information do you need to have?

- High level updates on the emerging situation in respect of any child protection and/or corporate parenting issues.

HSC Board Member Handbook

SECTION 6: Training and development

It is recognised that for ALB Board Members to meet all the requirements set out in summary in this guide considerable training and support is needed, both at the time of engagement and throughout the term of appointment. In practice this means that there are several levels of training and development that need to be addressed. These include but are not limited to:

- Induction;
- Appraisal and identification of individual learning needs;
- Training in core functions, leadership, statutory functions etc.;
- Support and mentorship.

6.1 Induction training

6.1.1 For all ALB Board Members

As a minimum it is expected that a structured checklist of induction materials, resources and training such as the 'On Board' training is used. These include but are not limited to the following.

- Following appointment, and before the first Board meeting, a **one-to-one meeting with the Chair** as a two-way process to both identify the skills and interests of the individual and to set out the expectations in the role as a Board Member.

- A **formal induction session** with other newly appointed Board Members (there may be value in part of this being on a regional basis). As a minimum this should include: a code of conduct for Board Members; declaration of interests; organisational structure and purpose; function and administration of the Board and committees; strategic planning for the organisation; roles of Chief Executive and Accounting Officer; Board role in budget and financial responsibilities; Board role in monitoring openness and duty of candour; performance monitoring of organisation and individual Board Members; governance arrangements including Board role in assuring the annual governance statement.

- **Orientation** to the organisation such as time spent with Executive Officers and other key staff, which may involve shadowing, visits to part of the organisation and/or attendance at meetings.

- Access to key **organisational publications,** including: the latest annual report, accounts and annual quality report, the corporate plan and operational/business plan; and any recent strategy or consultation document the organisation has published.

- Other **information** to be provided for new Board Members should include:
    - Relevant legislation;
    - Budget information;
    - Performance management framework;
    - Quality and safety plan, including the risk register;
    - Standing orders for the conduct of ALBs;
    - Organisation structure;
    - Staff directory and contact information;
    - Biographical and contact details of Board Members;
    - Summary of roles and responsibilities, i.e. the Board, subsidiary committees, Chief Executive/Accounting Officer, senior management team and other senior staff;
    - Forward work programme of Board meetings and other key events (for example conferences);
    - The organisation's code of conduct for Board Members;
    - The organisation's data protection policy and freedom of information policy;
    - Information on corporate governance;
    - Schedule of matters reserved for the decision of the Board and scheme of delegation;
    - Action plan arising from the most recent review of Board effectiveness – Ombudsman or similar complaints handing procedure; and
- Minutes from at least the last four Board and audit committee meetings.

- In preparation for the **first Board meeting** new members should be made aware of the protocols for speaking, presentations and conduct. Formal introductions should be made and the Chair should set time aside before and after the meeting to allow the new Board Member to ask questions or raise concerns.

- **Feedback** from new Board Members on the induction process is essential to ensure that the process remains effective.

6.1.2 Induction training for Board Chairs

When a new Chair is appointed, the Government sponsor body (for example a Government Department) should ensure that an early meeting is arranged with a senior member of the body or, where appropriate, the Minister.

The induction of the Chair should cover all the topics already mentioned. However, there are some topics specific to new Chairs including appraisal, leadership experience and involvement in the recruitment and selection of Board Members.

6.2 Appraisal and ongoing learning and development needs for all Board Members

HSC ALB Board chairs are ministerial appointments; it is therefore the Minister who conducts the appraisal. The Minister can delegate this function to a civil servant no lower than Deputy Secretary level for setting objectives for the Chair and conducting his/her appraisal. The appraisal process encourages critical reflection and provides an evidence base upon which Non-Executives can build for future development. It takes place annually and is the basis on which personal development plans are formed.

In turn the HSC Board Chair is responsible for the appraisal of all Non-Executive Directors while the Chief Executive is responsible for the appraisal of all Executive and Operational Directors.

Formal performance appraisal is a compulsory requirement of the code of practice[49] issued by the Commissioner for Public Appointments Northern Ireland (see Appendix 9).

> *"Departments must have in place performance assessment processes that provide evidence for the consideration of reappointments. A performance assessment should be carried out annually for each Chair and Board Member:*
>
> - *No one can be reappointed unless he or she has performed satisfactorily during his/her current term;*
> - *For audit purposes and for the investigation of complaints, it is essential that all performance assessments are fully documented;*
> - *Performance assessments for the Deputy Chair and the members must be completed by the Chair".*

The Department will issue guidance notes to Chairs on an annual basis, when appraisals are being commissioned. The guidance includes a template with five self-assessment areas for Non-Executive Members to complete in advance of a meeting with the Chair:

1. Making an impact on others – operating as part of a team.
2. Committing to the Non-Executive role.
3. Thinking strategically.
4. Analytical thinking.
5. Learning and self-development.

Board prompts to assist in self-assessment in each of these areas are set out below.

49 CPANI Code of Practice JL2 December 2016 and Appendix A – Statement of Compliance Summary of Codes of Practice in Public Life set out in Appendix 3.

Making an impact on others – operating as part of a team

- How do I operate and contribute to the team environment?
- How did my contribution make the team successful in meeting its aims?
- How do I effectively commit to the team?
- How do I foster good working relationships with both Executive and Non-Executive Board Members?
- How do I take others on and bring them to my point of view?

Committing to the Non-Executive role

- Do I understand corporate governance?
- Do I understand the obligation under the Principles of Public Life?
- Do I commit to decisions that are contrary to my own views?
- Do I have any conflicts of interest I need to declare?

Thinking strategically

- How have I contributed to planning the future focus and activities of the Board?
- Have I collected and reviewed information from the past to analyse what should happen in the future?
- How have I personally assisted the Board in meeting its strategic objectives?
- How have I personally assisted the Board in meeting its financial objectives?

Analytical thinking

- How did I contribute to solutions to problems of dealing with complex information when a decision had to made/solution found by the Board?
- What was my role on the Board at such times?
- How did I go about my analysis to generate options or solutions?

Learning and self-development

- How do I go about developing knowledge or understanding in a relatively short time?
- Have I showed willingness to learn quickly so my confidence and contribution increases?
- Have I gaps in knowledge or skill that I need to develop further?

As part of the appraisal process Non-Executive Directors are expected to provide evidence of their time commitment to the role, identifying any issues or development needs for the following year and declaration of any potential conflicts of interest. Evidence is also sought on the continued adherence to the Principles of Public Life as set out in the Committee for Standards in Public Life 1995 (also known as the Nolan Principles – summarised in Appendix 3).

6.3 Training in core functions for HSC Board Members

6.3.1 Leadership

The role of the Board Member is to provide effective leadership for the organisation. This leadership will include providing strategic direction, ensure effective corporate governance, constructive challenge of fellow Board Members as well as support and guidance to the organisation.

While the training and development needs may be similar for all Board Members, the way in which those needs are met will vary, particularly between Executive Directors who are employed by HSC organisations and Non-Executive Directors who are appointed on a part-time basis by Ministers or the Department. In the case of Executive Directors, they have access to a variety of leadership courses run at a regional level by organisations like the HSC Leadership Centre. The programmes are often modular, requiring eight to 12 days off the job and they have a focus on strategy and policy formulation. It is recommended that Executive Directors and operational directors attend such courses at least once every four years. While

there is no bar on Non-Executive Directors attending such courses the part-time nature of their appointments makes attendance at such courses unrealistic for most.

Non-Executive Directors are typically appointed for an average of three days a month. One of these days will be taken up by the monthly Board meeting, another by committee work and then there are site visits and other duties. However it is essential that time is set aside for Board Member training and that the time that Non-Executive Directors have available is used effectively. There are a variety of methods that can be used to deliver training and development opportunities in these circumstances. Typically, these include:

- One-to-one mentoring and support sessions;
- Short one to two-hour information and discussion sessions held prior to Board Meetings;
- One day seminars to address specific topics;
- Case based learning;
- Web-based interactive sessions; and
- Attendance at conferences, regional or UK wide.

All these methods can be used to enhance the contribution of Non-Executives to the working of their Board. The appraisal process should assist both the individual directors and the Chair to identify and prioritise training and development needs and to enable the organisation to plan to meet the needs.

Part of the leadership role of Non-Executive Board Members is to scrutinise the performance of their Executive Director colleagues particularly in relation to patient/client safety and quality of service.

6.3.2 Organisation and HSC service: functions and relationships

It is essential that directors are familiar with the roles and functions of their organisation. Board Members come to the boardroom with varying degrees of knowledge, skills and experience. The induction process outlined in section 6.1 of

this handbook plays a crucial role in helping directors familiarise themselves with the structures and functions of their organisation. Without such knowledge the effectiveness of a director can be limited. It is the responsibility of the Chair and Chief Executive to ensure that induction training for new Board Members is fit for purpose.

The HSC environment changes over time so it is essential that Board Members are provided with the opportunities to be briefed on policy or structural change. The short one to two-hour briefing sessions that can be held when members are meeting for other purposes are an effective way to update members on change and to facilitate discussion and debate. The Department will often provide information in the form of circulars or policy documents that will assist in disseminating the nature of the changes.

6.3.3 Statutory functions

The Board has ultimate responsibility to ensure that practices within their organisation comply with statutory requirements. This can range from health and safety regulation through to employment legislation. It will include HSC specific regulation and legislation. The Department will from time to time issue guidance in respect of the statutory function of HSC organisations. This may be in response to new legislation or to provide a renewed emphasis on duties in light of experience.

Statutory functions for Boards include:

- Duty of Quality;
- Duty on HSC Trusts in relation to improvement of health and social well-being;
- Duty of Financial Control and Requirement to Break Even;
- Data Protection/GDPR;
- Duty of Equality;
- Duty to Involve and Consult;
- Health and Safety at Work;
- Employment legislation and regulation; and

- Proposed Duty of Candour.

The statutory function of Board Members should be covered at the initial induction. The Executive Directors will play a vital role in ensuring that Non-Executive Directors are kept up to date and briefed about changes to statutory functions. Where a new statutory function is introduced or there are significant changes to existing functions it is essential that special awareness training is provided. Boards need to have an opportunity to consider how such changes might impact on how they provide services.

6.3.4 Openness and a statutory duty of candour

The Inquiry into Hyponatraemia Related Deaths recommended a statutory duty of candour should be enacted in Northern Ireland so that every health care organisation and everyone working for them must be open and honest in all their dealings with patients and the public. If brought into law the intention of this regulation is to ensure that providers of health and social care are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

Boards of HSC organisations will have to promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at Board level. Boards should have policies and procedures in place to support a culture of openness and transparency and ensure that all staff follow them. Each Board should have nominated Executive Directors with responsibility for issues of candour.

Boards should also have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered, including the obstruction of another in their professional duty of candour. This is likely to include an investigation and escalation process that may lead to referral to their professional regulator or other relevant body.

The introduction of a statutory duty of candour will provide a challenge to Boards to ensure that there is compliance at all levels of the organisation. There should be the opportunity to be briefed on the requirements of the new legislation (or regulation) and to discuss its wider implications for the organisation. There may be a need to change the culture or values of the organisation and if this is the case such change needs be led from the top. Board Members need to be aware of the requirements that a statutory duty of candour places on the corporate body and on individuals within it and the consequences of failing to adhere to the duty.

6.3.5 Involvement and engagement with service users, carers and families

An effective Board will have direct interactions with the organisation's staff, service users and carers, as well as with the wider public (as set out in sections 4.12 and 4.13).

Non-Executive Directors have a particular responsibility to set the culture of the organisation in being open, transparent and accountable in their dealings. The skills required include the ability to set an involvement and engagement strategy for the organisation and to seek qualitative and quantitative feedback on such engagement.

Board Members need to understand their statutory obligations to involve and consult as well as to embrace the principles of:

- Openness and transparency;
- Dignity, respect and equality;
- Inclusivity, equity and diversity;
- Collaboration and partnership; and
- Communication.

These principles are set out in more detail in section 4.14.

Board Members need to understand the requirements under the Standards for Involvement in Health and Social Care and their responsibility to ensure that service users have been meaningfully involved before any major decision is taken. The five standards for Boards are set out in section 4.14.4 as:

- Standard 1 Leadership
- Standard 2 Governance
- Standard 3 Opportunities and support for involvement
- Standard 4 Knowledge and skills
- Standard 5 Measuring outcomes

6.3.6 Scrutiny and challenge of Executive and Operational Directors in areas of performance and patient/client safety

It is essential that Non-Executive Directors fulfil the role of scrutiny and challenge on a Board. Having a cohesive Board is important and healthy debate and challenge is more likely to be achieved if Board communication is underpinned by a spirit of trust and professional respect. Scrutiny by Non-Executive Directors is greatly enhanced if they have a clear understanding of the structures, and functions of the organisation, hence the importance of the induction process. Other skills that are needed include the capacity to synthesise information, consider options, and seek out alternative perspectives. Added to this is the ability to analysis information that comes to the Board to detect trends or other underlying factors that might give an indication how the organisation is performing.

All Board Members should have an awareness of quality improvement methods. This should enable them to oversee improvements to patient or client experience, the efficiency of the organisation and improvements to population health

6.3.7 Who provides Board-level training and development?

The annual appraisal process will provide the opportunity for the Chair of the Board to reflect with appraisees on their performance and experience at the Board. It also facilitates a discussion about training of development needs. These needs can be brought together into a Board development plan. Some of the needs can be meet

internally by information sessions on seminars to address specific topics. There are a range of providers that the Board can call on to help deliver the Board development plan. These include but are not limited to:

- The HSC Leadership Centre;
- The Northern Ireland Confederation for Health and Social Care (NICON); and
- The 'On Board' training programme and regional or national health or social care conferences.

6.4 Mentorship and support

For all Board Members ongoing support is expected and essential to sustaining effectiveness in the role. This would include regular one-to-one meetings with the Chair, the frequency of which depends on the level of experience and role of the individual on the Board, i.e. that newly appointed Board Members would meet more frequently but for others it may be only be needed on an annual basis, such as at the time of appraisal.

It is also recognised that the availability of a network of support from those in similar roles, both within the organisation and across the sector, is invaluable in providing support through shared experience. A formal mentoring relationship is an extension of this informal arrangement and may be facilitated by a third party.

HSC Board Member Handbook

Appendices

Appendix 1. Acknowledgements

The work was undertaken as part of the planning for the delegated IHRD recommendations undertaken by the ALB Board Effectiveness Group (a sub-group of the Duty of Quality Workstream) who commissioned and oversaw the development of the handbook.

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It is acknowledged that the HSC Board Member Handbook is a combined effort of key stakeholders that will be the key to its success and usefulness to future members of HSC Boards.

Appendix 2. Health and Social Care Trusts

Northern Ireland Ambulance Service

The **Northern Ireland Ambulance Service** (**NIAS**) is an ambulance service that serves the whole of Northern Ireland (approximately 1.8 million people). As with other ambulance services in the United Kingdom, it does not charge its patients directly for its services, but instead receives funding through general taxation. It responds to medical emergencies in Northern Ireland with the 300-plus ambulance vehicles at its disposal. Its fleet includes mini-buses, ambulance officers' cars, support vehicles, RRVs and accident and emergency ambulances.

The Northern Ireland Ambulance Service was formed on 1 April 1995 through the amalgamation of its four predecessors. Its full title is the **Northern Ireland Ambulance Service Health and Social Care Trust.**

Services

The service employs approximately 1,300 staff of which approximately 420 are paramedics, 300 are emergency medical technicians and 100 are control staff, which work shift patterns to ensure the service is operational 24/7. They are based across 46 stations and sub-stations, two control centres (emergency and non-emergency) and a Regional Ambulance Training Centre. It responds to approximately 201,000 emergency (999) calls per year (with the number of 999 calls increasing per year) with a combination of traditional emergency ambulances with two crew members, and rapid response vehicles (RRVs) crewed by a single paramedic. RRVs respond mostly to calls where there is a potential immediate life-threat (Category A) because they can respond more quickly than a conventional ambulance. Double-crew ambulances respond to both emergency and non-

emergency (healthcare professional-initiated urgent) calls as well as providing critical-care transfers between hospitals. The Trust aims to provide at least one paramedic to every emergency call by staffing each double-crew, emergency ambulance with two paramedics or a paramedic and an emergency medical technician and utilising RRVs. The Trust has not adopted the controversial use of emergency care assistants in the way many other UK ambulance services have.

Currently there is no training programme in any Northern Ireland universities to train paramedics.

In addition to the emergency service, NIAS has a fleet of patient care service vehicles which are used for more routine patient transport to/from hospital. Within the Patient Care Service there are both single-crewed 'sitting case' (minibus) vehicles as well as double-crewed 'intermediate care vehicles' which carry a stretcher.

Helicopter Emergency Medical Service

In 2016 NIAS was commissioned to provide a Helicopter Emergency Medical Service (HEMS) for the first time in Northern Ireland which was by then the only region of the UK not to have one. Following a public consultation, they partnered with the charity Air Ambulance Northern Ireland which provides the aircraft and airbase, with the doctors and paramedics provided by NIAS. The service undertook its first live mission in August 2017.

Area covered by Northern Ireland Ambulance Service

Northern Ireland Ambulance Service	
Headquarters	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8SG
Region served	Northern Ireland
Area size	5345 sq. miles
Population	1.8 million
Establishments	46 stations and deployment points
Chair	Nicole Lappin
Chief Executive	Michael Bloomfield
Staff	1,300 (2018/19)
Budget	£70.7 Million
Website	www.nias.hscni.net

Belfast Health and Social Care Trust

The **Belfast Health and Social Care Trust** provides integrated health to the local population in Belfast as well as providing the majority of regional specialist services across the region.

The Trust came into existence on 1 April 2007. It was formed under the Belfast Health and Social Services Trust Establishment Order Northern Ireland 2006 – and is responsible for the services formerly delivered by six Trusts which were merged on 31 March 2007. These Trusts were:

- Royal Group of Hospitals and Dental Hospital Health and Social Services Trust;
- Mater Hospital Health and Social Services Trust;
- North and West Belfast Health and Social Services Trust;
- South and East Belfast Health and Social Services Trust;
- Green Park Health and Social Services Trust; and
- Belfast City Hospital Health and Social Services Trust.

The Belfast Trust employs 20,000 staff. It has responsibility for services to over 340,000 patients, provided at various hospitals including Belfast City Hospital, The Royal Hospitals, the Mater Hospital and Musgrave Park Hospital. With an annual budget of £1.3bn Belfast Trust also comprises the major teaching and training hospitals in Northern Ireland.

Services

Belfast Trust delivers a range of both community and hospital-based care including cardiology, anaesthetics and theatre services, medicine and neurosciences, cancer services, nephrology and transplant services, rheumatology, dermatology and neuro rehabilitation services, adult social and primary care incorporating learning disability, mental health services, services for older people, physical and sensory disability services and psychological services, maternity and women's services, dentistry and child health, trauma and orthopaedics, children's community services, and social services.

Activity

- Adult Emergency Department Services – 135,505 new and unplanned attendances per year.
- 2015/16 delivered 5,961 babies.
- Corporate parent to 740 looked after children in the Belfast Trust of whom 572 (77%) were in fostering placements.
- 10,000 hours of home care support per week is delivered to clients through in-house services.
- Over 6,000 meals per day are produced in Trust canteens.
- 1,800 requests for porters.
- Trust estate of eight million square feet of floor space.
- 35 million lab tests per year.

The area covered by Belfast Health and Social Care Trust has a population of 348,204 residents according to the 2011 Northern Ireland census.

Belfast Health and Social Care Trust	
Type	Health and Social Care Trust
Established	1 April 2007
Headquarters	51 Lisburn Road, Belfast, BT9 7AB
Hospitals	Belfast City Hospital Mater Infirmorum Hospital Musgrave Park Hospital Royal Belfast Hospital for Sick Children

Royal Victoria Hospital	
Chair	Peter McNaney
Chief Executive	Dr Cathy Jack
Staff	19,732 (2018/19)
Budget	£1.3 billion
Website	www.belfasttrust.hscni.net

Northern Health and Social Care Trust

The **Northern Health and Social Care Trust** is a provider of Health and Social Care services across four council areas in Northern Ireland – Antrim and Newtownabbey, Causeway Coast and Glens, Mid and East Antrim and part of Mid-Ulster.

The Trust became operational on 1 April 2007. It has an annual operating budget of around £865m and employs around 12,700 people. Funding is secured from a range of commissioners, the main one of which is the Health and Social Care Board.

Services

The Trust provides acute services through two hospitals – Antrim Area and Causeway – and community-based Health and Social Care services from four localities which together include approximately 300 facilities, including day centres, health centres and residential homes.

Outpatient services are provided from Antrim Area, Causeway, Whiteabbey, Mid-Ulster and Moyle Hospitals and Ballymena Health and Care Centre, as well as from a range of community settings.

Holywell Hospital, a 115-bed psychiatric hospital in Antrim, provides a range of inpatient mental health and addiction services. The Trust also provides 20 acute mental health inpatient beds in the Ross Thompson Unit in Causeway Hospital.

Population profile

Geographically the Northern Trust is the largest Trust in Northern Ireland, covering an area with a population of 463,297 residents, according to the 2011 Northern

Ireland census. It also provides services to Rathlin, the only inhabited island off the coast of Northern Ireland.

The population profile indicates that the Trust has the largest older population and the largest child population, when compared to other HSC Trusts in Northern Ireland. The population is predicted to increase by 3.6% over the next 10 years, with significant increases in the older population over age 85, and a drop in the number of children and working age adults. This demographic change is evidenced through the increase in frail older people presenting to the Trust's Emergency Departments and in increased demand for community services. In addition, the north coast is a popular retirement and holiday venue and this tends to increase the number requiring health and social care in the summer months.

Northern Health and Social Care Trust	
Type	Health and Social Care Trust
Established	2007
Headquarters	Bush Road, Antrim, BT41 2RL
Population	463,297
Staffing	12,687 (Aug 2020)
Budget	£865m
Hospitals	Acute Antrim Area Hospital Causeway Hospital Mental Health Holywell Hospital Community Mid Ulster (Magherafelt) Whiteabbey Moyle (Larne) Robinson (Ballymoney) Dalriada (Ballycastle)
Chair	Bob McCann
Chief Executive	Jennifer Welsh
Website	www.northerntrust.hscni.net

South Eastern Health and Social Care Trust

The **South Eastern Health and Social Care Trust** is a health organisation in Northern Ireland. Hospitals served by the Trust include Downe Hospital, Lagan Valley Hospital and Ulster Hospital.

The area covered by South Eastern Health and Social Care Trust has a population of 346,911 residents according to the 2011 Northern Ireland census.

The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approximately 345,000 people with an annual budget of £600 million. The Trust employs 12,500 staff.

Services

The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approximately 440,000 people with a budget of over £600 million. The Trust covers an area of 425 square miles and incorporates the Local Government Districts of Ards & North Down, Lisburn & Castlereagh and Newry, Mourne & Down. The main hospital bases are:

- Ards Community Hospital;
- Bangor Community Hospital;
- Downe Hospital, Downshire Hospital;
- Lagan Valley Hospital and the Ulster Hospital; and
- Acute services at the Ulster Hospital, which serve a wider population, including East Belfast.

Community bases are located in many local towns and villages from Moira in the west to Portaferry in the east and from Bangor in the north to Newcastle in the south.

The Trust employs in the region of 12,500 staff across a range of disciplines.

Profile

In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, embracing areas of relative wealth and prosperity as well as pockets of considerable deprivation and need.

South Eastern Health and Social Care Trust	
Type	Health and Social Care Trust
Established	1 April 2007
Headquarters	Upper Newtownards Road, Dundonald, Belfast, BT16 1RH
Population	400,000
Staffing	12,500
Budget	£600 million
Hospitals	Downe Hospital Lagan Valley Hospital Ulster Hospital Ards Community Hospital, Bangor Community Hospital
Chair	Jonathan Patton (Acting)
Chief Executive	Seamus McGorran (Interim)
Website	www.setrust.hscni.net

Southern Health and Social Care Trust

The **Southern Health and Social Care Trust** provides Health and Social Care services in Northern Ireland. It runs Craigavon Area Hospital, Daisy Hill Hospital in Newry, Lurgan Hospital, South Tyrone Hospital, Armagh Community Hospital and St Luke's Hospital in Armagh. St Luke's provides mental health services. Daisy Hill Hospital Emergency Department is under threat because of difficulty in retaining staff. The Trust serves an estimated population of 380,312 (June 2017 estimates).

The Trust was established on 1 April 2007 when the Health and Social Services Trusts in the five Local Government Districts of Newry & Mourne, Banbridge, Armagh, Craigavon and Dungannon were dissolved under the Dissolution Orders 2007.

The Trusts in the Southern Health and Social Services Board Area that were merged were:

- Craigavon Area (Lurgan/Portadown) Hospitals Trust;
- Craigavon and Banbridge Health and Social Services Trust;
- Armagh and Dungannon Health and Social Services Trust; and
- Newry & Mourne Health and Social Services Trust.

Services

The Trust employs approximately 13,000 staff and spends £532 million annually in the delivery of Health and Social Care Services.

The Trust delivers services from a number of hospitals, community-based settings and in some cases directly in individuals' homes. A comprehensive range of services is provided through the following directorates:

- Acute services;

- Adult mental health and disability services;
- Older people's and primary care services; and
- Children and young people's services.

Activity

- 50,000 inpatients
- 120,000 Emergency Department patients
- 190,000 outpatients

Profile

- The second largest resident population compared to other Trusts in Northern Ireland at 365,712 (20% of population).
- 9% growth in population between 2000 and 2013, compared to Northern Ireland average of 8.7% with projected growth of a further 25% by 2023, compared to the Northern Ireland average of 10%.
- The largest increase in births since 2001 at 17%, compared to Northern Ireland average of 10%. An 11.3% growth in 0–17 population is expected between 2012 and 2037, compared to a decrease in Northern Ireland of 3.3%.
- The highest projected growth in the over 65 population between 2012 and 2037 of 95%, compared to Northern Ireland average of 79%.
- Central and Eastern European migration accounts for 4.2% of the Trust population, compared to the Northern Ireland average of 2.2%.

Southern Health and Social Care Trust

Type	Health and Social Care Trust
Established	2007
Headquarters	Southern College of Nursing, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Population	365,712
Budget	£532m

Hospitals	Craigavon Area Hospital Daisy Hill Hospital South Tyrone Hospital
Staff	13,000
Chair	Roberta Brownlee
Chief Executive	Shane Devlin
Website	www.southerntrust.hscni.net

Western Health and Social Care Trust

The **Western Health and Social Care Trust** is a health organisation in Northern Ireland. Hospitals served by the Trust include Altnagelvin Area Hospital, Tyrone and Fermanagh Hospital, Omagh Hospital and Primary Care Complex and the South West Acute Hospital.

The Western Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of three separate Trusts: Altnagelvin, Foyle and Sperrin Lakeland Trusts and Westcare Business Services.

The area covered by Western Health and Social Care Trust has a population of 294,417 residents according to the 2011 Northern Ireland census.

The Western Health and Social Care Trust provides Health and Social Care Services across the super council areas of Strabane and Derry City, Fermanagh and Omagh District and a portion of the Causeway Coast and Glens Borough Council area.
The Western Trust employs approximately 12,500 staff and spends £588 million annually in the delivery of Health and Social Care Services.

Our aim is: “to provide high-quality patient and client-focused Health and Social Care services through well trained staff with high morale”.

The Trust provides services across 4,842 sq. km of landmass and delivers services from a number of hospitals, community-based settings and in some cases directly in individuals’ homes. These comprehensive range of services are provided through the following directorates:

- Primary care and older people’s services (including nursing services);
- Women and children’s services (includes social work services);

- Adult mental and health and learning disability services; and
- Acute services.

Western Health and Social Care Trust	
Type	Health and Social Care Trust
Established	2007
Headquarters	MDEC Building Altnagelvin Area Hospital Glenshane Road Londonderry BT47 6SB
Population	294,417
Staffing	12,500
Budget	£588 million
Establishments	Altnagelvin Area Hospital Tyrone and Fermanagh Hospital Omagh Hospital and Primary Care Complex South West Acute Hospital
Chair	Sam Pollock
Chief Executive	Dr Anne Kilgallen
Website	http://www.westerntrust.hscni.net/index.htm

Appendix 3. Nolan Principles for Public Life

The **Committee on Standards in Public Life** is an advisory Non-Departmental Public Body of the United Kingdom Government, established in 1994 to advise the Prime Minister on ethical standards of public life. It promotes a code of conduct called the Seven Principles of Public Life.

The Seven Principles of Public life

- Selflessness – Holders of public office should act solely in terms of the public interest.
- Integrity – Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- Objectivity – Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- Accountability – Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- Openness – Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- Honesty – Holders of public office should be truthful.
- Leadership – Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

These seven principles apply to anyone who works as a public office holder including:

- Those elected or appointed to public office, nationally or locally;

- Those appointed to work in the civil service, local government, the police, courts and probation services, Non-Departmental Public Bodies, and in the health, education, social and care services; and
- Those in the private sector delivering public services.

Appendix 4. Template for HSC Board cover papers

Sections

- Title of paper
- Author(s) of paper
- Purpose of paper
- Key issues
- Organisational implications (implications specific to the core business)
- Financial implications
- Which key areas of the strategic plan does this align to?
- Impact on quality
- Key risks and proposals to mitigate the risks
- Equality and diversity impact
- Communications issues
- Recommendations (including discussion, decision, approval, or noting, in some circumstances).

The author of each Board paper should be required to complete all sections of the cover paper template. If the author believes that N/A is the correct response in any section, he/she should explain why this is the appropriate response.

Appendix 5. (i) DAO (DoF) 06/19 – Guidance on Proportionate Autonomy for Arm's Length Bodies

Partnership working: proportionate autonomy for ALBs

Introduction/Background

As laid out in The Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice (the code), there are around 120 ALBs delivering public services in Northern Ireland, and they account for roughly 70% of the Northern Ireland Executive's departmental expenditure limit budget. The partnerships/relationships between these ALBs and Departments are therefore critical to the delivery of high-quality public services.

While ALBs should all operate with a level of autonomy in order to deliver their services/business, Departments will always be responsible to the Northern Ireland Assembly for the funding granted to them. As reflected in Managing Public Money NI, the Accounting Officer of a Department should make arrangements to satisfy themselves that the ALB Accounting Officer is carrying out his or her responsibilities, and that their organisation, or any organisation funded by the ALB operates effectively and to a high standard of probity. It follows therefore that there will always be a certain level of engagement and assurance required from ALBs.

As partnerships and the nature of relationships between Departments and ALBs will vary according to the purpose, size, structure and public interest in the ALB, so too will the level of autonomy with which an ALB operates at any one point in time, i.e. not one size fits all, all of the time. It is also important to remember that the level of autonomy may also depend on the judgement of Ministers concerning the degree of risk that they may be prepared to bear as well as the accountability that is required.

Partnership agreements

Partnership agreements set out the overall governance framework within which ALBs should operate, including the framework through which the necessary assurances are provided to stakeholders in order to satisfy accountability

requirements. The various roles/responsibilities of partners within the overall governance framework are also outlined.

Delivering public services in partnership

Good public policy requires a focus on outcomes rather than on outputs, processes or inputs. An outcomes delivery plan has been developed as a basis for delivering public services in as effective and co-ordinated manner as possible. Based on the framework of outcomes prepared by the Northern Ireland Executive formed after the election in May 2016, the aim is to build ways of working within the Northern Ireland Civil Service and wider public sector that are outcomes-based and are characterised by focus on impact through collaboration with others. For this system to work well and achieve good outcomes, it is essential that relationships between Departments and ALBs are based on trust, shared values and outcomes, transparency and clear lines of accountability and responsibility.

In this system the focus of engagement between Departments and ALBs will be on strategic issues and delivery of outcomes.

Partnership working

As reflected in the partnership agreement template, there should be strategic alignment between the aims, objectives and expected outcomes and results of the ALB and Department concerned. Departments and ALBs should be clear about the outcomes they are seeking to achieve, and when planning and discussing performance focus on what high-level outcomes the ALB is required to achieve.

Important features of partnership working to help achieve these outcomes are shared values and vision; open, transparent and honest two-way communication – there should be no surprises to either party; shared and agreed understanding of risk and increased co-operation and collaboration. In order to achieve better outcomes and more collaborative working, Departments and ALBs need to embed a co-working partnership approach recognising they are part of one eco-system. This should lead to a better understanding of the delivery of our public services on an

outcomes-based approach, and the ability to identify and understand emerging risks and trends.

Partnership working may require more strategic engagement at a senior level (primarily Executive but also Non-Executive) with the onus on the ALB Board for the delivery of agreed outcomes.

What is 'proportionate autonomy'?

The concept of proportionate autonomy is about the level of independence and autonomy with which an ALB can operate from its Department, and relates to the extent and nature of engagement and assurance required between a Department and an ALB. Essentially, it is about trust, and the basis for it. It is however flexible, and will be subject to individual circumstances – i.e. not one size fits all, all of the time.

In practice, therefore, this should mean that ALBs that deliver their agreed outcomes on an ongoing basis, and provide sound and reliable assurances should be able to operate with a high degree of autonomy from their Department in recognition of that level of trust that has been established and consistently demonstrated through evidence of good standards of governance, good financial management, compliance with relevant guidance and provision of reliable and accurate information.

Where ALBs are not yet in this position the interactions necessary will be reflected in the engagement plan. In some instances specific issues may have arisen, in which case the extent and nature of engagement may need to change for a period of time until they are resolved.

How to assess proportionate autonomy

Due to the differing nature of ALBs, it is difficult to be prescriptive about what proportionate autonomy should look like. While there will be some commonality, each case will be unique and as stated above, not one size fits all, all of the time. In

general as partnerships mature, trust will grow and as confidence increases in the efficacy of systems, so too will the level of autonomy.

In practice, ALBs should all be operating with a certain level of independence/autonomy in order to deliver their services/business, and where they achieve their agreed outcomes in line with any policy set, this should be taken into consideration as part of the overall assessment to determine the appropriate level of autonomy.

Further areas for consideration include an assessment of the effectiveness of the ALB's governance procedures, systems of internal control and assurance mechanisms, together with any relevant risk issues, quality of financial management and general compliance with guidance. All of these, together with an assessment of the relevant assurances provided, will help assess what is an appropriate level of autonomy, and set the tone for the relationship. It is important that Departments rely on assurances from ALBs as appropriate, and do not carry out excessive checking of information/returns provided by ALBs or duplicate administrative functions of ALB staff.

It should also be recognised, that the level of autonomy with which an ALB operates can change. Where things do go wrong however, any response by Departments should be proportionate to the risk posed.

The engagement plan annex within the partnership agreement allows flexibility for an ALB and a Department to specify and agree the nature and extent of engagement between them, and will reflect the level of ALB autonomy. This should be considered on an annual basis, and in conjunction with the principles laid out in the code.

Annex A, set out in Appendix 5 (ii), provides a summary of assurances/indicators that Departments and ALBs should consider when establishing their engagement plans. Engagement plans will reflect the appropriate level of ALB autonomy based

on assurances/indicators of good governance and the maturity of the partnership/relationship.

Benefits of a higher degree of autonomy

Potential benefits though from a practical point of view may include the following:

- Reduced bureaucracy and burden of duplicate checking/compliance/assurance processes for both ALBs and Departments;
- Streamlining of processes – information should only be provided once;
- Increased delegated levels of expenditure for ALBs;
- Better use of resources; and
- Potential efficiency savings.

It is important to remember that the pace of movement towards higher degrees of autonomy will differ and the end point may also vary depending on the nature and structure of the ALB and Department.

Review

Departments and ALBs should consider and review the nature of their relationship (as part of the review of the engagement plan within the partnership agreement) either on an annual basis as part of existing governance processes, or in the case of any specific event that has the potential to change the relationship and the level and nature of engagement that may be necessary.

It is also important to emphasise the need for Departments to be careful not to introduce disproportionate measures in response to specific governance events or failings. Departments should review on a periodic basis (at least every three years) the extent to which its practices adhere to the principle of proportionality so as to ensure that excessive processes have not been introduced over time.

Developing/sharing best practice

In taking forward the transition to partnership working, it will be beneficial to share lessons learned and best practice between Departments to help embed the new arrangements and to build contacts through a more formalised network. This may

include some common training, events around common issues and problems as well as a repository of best practice available on the accountability and financial management section of the DoF website. The Departmental Implementation Group, set up to help implement the new approach, will remain as a forum for Departments to meet and share experience and will also be a forum to develop knowledge and expertise around partnership working with ALBs through peer-led learning.

Appendix 5. (ii) Annex A

Assurances/Indicators to consider in determining proportionate autonomy and establishing engagement plans.

Guide for Departments and ALBs

A qualitative overall assessment of the effectiveness of available assurances should be carried out.

1. Board effectiveness

Assurance sources

Most recent internal and independent Board effectiveness review.

Considerations

- What were the results of the last Board effectiveness review?
- What actions were planned as a result?
- Did the review highlight significant issues to be addressed?
- If so what progress has been made in implementing these?
- What are the results of the most recent Chair and Board Member appraisals?
- What are the results of the most recent Board Chair peer review?
- Are there any indications of ineffective Board relationships?
- Are there any other indications that the Board may not be operating effectively or in accordance with its role and code of conduct?

2. Independent audit opinions – internal audit

Assurance source

Head of Internal Audit (HIA) annual report and opinion.

Considerations

- What overall opinion has been provided by the HIA?
- What areas of concern/limited assurance have been referred to in the HIA's annual opinion and report?
- Does the report indicate concern in relation to the timely implementation of audit recommendations?
- What was the result of the most recent external quality assessment of the internal audit function?

3. Independent audit opinions – external audit

Assurance sources

Annual external audit opinion – annual report and accounts.

Annual report to those charged with governance.

Considerations

- Is the external audit opinion 'clean' or qualified?
- If qualified what actions are in place to address the qualification matters?
- Are there any regularity or other matters referred to in the opinion?
- What matters are raised within the report to those charged with governance?
- What plans are in place to address matters raised within the report to those charged with governance?

4. Risk management

Assurance source

Risk management framework

Considerations

- Has the organisation a risk management framework in place integrated with the business and strategic planning process?
- Have shared risks been identified and evaluated through shared understanding on strategic alignment?

5. Annual governance statement

Assurance source

Governance statement – annual report and accounts.

Considerations

- Are there any significant internal control weaknesses referred to in the governance statement?
- If weaknesses are identified what actions are in place to address the identified weaknesses?
- What is the Board's recorded assessment of compliance with its corporate governance code of good practice?

6. ALB assurance statements

Assurance source

In-year ALB assurance statements.

Considerations

- Are the ALB assurance statements signed by the Accounting Officer (considered by the ALB audit committee and provided to the Board where possible) and agreed by the Chair or Board before submission to the relevant Department, in line with the process set out in the partnership agreement?
- What issues have been identified within the statements?

7. Other assurance sources

Assurance sources

- **Outcomes delivery/performance targets**
- **Financial performance**
- **Annual ALB Accounting Officer declaration of Fitness to Carry Out the Accounting Officer Role**

- **Robustness of expenditure decisions in business cases/economic appraisals**
- **Other Departmental returns**

Considerations

- Has the ALB consistently demonstrated a sound track record of delivery against required outcomes and performance targets?
- Has the ALB consistently demonstrated the ability to deliver within budget?
- Has the ALB Accounting Officer provided annual declaration of Fitness to Carry Out the Accounting Officer Role?
- Where business cases/economic appraisals are presented to the relevant Department for approval are these compliant with the Northern Ireland Guide to Expenditure Appraisal and Evaluation and Managing Public Money NI requirements and provide a robust case for the proposed expenditure?
- Are returns provided to the Department by the ALB of good quality with minimal need for revision following review?

Appendix 6. Information management assurance checklist

In conjunction with the organisation's SIRO and personal data guardian, as Chief Executive of [*insert name of organisation*], I hereby give an assurance that a systematic and planned approach to the governance of information is in place that ensures the organisation can maintain information in a manner that effectively services its needs and those of its stakeholders in line with appropriate legislation.

I can confirm that:

YES/NO

1. INFORMATION GOVERNANCE FRAMEWORK

i) My organisation has in place an information governance management framework which is supported by policies, strategies and improvement plans.

ii) My organisation has in place information governance awareness and mandatory training procedures and staff are appropriately trained.

iii) The information governance agenda in my organisation is supported by adequate information quality and records management skills, knowledge and experience.

iv) My organisation's SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy.

v) My organisation has documented and agreed procedures in place to ensure compliance with the requirements of the General Data Protection Regulation.

2. FOI/EIR

i) My organisation has documented and publicly available procedures in place to ensure compliance with the Freedom of Information (FOI) Act 2000 and Environmental Information Regulations 2004 (EIR).

3. DATA PROTECTION AND CONFIDENTIALITY

i) All staff in my organisation are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users.

ii) Information governance in my organisation is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs.

iii) In my organisation there are appropriate procedures in place for recognising and responding to individuals' requests for access to their personal data.

iv) Individuals are informed about the proposed uses of their personal information which is held by my organisation.

v) Processing outside the UK of person identifiable data held by my organisation complies with the General Data Protection Regulation and Department of Health (NI) guidelines.

vi) The processes for all transfers of hardcopy and digital person identifiable and sensitive information held by my organisation have been identified, mapped and risk assessed, and technical and organisational measures adequately secure these transfers.

vii) The confidentiality of service user information held by my organisation is protected through use of pseudonymisation and anonymisation techniques where appropriate.

4. THIRD PARTIES

i) My organisation has contractual arrangements in place with all contractors, support organisations and individuals carrying out work on behalf of the organisation which include compliance with information governance and relevant legislative requirements.

ii) In situations where the use of personal information held by my organisation does not directly contribute to the delivery of care services such information is only processed where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected.

iii) Where required, protocols governing the sharing of personal information by my organisation have been agreed with the other organisation.

5. MANAGEMENT OF CLINICAL RECORDS

i) In my organisation there is consistent and comprehensive use of the Health + Care Number (HCN) in line with the Department's best practice guidance.

ii) Procedures are in place in my organisation to ensure the accuracy of service user information on all systems and/or records that support the provision of care.

iii) A multi-professional audit of clinical and social care records across all specialties has been undertaken in my organisation.

iv) Procedures are in place within my organisation for monitoring the availability of paper health/care records and tracing missing records.

v) In my organisation national data definitions, standards and validation programmes are incorporated within key systems and local documentation is updated as standards develop.

vi) External data quality reports are used for monitoring and improving data quality within my organisation.

vii) In my organisation audits of clinical coding, based on national standards, have been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months.

viii) A documented procedure and a regular audit cycle for accuracy checks on service user data is in place within my organisation.

ix) In my organisation clinical/care staff are involved in validating information derived from the recording of clinical/care activity.

x) In my organisation training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards.

6. MANAGEMENT OF CORPORATE RECORDS

i) Documented and implemented procedures are in place for the effective management of corporate records in my organisation.

ii) As part of the information lifecycle management strategy, an audit of corporate records held by my organisation has been undertaken and an information asset register is maintained.

If you are unable to provide any of these assurances, please explain what the current circumstances are on a separate page and detail what action is being taken to resolve the issues including timeframes.

This information should be returned to the Department.

Signed:

Chief Executive

Organisation:

Date:

Appendix 7. Information governance management framework

DoH Amended Guidance 2019

Organisations are expected to assure their Department that they have an information governance management framework in place which is supported by policies, strategies and improvement plans.

Robust information governance requires clear and effective management and accountability structures, governance processes, documented policies and procedures, trained staff and adequate resources. The way that an organisation chooses to deliver against these requirements is referred to as the organisation's information governance management framework.

Requirement

The information governance management framework must be documented, approved at senior management level and reviewed annually.

Key governance bodies must be established, comprehensive information governance policies must be communicated to staff and strategies/improvement plans must be in place.

In-year reports and briefings on information governance arrangements, implementation of strategies and improvement plans must be provided to, and considered by, senior management in the organisation, who must annually approve any necessary improvements to existing arrangements.

The information governance management framework may be described in a single one page stand-alone document or incorporated within an overarching information governance policy or strategy, but it must provide a summary/overview of how an organisation is addressing the information governance agenda.

Guidance

Example of an information governance management framework.

INFORMATION GOVERNANCE MANAGEMENT FRAMEWORK		
Heading	**Requirement**	**Notes**
Senior roles	• IG lead • Senior information risk owner (SIRO) • Personal data guardian	These roles should be at Board or the most senior leadership team level.
Key policies	• Overarching information governance policy • Data Protection Act/confidentiality policy • Organisation security policy • Information lifecycle management (records management) policy • Corporate governance policy • Freedom of information policy • Risk management • Information quality	This documentation should consist of an overarching high-level information governance policy (which is a statement of the organisation's intentions and approach to fulfilling its statutory and organisational responsibilities) supported by corporate policies, strategies and plans covering the key areas of information governance. An information governance strategy or improvement plan may cover several years and should identify how the corresponding information governance policy will be delivered.
Key governance bodies	IG Board/Forum/Steering Group	A group, or groups, with appropriate authority should have responsibility for the IG agenda.
Resources	Details of key staff roles and dedicated budgets	The key staff involved in the information governance agenda should be identified with a description of their roles and responsibilities. Any dedicated budgets and high-level plans for expenditure in-year should also be identified, including outsourcing to external resources or

		contractors.
Governance framework	Details of how responsibility and accountability for information governance is cascaded through the organisation	This should include staff contracts, contracts with third parties, information asset owner arrangements, departmental leads on aspects of information governance etc.
Training and guidance	Training for all staff Training for specialist information governance roles	Staff need clear guidelines on expected working practices and on the consequences of failing to follow policies and procedures. The approach to ensuring that all staff receives training appropriate to their roles should be detailed.
Incident management	Documented procedures and staff awareness	Clear guidance on incident management procedures should be documented and staff should be made aware of their existence, where to find them and how to implement them.

Organisations are expected to assure their Department that mandatory information governance awareness and training procedures are in place and staff are appropriately trained.

To ensure compliance with legal requirements and central guidelines relating to information governance staff must receive appropriate training. Information governance training is therefore mandatory for all staff and training needs must be routinely assessed, monitored and adequately provided for.

Requirement

An information governance training programme must be developed that includes training needs analyses and induction for new entrants. Training needs must be regularly reviewed and re-evaluated. **It is expected that at least 95% of all staff should have completed their information governance training in the period 1 April to 31 March.**

All staff must receive information governance training and continue to receive it every three years. Action must be taken to test and follow up staff understanding of information governance and additional support provided where need is identified.

Training material must be reviewed regularly for equivalence to best practice and updated in line with legal requirements, corporate and/or Department of Health policy, or any major changes which may impact on the information governance agenda, at a local or national level.

Guidance

The HSC Leadership Centre has developed an e-learning suite of programmes for information governance. The suite of programmes includes freedom of information, data protection, ICT security, records management and confidentiality and is available regionally to all HSC organisations through the HSC Leadership Centre.

Organisations are expected to assure their Department that information governance is supported by adequate information quality and records management skills, knowledge and experience.

Information quality and records management are key elements of information governance. An information quality and records management assurance framework should be in place around healthcare and corporate records across the whole organisation.

Requirement

Skilled information quality and records managers/officers must be in place along with documented information quality and records management strategies, approved by senior management/committee, which form part of the broader information lifecycle policy.

There must be an information quality and records management framework in place with adequate skills, knowledge and experience to successfully co-ordinate and implement the information quality and records management action plan.

Information quality and records management arrangements must be co-ordinated by the lead manager/officers and incorporated within broader information governance arrangements.

Guidance

Information quality and records managers/officers

Organisations must ensure they have individuals with clear responsibility for the quality of service user, staff and corporate data across all systems.

Organisations must ensure there are individuals with clear responsibility for the management of records within the organisation.

Awareness and training

The organisation must assess (and annually review) its legal obligations and associated risks to determine the resources, awareness and training needed to establish and maintain the level of assurance required for managing records and dealing with any requests. Appropriate training must be provided according to staff job roles, level of access to person identifiable information and responsibilities for processing/managing records.

The HSC Leadership Centre has developed an e-learning suite of programmes for IG. The suite of programmes includes freedom of information, data protection, ICT security, records management and confidentiality and is available regionally to all HSC organisations through the HSC Leadership Centre.

Strategies

There must be documented strategies in place, signed off by senior management, to support the information quality and records management work programme which:

- Identify key individuals, and the reporting structure across the organisation, to lead on information quality and records management;
- Outline key aspects of the work programme;

- Identify the support needed to ensure the work is completed; and
- Form part of the broader information lifecycle policy.

These must be supported by an improvement plan which clearly identifies work/actions, responsible individuals and timescales for completion.

There must be adequate arrangements in place to assure senior management that the organisation complies with current information governance standards. Senior management should be kept informed of changes and risks which need to be considered and addressed.

Organisations are expected to assure their Department that the senior information risk owner or SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy.

Organisations must ensure an appropriate senior individual is allocated responsibility for owning information risk. In HSC organisations this role is referred to as the SIRO. The SIRO should be familiar with information risks, and the organisation's response to risk, to ensure they can provide the necessary input and support to the Board and to the Accounting Officer.

Requirement

The SIRO must have an effective support infrastructure and adequate information risk skills, knowledge and experience to successfully co-ordinate and implement information risk management.

The SIRO and the supporting information risk management leads (information asset owners and supporting staff) must be appropriately trained and conduct regular risk reviews for all key assets.
The arrangements for information risk management must be regularly reviewed to ensure they remain current and effective.

The SIRO must successfully complete strategic information risk management training followed by annual refresher training.

Guidance

Information risk – responsibilities and accountability

Information risk should be managed in a robust way within all work areas and not be perceived as the sole responsibility of IT or information governance staff. Assurances need to be provided in a consistent manner through the development of an information governance framework.

This structured approach relies upon the identification of information assets and assigning ownership of assets to senior accountable staff.

Accountability and performance

Senior level ownership of information risk is a key factor in successfully raising the profile of information risks and embedding information risk management into the overall risk management culture of the organisation.

Roles

The role of the Accounting Officer

In HSC organisations, the Chief Executive is the Accounting Officer and has overall accountability and responsibility for information governance. They are required to provide assurance, through a statement of internal controls, that all risks to the organisation, including those relating to information, are effectively managed and mitigated.

The role of the SIRO

The SIRO, who should be an Executive Director or other senior member of the Board familiar with information risks, is the focus for management of information risk at Board level. They should not be the personal data guardian as the SIRO should

be part of the organisation's management hierarchy rather than having an advisory role.

As the SIRO will be expected to understand how the strategic business goals of the organisation may be impacted by information risks it may therefore be logical for this role to be assigned to a Board Member already leading on risk management or information governance.

The role of the information asset owner

Information asset owners (IAOs) are directly accountable to the SIRO and will provide assurance that information risk is being managed effectively for their assigned information assets.

The role of the IAO is to understand what information is held, what is added and what is removed, how information is moved, who has access to it and why. As a result they should be able to understand and address risks to the information and ensure that it is fully used within the law for the public good. The IAO will also be responsible for providing or informing regular written reports to the SIRO, a minimum of annually, on the assurance and usage of their asset.

**** It is important that ownership of information assets is linked to a post, rather than a named individual, to ensure that responsibilities for the asset are passed on, should the individual leave the organisation or change jobs within it.**

Information assets

Information assets are identifiable and definable assets owned or contracted by an organisation which are valuable to the business of that organisation. Information assets include computer systems and network hardware and software. Information assets include information which is of value to the organisation, is not easily replaced, supports delivery of business outcomes and if lost could seriously impact on business delivery and organisational reputation.

Information asset register

It is very important that all organisations ensure their information assets are identified and assigned to an information asset owner (or equivalent). Information assets should be documented in a register. The SIRO (or equivalent), should oversee a review of the organisation's asset register to ensure it is complete and robust.

In order to establish corporate coherence it should be possible for a single asset register to be created for the organisation. As a priority, it is essential that all critical information assets are identified and included in this asset register, together with details of business criticality, the information asset owner (or equivalent), and risk reviews carried out. To improve its usability and maintainability, the information asset register may be organised by service, rather than location.

With the introduction of the General Data Protection Regulation there is a requirement to identify what information is held in an organisation, in particular, all personal and sensitive information assets to ensure full compliance with the new regulations. GDPR requires that the lawful basis for processing activities is established and documented in an information asset register. GDPR introduces a new accountability and governance principle, which requires organisations to maintain internal records of their processing of personal data. Formally documenting assets and any associated risks to information in an information asset register will help demonstrate compliance with this principle.

Organisations are expected to assure their Department that documented and agreed procedures are in place to ensure compliance with the requirements of the General Data Protection Regulation.

From 25 May 2018 organisations have a statutory duty to comply with the requirements of the GDPR. Compliance includes knowing what personal data is held, how and why it is processed, who has access to it, and with whom it is shared.

Failure to comply with the requirements of the GDPR can carry a penalty of up to €20million or 4% of global turnover.

Requirement

There must be documented and agreed procedures in place to ensure compliance with the requirements of the GDPR, including the allocation of appropriate resources and the provision of ongoing staff training and awareness.

Guidance

Data protection key actions

The key actions of the data protection work are to:

- Ensure compliance with all aspects of the GDPR and related provisions and provide reports to the senior level of management in the organisation;
- Draft and/or maintain a data protection policy;
- Promote awareness throughout the organisation about the requirements of the GDPR by organising training and providing written procedures that are widely disseminated and available to all staff;
- Ensure service users are provided with information on their rights under data protection legislation;
- Maintain a record of, and monitor for GDPR compliance all data processing undertaken by the organisation, for example in an information asset register;
- Manage an audit programme of data protection and health checks to monitor and ensure GDPR compliance. Implement and report on action plans that derive from compliance activities;
- Co-ordinate a risk management and compliance framework for privacy including working with IT leads to ensure systems are GDPR compliant;
- Assess the risks associated with data processing operations and ensure internal controls are in place to mitigate these risks. Privacy impact assessments must be carried out on all new projects/policy that involve the processing of personal or sensitive personal data and for any

changes to current policies/procedures/processes that similarly involve the processing of personal or sensitive personal data;

- Advise the organisation on whether or not a data protection impact assessments should be undertaken, the methodology it should use, safeguards, monitoring of performance and whether its conclusions comply with the GDPR;
- Maintain and forward the organisation's notification to the ICO;
- Oversee the breach management process; and
- Lead on the resolution of complaints from data subjects, staff and the general public.

The Information Commissioner's Office, the regulator, publishes GDPR-related guidance which can be accessed on the Information Commissioner's Office website.

Appendix 8 (i) Summary of the Human Rights Act 1998

Article 2 Right to life

For health and social care this means that nobody, including the Government, can act to end a life and must take steps to protect it if an individual's life is at risk. Public bodies have to consider an individual's right to life when making decisions that might put them in danger or that affect their life expectancy.

Article 3 Freedom from torture and inhuman or degrading treatment

For health and social care this means that no individual should be subject to inhuman or degrading treatment or punishment. Public bodies must not inflict such treatment and must act to protect the individual if others are treating the individual in this way. Inhuman treatment is defined as treatment that causes intense physical or mental suffering.

Article 6 Right to a fair trial

For health and social care this relates to a public authority making a decision that has an impact on an individual's civil rights or freedoms. Although not directly relevant it has been argued that decisions in health care should also follow the requirements for impartiality, openness and transparency and that the consent process allows for the individual to be given sufficient information to make an autonomous decision.

Article 8 Respect for your private and family life, home and correspondence

For health and social care this relates to the confidentiality and privacy of family life and has been interpreted by the court as covering sexual orientation, lifestyle and how an individual dresses. It also includes who sees and touches another person's body, so that permission (through the consent process as required) is needed for such activities. Article 8 also covers the right to enjoy family relationships without interference, including the right to live with your family and to have regular contact.

Article 14 Protection from discrimination in respect of these rights and freedoms

For health and social care this means when a person is treated less favourably than others in a similar situation and this treatment cannot be objectively and reasonably justified. Discrimination can also occur if an individual is disadvantaged by being treated the same as another person when the circumstances are different. These rights are also covered by the Northern Ireland Act 1998.

Appendix 8 (ii) Equality legislation

The Northern Ireland Act 1998 (the Act)[50] is set out to change the practices of Government and public bodies so that equality of opportunity and good relations are central to policy making and service delivery.

Section 75 of the Act requires public bodies (including Health and Social Care organisations) to comply with the *Equality of Opportunity duty* in promoting equality of opportunity between nine equality categories*:*

- Religious beliefs;
- Political opinion;
- Racial group;
- Age;
- Marital status;
- Sexual orientation;
- Gender;
- Disability; and
- Persons with dependents and persons without.

A second *Good Relations duty* requires public bodies to promote good relations between persons of different religious belief, political opinion and racial group.

For health and social care this means that every HSC organisation has to have an *Equality Scheme* in place as a public statement of the organisation's commitment to fulfilling its Section 75 responsibilities including procedures for measuring performance which is scrutinised by the Equality Commission (now the Equality and Human Rights Commission).

50 https://www.equalityni.org

Appendix 8 (iii) Disability Discrimination Act 1995[51]

The Equality Commission has responsibility for enforcing the Disability Discrimination Act 1995 (DDA), as amended, in Northern Ireland. It also has a legal duty to work towards the elimination of discrimination against disabled people, to promote the equalisation of opportunities for disabled people, and to keep under review the working of the DDA.

Disability discrimination law in Northern Ireland – a short guide

The following is an extract from the short form guidance provided by the Equality Commission for Northern Ireland as it relates to the **provision of services and employment.** Further information is available from the Commission's enquiry line and on the website.

The Equality Commission for Northern Ireland

The Equality Commission has responsibility for enforcing the Disability Discrimination Act 1995, as amended, in Northern Ireland. It also has a legal duty to work towards the elimination of discrimination against disabled people, to promote the equalisation of opportunities for disabled people, and to keep under review the working of the Disability Discrimination Act 1995.

The law

The Disability Discrimination Act introduced, over a period of time, new laws and measures aimed at ending the discrimination faced by many disabled people. It gives disabled people rights in:

- Employment;
- Access to goods, facilities and services, including transport;
- The management, buying or renting of property; and
- Education.

The DDA only protects people who meet its definition of disability.

51 Equality Commission, Short Form Guidance on the Disability Discrimination Act 1995.

The DDA defines disability as “a **physical** or **mental** impairment which has a **substantial** and **long-term adverse effect** on a person’s ability to carry out **normal day-to-day activities**”.

Physical impairment – this includes, for instance, a weakening of part of the body (eyes, ears, limbs, internal organs) caused through illness, by accident or from birth. Examples are blindness, deafness, paralysis of a leg or heart disease.

Mental impairment – this includes mental ill health and what is commonly known as learning disability.

Substantial – put simply, this means that the effect of the physical or mental impairment on ability to carry out normal day-to-day activities is more than minor or trivial. It does not have to be a severe effect.

Long-term adverse effect – the effect has to have lasted, or be likely to last, overall for at least 12 months and the effect must be a detrimental one. People who are diagnosed with cancer, HIV and multiple sclerosis are deemed to be disabled from the point of diagnosis rather than from the point when the condition has some adverse effect on their ability to carry out normal day-to-day activities.

A **normal day-to-day activity** is something which is carried out by most people on a fairly regular and frequent basis, such as washing, eating, catching a bus or turning on a television. It does not mean something as individual as playing a musical instrument to a professional standard or doing everything involved in a particular job.

To meet the definition, a person must be affected in at least one of the respects listed in the DDA:

- Mobility;
- Manual dexterity;
- Physical co-ordination;
- Continence;

- Ability to lift, carry or otherwise move everyday objects;
- Speech, hearing or eyesight;
- Memory or ability to concentrate, learn or understand; or
- Perception of risk of physical danger.

People who satisfy the definition of 'disability' are covered by the DDA. This includes people who have had a disability in the past.

Discrimination in employment

Under the DDA, discrimination in employment occurs when:

- A disabled person is **treated less favourably** than someone else on the grounds of his/her disability (direct discrimination);
- A disabled person is **treated less favourably** than someone else and the treatment is for a **reason relating to the person's disability**, and this treatment **cannot be justified** (disability related discrimination);
- There is a **failure to make a reasonable adjustment** for a disabled person; or
- **Victimisation** occurs if a disabled person is subjected to **harassment** for a reason which relates to their disability.

Provision of goods, facilities and services

Those who provide goods, facilities and services to the public, or a section of the public, cannot discriminate against a disabled person. Under the DDA, discrimination in the provision of goods, facilities and services occurs when:

- A disabled person is **treated less favourably** than someone else and the treatment is for a **reason relating to the person's disability**, and this treatment **cannot be justified;** or when
- There is a **failure to make a reasonable adjustment** for a disabled person.

Education

A separate piece of legislation deals with disability discrimination in education. Under the Special Educational Needs and Disability (NI) Order, discrimination in education occurs when:

- A disabled pupil or student or prospective pupil or student is **treated less favourably** than someone else and the treatment is for a **reason relating to the pupil's or student's disability**; and this treatment **cannot be justified.**
- There is a failure to make a **reasonable adjustment** for a disabled pupil or student; and when
- **Victimisation** or **harassment** occurs.

Reasonable adjustments by service providers

Service providers who offer services to the public must make reasonable adjustments. In order to make a reasonable adjustment, a service provider may have to:

- Change a **practice, policy or procedure** which makes it impossible or unreasonably difficult for disabled people to use their services, for example, amending a 'no dogs' policy to allow a disabled person accompanied by a guide dog to enter their premises;
- Provide an **auxiliary** aid or service if it would make it easier for disabled people to make use of their services, for example, the provision of information in alternative formats such as audio tape, Braille or large print; or
- Provide a reasonable **alternative method** of making services available to disabled people where a **physical feature** makes it impossible or unreasonably difficult for disabled people to make use of them, for example, providing staff assistance to disabled customers who cannot access goods due to their disability when shopping.

Service providers have to make reasonable adjustments to the physical features of their premises to overcome physical barriers to access. A physical feature includes:

- Any feature arising from the design or construction of a building on the premises occupied by the service provider;
- Any feature on those premises or any approach to, exit from or access to such a building; and
- Any fixtures, fittings, furnishings, furniture, equipment or materials on such premises, including steps, kerbs, internal and external doors, toilet and washing facilities, lighting, signs and furniture.

All features are covered whether temporary or permanent. A building means an erection or structure of any kind.

Can a service provider treat a disabled customer less favourably or not make reasonable adjustments?

A service provider can justify treating a disabled customer less favourably or refusing to make reasonable adjustments in the following circumstances.

- Where the treatment is necessary in order to avoid endangering the health and safety of any person.
- Where the disabled person is incapable of entering into a legally enforceable agreement or of giving informed consent.
- If they would otherwise be unable to provide the service to the disabled person or other members of the public.
- When greater expense is involved in providing a special service for a disabled customer.
- When an adjustment would fundamentally alter the nature of a business or service.

The service provider must believe that one or more of the above conditions exist and it must be reasonable to hold that belief.

Is there anything to stop a disabled person being given more favourable treatment?

A service provider may treat a disabled person more favourably than others. For example, a theatre manager can offer people who are hard of hearing front stall seats at rear stall prices; football clubs can reserve pitch-side places for wheelchair users; and historic houses can offer concessionary prices for disabled people.

Appendix 9. Code of Practice for Ministerial public appointments in Northern Ireland

Version JL2 December 2016

Extract, section 4

Performance assessment

4.5 Departments must have in place performance assessment processes that provide evidence for the consideration of reappointments. A performance assessment should be carried out annually for each Chair and Board Member.

- No one can be reappointed unless he or she has performed satisfactorily during his/her current term.
- For audit purposes and for the investigation of complaints, it is essential that all performance assessments are fully documented.
- Performance assessments for the Deputy Chair and the members must be completed by the Chair.

Number of terms served

4.6 Appointments for the same position are restricted to two terms. Those who have served two appointment terms, of whatever length, on a Board are ineligible to apply for the same position.

- The length of appointment terms will be determined by statute, or be a matter for decision by Ministers.
- Notwithstanding the length of individual appointment terms, the maximum period in a post must not exceed 10 years.

Appendix 10. References and further reading

Statute (including Statutory Instruments[52] and Rules)[53]

The following can be accessed here (unless otherwise indicated)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1972 S.I.1972/1265 (N.I.14)

Statutory Instrument: Sex Discrimination (Northern Ireland) Order 1976 SI 1976 No 1042 (NI15)

Statutory Instruments: The Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 S.I.1990/247 (N.I.3)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1991 SI 1991/194 (N.I. 1)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1994 SI 1994 No 429 (NI 2)

Statutory Instruments: The Health and Social Care (Reform) Act (Northern Ireland) 2009

Statutory Instruments: The Health and Social Care (Amendment) Act (Northern Ireland) 2014

United Kingdom Act (1995): Disability Discrimination Act 1995 (1995 c.50). The Stationery Office, Statutory Instrument: Race Relations (Northern Ireland) Order 1997 SI 1997 No 869 (NI6)

United Kingdom Act (1998): Human Rights Act 1998 (1998 c.42). The Stationery Office, London

United Kingdom Act (1998): Northern Ireland Act 1998, Section 75 (1998 c.47). The Stationery Office, London

Statutory Instruments: The Public Interest Disclosure (Northern Ireland) Order 1998 SI 1998 No 1763 (NI 17)

52 Statutory Instruments also known as SIs, are a form of legislation which allows the provisions of an Act of Parliament to be subsequently brought into force or altered without Parliament having to pass a new Act. They are also referred to as secondary, delegated or subordinate legislation.
53 Statutory Rules are made under the Statutory Rules (Northern Ireland) Order 1979. They replaced statutory rules and orders made under the Rules Publication Act (Northern Ireland) 1925 and are comparable with SIs in the rest of the UK.

Statutory Instrument: Fair Employment and Treatment (Northern Ireland) Order 1998 SI 1998 No.3162 (N.I.21)) London

United Kingdom Act (2000): The Freedom of Information Act 2000 (2000 c.36). The Stationery Office, London

Statutory Instrument: Equality (Disability, etc.) (Northern Ireland) Order 2000 SI 2000 No. 1110 (N.I.2)) http://www.legislation.gov.uk/nisi/2000/1110/contents

Acts of the Northern Ireland Assembly: The Health and Personal Social Services Act (The Health and Personal Social Services Act (N.I.) 2001) 2001 (2001 c.3)

Statutory Instruments: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003 No 431 (NI 9) http://www.legislation.gov.uk/nisi/2003/431/contents

Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994 SR 1994 No 63

Statutory Rules: The Northern Ireland Blood Transfusion Service (Special Agency) (Establishment and Constitution) Order (Northern Ireland) 1994 SR 1994 No 175

Statutory Rules: The Northern Ireland Guardian Ad Litem Agency (Establishment and Constitution) Order (Northern Ireland) 1995 SR 1995 No 397

Statutory Rules: The Northern Ireland Medical and Dental Training Agency (Establishment and Constitution) Order (Northern Ireland) 2004 SR 2004 No 62

The Health and Social Care (Reform) Act (Northern Ireland) 2009

Statutory Rules: The Patient and Client Council (Membership and Procedure) regulations (Northern Ireland) 2009 SR 2009 No 98

Statutory Rules: The Regional Health and Social Care Board (Membership) Regulations (Northern Ireland) 2009 SR 2009 No 95

Statutory Rules: The Regional agency for Public Health and Social Well-being (Membership) regulations (Northern Ireland) 2009 SR 2009 No 93 & No 97

Statutory Rules: The Northern Ireland Practice and Education Council for Nursing and Midwifery (appointments and procedure) regulations (Northern Ireland) 2002 SR 2002 No 386

Statutory Rules: The Northern Ireland Social Care Council (Appointments and Procedure) regulations (Northern Ireland) 2001 SR 2001 No 313

Statutory Instrument: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003 No 431 (N.I. 9)

Guidance and codes

Committee on Standards in Public Life Reports

ISO 3100: 2009 – Risk Management

Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies July 2012

Code of Conduct and Code of Accountability for Board Members of Northern Ireland Fire and Rescue Service February 2013

Board Governance Self-Assessment Tool January 2013

NAO Audit Committee Self-Assessment Checklist

HMT Audit Committee Handbook

NHS Internal Audit Manual

An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies

Managing Public Money NI A3.1: Governance Statement –Managing Public Money NI - Chapter 3 and associated annex | Department of Finance (finance-ni.gov.uk)

Circulars

Archived circulars can be accessed via DoH website using the link to archived DHSSPS unless otherwise indicated.

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation

Circular HSS (PPM) 8/2002 – Risk Management in the HPSS

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management

Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers, Department of Health, Social Services and Public Safety (2003): Code of Conduct for HPSS Managers

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls Assurance Standards – update

Circular HSS (PPM) 4/2005 – AS/NZS 4360: 2004 – Risk Management

Circular HSC (SQSD) 22/2009 – Learning from Adverse Incidents and Near Misses Reported by HSC organisations and Family Practitioner Services

Circular HSC (SQSD) 5/2010 – Handling Clinical and Social Care Negligence and Personal Injury Claims

Other relevant publications

Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in Health and Social Care

The Quality Standards for Health and Social Care

Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS

HM Treasury (2004) Management of Risk: Principles and Concepts

Health & Safety Executive (2003): 'Interventions to control stress at work in hospital staff'. The Health & Safety Executive, London

Department of Health, Social Services and Public Safety (2004) Embracing Diversity – Understanding and valuing ethnic diversity in the HPSS

Safety First: a Framework for Sustainable Improvement in the HPSS

Integrated Governance Handbook (DH, 2006)

National Audit Office: Managing Risks in Government 2011

National Audit Office: Managing Risks to Improve Public Services 2004

Equality Commission NI 2005: Guide to Statutory Duties Arising from Section 75

Programme for Government Outcomes Framework

Appendix 11. Abbreviations

ALB – Arm's Length Body

BHSCT – Belfast Health and Social Care Trust

BSO – Business Services Organisation

CAMHS – Children and Adolescent Mental Health Service

CCG – Clinical Commissioning Group

COPD – chronic obstructive pulmonary disease

CQUIN – Commissioning for Quality and Innovation

CSD – clinical support desk

CT – computerised tomography

DHSSPS – Department of Health, Social Services and Public Safety (Northern Ireland) - now known as DoH

DoH – Department of Health (Northern Ireland)

GDPR – General Data Protection Regulation

HSC – Health and Social Care

HSCB – Health and Social Care Board

HSENI – Health and Safety Executive for Northern Ireland

IAO – information asset owner

IHRD – Inquiry into Hyponatraemia-Related Deaths

MOU – Memorandum of Understanding

MRI – magnetic resonance imaging

MTS – Manchester Triage System

NDPB – Non-Departmental Public Body

NHS – National Health Service

NHSCT – Northern Health and Social Care Trust

NIAS – Northern Ireland Ambulance Service

NICON – Northern Ireland Confederation for Health and Social Care

NIPSO – Northern Ireland Public Services Ombudsman

NISCC – Northern Ireland Social Care Council

PCC – Patient and Client Council

PDSA – Plan-Do-Study-Act

PfG – Programme for Government

PHA – Public Health Agency
PKU – phenylketonuria
PPI – personal and public involvement
PSA – Professional Standards Authority
PSNI – Police Service of Northern Ireland
QI – Quality Improvement
RQIA – Regulation and Quality Improvement Authority
SAI – serious adverse incident
SEA – significant event audit
SEHSCT – South Eastern Health and Social Care Trust
SHSCT – Southern Health and Social Care Trust
SIRO – senior information risk owner
UKAS – United Kingdom Accreditation Service
WHSCT – Western Health and Social Care Trust
WHO – World Health Organization

Appendix 12. Examples, policies, procedures and legislation relevant to openness at each level

LEVEL	POLICIES AND PRODECURES		LEGISLATION
	ORGANISATIONAL	INDIVIDUAL	
1 – OPEN CULTURE	• Performance reporting and monitoring • Information management policies • Freedom of information policies • Consent policies • Confidentiality policies • Staff welfare • Schwartz Rounds/Balint Groups • NICE Guideline 138 • Shared decision-making • The Sanctuary Model • Caring to Change • PPI	• Training, undergraduate and postgraduate • Leadership • Being Open guidance • Staff support groups	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016
2 – OPENNESS TO PROMOTE IMPROVEMENT	• Service user Feedback/Compliments • Staff feedback • Complaints policy • Quality improvement	• Training, undergraduate and postgraduate • Leadership • Being Open guidance	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of

	ORGANISATIONAL	INDIVIDUAL	
	Initiatives • Clinical audit • Cultural assessment tools • Early alerts • Whistle blowing • Near miss reporting	• Peer review • Professional development opportunities • Support for quality improvement research	Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016
3 – OPENNESS WHEN THINGS GO WRONG	• Complaints policy • A just culture • Adverse incident reporting procedures • Serious adverse incident review procedures • Morbidity and mortality Reviews • Referrals to the Coroner • Early alerts • Independent oversight or review of incidents • Signs of Safety • Contracts of employment • Joint protocols with PSNI • Being Open – Saying sorry when things go wrong (January 2020)	• Training, undergraduate and postgraduate • Leadership • Guidance, including how to make an apology • Access to expert advice, including legal support and protections • Counselling • Occupational health and independent support • Being Open – Saying sorry when things go wrong (January 2020)	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016

Departmental Assurance and Accountability Framework for the Sponsorship of Arm's Length Bodies

Version 1.4– 23 November 2012

TABLE OF CONTENTS

1. Introduction

1.1. The guidance and arrangements described within this Assurance and Accountability Framework Document have been developed to meet the responsibilities placed on the Department, under Managing Public Money NI (MPMNI), for the sponsorship of Arms Length Bodies (ALBs) operating under the control of DHSSPS.

1.2. The intention of the framework is to build on and strengthen the arrangements which already exist to ensure that the Department discharges its sponsorship role in a consistent and in each case proportionate manner with respect to all and each of its ALBs.

1.3. Successful operation of the framework will require familiarity with and application of guidance etc. which is already in place. This existing guidance is not reproduced within this document as it would be inappropriate to attempt to précis it in the context of this framework. Appropriate references to other guidance and material are listed below (Appendix A). The contents of this appendix will be reviewed and updated annually.

1.4. The framework has been developed following discussion with individual members of the Top Management Group and other members of the Senior Civil Service in the Department. Some material included in the documentation and guidance underpinning the sponsorship of NHS bodies elsewhere in the UK has been adapted for use in this framework and in associated guidance.

1.5. Professional assurance frameworks and other arrangements that support standards of professional practice and the fulfilment of professional roles and responsibilities at organisational level will form part of these assurance and accountability arrangements.

1.6. The ultimate objective is to enable the Department and Minister to be assured and in turn provide assurance that each of our ALBs is delivering on the Programme for Government, Ministerial and statutory responsibilities and Department policies and strategies. In so doing we must also be able to give reasonable assurances that public funds allocated by us to our ALBs are being used to deliver the intended objectives.

Scope of this Framework

1.7. The arrangements set out in this framework apply to 16 Health and Social Care Bodies and to the Northern Ireland Fire and Rescue Service. Each of these bodies has:

a) A Management Statement and Financial Memorandum signed by both their Chief Executive and the Department Accounting Officer; and
b) A Chief Executive who has been formally designated as an Accounting Officer by the Department Accounting Officer.

Other Arms Length Bodies

1.8. There are a number of other organisations which are wholly or partially within the control of DHSSPS and which will fall within the scope of HMTs Clear Line of Sight (CLoS) Project requiring full consolidation of all Arms Length Bodies into Departmental Resource Accounts (DRA). These bodies are:

a) the Institute of Public Health in Ireland which has been established as a limited company; and
b) the Food Safety Promotion Board (Safefood) established under the terms of the British-Irish Agreement Act 1999 and the North-South Co-operation (Implementation Bodies) Northern Ireland Order 1999.

1.9. It is not appropriate that the full set of arrangements described in this framework and associated guidance should be applied to these bodies. However, it is appropriate:

a) taking account of the arrangements prescribed in the legislation based on which each of them was established; and
b) the accounting officer lines of accountability which have been agreed in each case;

that the arrangements for sponsorship of these other bodies should as far as is proportionate be consistent with the arrangements set out in this assurance and accountability framework.

1.10. The same applies to the Safeguarding Board for Northern Ireland which has been established as an unincorporated public body although it is not within scope for the CLoS project.

1.11. Consideration must be given to how the specific assurance and accountability arrangements established for each of these bodies should be reflected within the formal documentation underpinning their establishment e.g. management statements.

Key Principles

1.12. The sponsorship by DHSSPS of each of its Arms Length Bodies is governed by 7 key principles.

1.13. These principles encapsulate and underpin many of the key elements which the Department must have in place to discharge its responsibilities under MPMNI for the sponsorship of ALBs. As such they have direct relevance to the contents of the rest of this document.

Principle 1: An ALB is sponsored by the Department as a whole.

Principle 2: The primary responsibility for the performance of an ALB rests with its board.

Principle 3: An ALB will be held to account for the delivery of its prescribed functions and its compliance with other statutory responsibilities.

Principle 4: An ALB will be held to account for the delivery of commitments, objectives, targets and requirements contained within its Corporate and Business plans as approved by the Department and reflecting Departmental priorities .

Principle 5: The Department must discharge its sponsorship responsibility (Assurance and Accountability) on an ongoing basis.

Principle 6: Each ALB will be subject to regular performance assessments by the Department taking account of both achievements and areas where the ALB has failed to deliver.

Principle 7: The Departmental Board will have oversight of the discharge of the Departments ALB sponsorship role within a planned and managed set of arrangements.

2 Arms Length Body Functions

2.1 **The assurance and accountability arrangements operated by the Department, (including the priorities, commitments, objectives, targets and requirements set for each ALB), must align with the statutorily prescribed functions for which the ALB was established**. The functions of each of the ALBs covered by this framework are described in their founding legislation (see Table 2a below).

Health and Social Care

2.2 The Health and Social Care (Reform) Act (NI) 2009 provides the legislative framework within which the new health and social care (HSC) structures operate. It sets out the high level functions of the various HSC bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

2.3 The framework document produced by the Department to meet the statutory requirement, placed upon it by the Reform Act, describes the roles and functions of each of the 16 health and social care bodies covered by this assurance and accountability framework. The framework document also describes the systems that govern the relationships of ALBs with each other and with the Department.

NIFRS

2.4 The core functions of the Northern Ireland Fire and Rescue Service are outlined in Articles 4 – 7 of the Fire and Rescue Services (NI) Order 2006. They are:

- the promotion of fire safety through the providing information about preventing fires and giving advice on how to restrict the spread of fires in buildings and how to escape from premises:
- extinguishing fires and protecting life and property in the event of fire;
- rescuing people or protecting them from serious harm in the event of road traffic accidents; and
- emergencies.

2.5 The Emergencies for which the NIFRS must prepare were defined in the Fire and Rescue Services (Emergencies) Order (NI) 2011:

- the removal of chemical, biological or radioactive contaminants in the event of a chemical, biological, radiological or nuclear incident and ensuring reasonable steps are taken to prevent harm to the environment.
- rescuing people who may be trapped and protecting them from serious harm in the event of:
  - a landslide, the collapse of a building, tunnel or other structure;
  - serious flooding; and
  - a serious transport incident.

Table 2a – Legislation under which DHSSPS Arms Length Bodies are established.

Departmental ALB	Legislation establishing the Departmental ALB
Health and Social Care Trusts	Article 10 of the HPSS (NI) Order (1991) - gives the Department the power to establish Trusts by means of Orders (i.e. subordinate legislation). The relevant subordinate legislation under which each of the six existing HSC Trusts have been established are:

	The Belfast Health and Social Services Trust (Establishment) Order (NI) 2006 - (SR 2006/292) *The Northern Health and Social Services Trust (Establishment) Order (NI) 2006 - (SR 2006/295)* *The South Eastern Health and Social Services Trust (Establishment) Order (NI) 2006 - (SR 2006/293)* *The Southern Health and Social Services Trust (Establishment) Order (NI) 2006 - (SR 2006/294)* *The Western Health and Social Services Trust (Establishment) Order (NI) 2006 - (SR 2006/296)* *Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 – (SR 1995/143)* The 1991 Order provisions with regard to HSC Trusts must be considered alongside the provisions of the Health and Personal Social Services (Northern Ireland) Order 1994
Health and Social Care Board	Health and Social Care (Reform) Act (NI) 2009 – Section 7
Public Health Agency	Health and Social Care (Reform) Act (NI) 2009 – Section 12
Business Services Organisation	Health and Social Care (Reform) Act (NI) 2009 - Section 14
Patient and Client Council	Health and Social Care (Reform) Act (NI) 2009 - Section 16

Special Agencies	Article 3 of the HPSS (Special Agencies) (NI Order 1990 gives the Department the power to establish Special Agencies by means of Orders (i.e. subordinate legislation). Currently the Department has established three special agencies as follows: *Northern Ireland Blood Transfusion Service (Special Agency) (Establishment and Constitution) Order (Northern Ireland) 1994 - (SR 1994/175)* *Northern Ireland Guardian Ad Litem Agency (Establishment and Constitution) Order (Northern Ireland) 1995 - (SR 1995/397)* *Northern Ireland Medical and Dental Training Agency (Establishment and Constitution) Order (Northern Ireland) 2004 - (SR 2004/62*
NI Practice and Education Council for Nursing and Midwifery	Health and Personal Social Services Act (NI) 2002 – Section 2
NI Social Care Council	Health and Personal Social Services Act (NI) 2001 - Section 1
Health and Social Care Regulation and Quality Improvement Authority (RQIA)	Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003 - Article 3
NI Fire and Rescue Service	Fire and Rescue Services (Northern Ireland) Order 2006 – Article 3 The Emergencies for which the NIFRS must prepare were defined in the Fire and Rescue Services (Emergencies) Order (NI) 2011

Other Statutory Responsibilities

2.6 All of the ALBs must meet the requirements of extant statutory obligations, and all of the associated standards, policies and strategies set by the Department; and Departmental Guidance and Guidelines.

2.7 In addition, there is a wider requirement to comply with relevant legislative provisions applicable to all corporate bodies (covering, for example, employers' responsibilities, equality and human rights requirements, confidentiality of personal data, financial probity, health and safety matters, etc.), which from time-to-time may be enacted by the NI Assembly or Westminster Parliament or through EU Directives, International Treaties or United Nations Conventions.

3. Arms Length Body Corporate and Business Plans

3.1 **ALBs must be held to account for delivering against their priorities, commitments, objectives, targets and requirements included in their published Corporate and Business plans.** The content of these plans must reflect the priorities etc. communicated to them by the Department and the final plans must be approved both by the ALB board and by the Department.

Ministerial/Departmental Priorities

3.2 Ministerial priorities are communicated to all ALBs across NI through the publication by the Executive of the Programme for Government. ALBs are also required to contribute as required to the delivery of the Executive's Economic Strategy and Investment Strategy.

3.3 The Department communicates its requirements to ALBs primarily through its policies and strategies. These are often underpinned by legislation, standards, guidance and circulars which are mainly developed or signed off by the Department for use with our ALBs.

3.4 The Department communicates additional or specific requirements in the form of priorities, objectives and targets annually to its ALBs. In the case of most ALBs these are communicated by the Departmental Sponsor often supplemented by communications from a number of policy and professionally led business areas.

3.5 In the case of the HSCB the arrangements whereby the Department communicates its priorities are underpinned by statute in the Reform Act. The Act requires that the Department issue an annual Commissioning Plan (CP) Direction to the HSCB. The targets and requirements specified in the CP Direction primarily relate to service/programme delivery rather than the organisational performance of the HSCB. It is for the HSCB to deliver on these targets and

requirements at Regional level through the effective exercise of its main functions which are described in the Framework Document. These are:

- the management of resources allocated to the HSCB;
- the commissioning of services (based on an assessment of population needs and in line with Departmental requirements); and
- the effective performance management of HSC Trusts.

3.6 It is for the HSCB to stipulate as part of their commissioning what level of performance they expect from each Trust and the expectation is that this will be in line with the targets and requirements set for the HSCB in the CP Direction. Whilst it is not an absolute requirement that the HSCB should expect every Trust to perform at the same level for every target and indicator in any given year, there is an implicit expectation that this will be the case. Where this is not the case the expectation is that plans must be in place to achieve a state where all Trusts are performing at the regionally set level for each target.

3.7 To assist the HSCB in the performance management of HSC Trusts the Department also issues an Indicators of Performance (IoP) Direction. This identifies a minimum number of indicators which the Department expects the HSCB to utilise in the performance management of HSC Trusts to ensure the delivery of the targets and requirements specified to the HSCB in the CP Direction. At Trust level, these indicators will align with and in many cases duplicate the targets included within the CP Direction.

3.8 Therefore, whilst the commissioning plan direction is issued to the HSCB and not to HSC Trusts, it is understood that the Trusts are the primary organisations from whom the HSCB will commission services to deliver on Departmental targets and requirements. As a result, the content of the CP Direction taken in conjunction with indicators

specified within the IoP Direction will also set a significant part of the context in which HSC Trusts performance in delivering services will be assessed.

3.9 Under this assurance and accountability framework the Department will build on the existing statutory arrangements for the communication of requirements and priorities to the HSCB and implement a planned and managed approach to the setting of annual and four yearly priorities etc. for all 17 ALBs covered by the framework. **These arrangements will cover organisational performance requirements in addition to the service delivery requirements covered for example by the CP and IoP Directions.**

Structure and Content of Corporate and Business Plans

3.10 Specific guidance to ALBs on the naming, structure and content of ALB Corporate and Business plans will be issued to ALBs by the Department. This guidance will support the arrangements described in this framework and will ensure that the relationships between the various planning documents produced by each ALB are clearly understood, especially where there is interaction between ALBs.

3.11 The Department must ensure that ALBs are clear about the need for these plans to align with their functions and to deliver on Executive and Departmental priorities. The arrangements for Departmental approval, where this is required of ALB plans, will be explicit and the timetable of events included in the planning calendar will provide sufficient time for:

a) Departmental priorities etc. to be developed and formally communicated to the ALB;
b) the ALB to draft plans, submit them to their board for approval and for their Board to submit them to the Department for its approval; and
c) all plans to be approved by the Department;

so that fully approved plans can routinely be in place by the 1st April of the first year to which the plans relate.

Departmental Priorities

3.12 The specific arrangements by which the Department communicates its priorities etc. to each ALB must be tailored to reflect statutory requirements e.g. the Reform Act. The Department will communicate priorities etc. to each ALB under two main headings which are:

a) Organisational requirements; and
b) Service/Programme Delivery requirements.

3.13 Organisational requirements will cover a number of areas of performance, some of which may also feature as service delivery requirements, including:

a) Effectiveness of Systems of Internal Control;
b) Human Resources;
c) Finance;
d) Procurement;
e) Estate;
f) Asset Management;
h) Information Governance;
i) Public and Patient Involvement;
j) Compliance with statutory, licensing and regulatory requirements;
k) Compliance with other relevant statutory responsibilities;
l) Contribution to the Wider Programme for Government; and
m) Compliance with NI, UK and European Law and with UN Conventions.

ALB Plans

3.14 The various assorted plans produced by ALBs will be marshalled under two main headings which are:

a) Corporate plans covering a four year period; and
b) Business plans covering the twelve month period ahead.

3.15 Departmental guidance to ALBs will stipulate that each ALB must produce a four year Corporate Plan and an annual Business Plan which must as a minimum demonstrate how the ALB intends to deliver on Departmental priorities, targets etc. which will be communicated annually to each ALB to cover the year ahead.

3.16 Organisational requirements for ALBs will be developed through a central process covering all 17 ALBs. These requirements will be subject to agreement by TMG and will be communicated annually by the Accounting Officer (AO)/Executive Board Member Sponsor (EBM Sponsor). The development of service/programme requirements will be led by EBM sponsors mirroring the current arrangements for the development of the commissioning plan Direction. With the exception of the HSCB, these priorities will be communicated to ALBs by the AO/EBM sponsors.

3.17 Business plans will cover both organisational and service delivery requirements. Through the successful planning and management of the ALB business planning process, most ALBs will be able to produce an annual business plan as a single document. However, some ALBs will need to produce their business plans as two separate documents, depending on the different structures and arrangements. The arrangements for each ALB are summarized at Table 3a below.

Corporate Plans

3.18 All ALBs must produce a four year Corporate Plan as a single document. This plan must align with the lifespan of an Executive

lasting from the beginning of the second year of a new Executive to the end of the first year of the life of the succeeding Executive. The intention is to allow for continuity of Business Planning during the first year of a new Executive and allow sufficient time for newly appointed Ministers within a new Executive to set their own agenda.

Business Plans

3.19 Eight ALBs:

- Business Services Organisation;
- Patient and Client Council;
- Northern Ireland Blood Transfusion Service;
- Northern Ireland Guardian Ad Litem Agency;
- Northern Ireland Medical and Dental Training Agency;
- NI Practise and Education Council for Nursing and Midwifery;
- NI Social Care Council; and
- NI Fire Rescue Service;

will produce an annual business plan as a single document detailing how they will meet both organisational and service/programme delivery priorities etc., set by the Department.

3.20 The Public Health Agency will also produce an annual business plan as a single document. The plan will cover organisational performance and service/programme delivery whether commissioned or delivered directly by the PHA. The plan will include the utilisation of funds allocated directly to the PHA including funding provided from outside of the Department. It will also cross reference, as necessary, to the HSCB Commissioning Plan.

3.21 The six HSC Trusts will produce an annual business plan with two parts. Strict adherence to the timeframes included within a planning calendar and working closely with the HSCB, PHA and the Trusts, will

enable HSC Trusts to present and publish both parts of the business plan as a single document. The two parts of the Plan are:

a) Part A – to be approved by the Department covering Organisational delivery and performance (for all relevant Department led responsibilities). In submitting this plan to the Department, Trusts must also share their Delivery Plan with the Department for information; and
b) Part B – to be approved by the HSCB – a Trust (service) Delivery Plan. In submitting this plan to the HSCB, Trusts must also share their Organisational delivery plan with the HSCB for information.

3.22 The Health and Social Care Board will produce an annual business Plan as two separate documents:

a) Part A – Covering Organisational delivery and performance; and
b) Part B – The Commissioning (Services) Plan produced in response to the annual Direction made by the Department in exercise of the powers conferred by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

3.23 The Regulation and Quality Improvement Authority publishes a Review Programme, covering three years ahead. The timing and content of the actual programme delivered can vary from year to year, from this published forward plan as the RQIA responds to external factors such as additional reviews etc. requested by the Department. The RQIA will be required to produce a single annual business plan covering:

a) Organisational delivery requirements etc. communicated by the Department;
b) Its annual programme of regulation/inspection; and
c) The relevant year within the RQIA's planned Three Year Review Programme updated to take account of additions/changes.

3.24 More detailed guidance issued to ALBs on the naming and content of their Corporate and Business Plans can be found at [Under development].

Table 3a – General format of ALB Corporate and Business Plans

Departmental ALB	**ALB Corporate and Business Plans**		
	Corporate Plan	**Business Plan (encompassing Organisation and Service/Programme Delivery)**	
Health and Social Care Board	✓	Part A - Organisational Performance	Part B - Commissioning Plan
Public Health Agency	✓	✓	
Health and Social Care Trusts	✓	Part A - Organisational Performance Part B – Trust Delivery Plan ✓	
Health and Social Care Regulation and Quality Improvement Authority (RQIA)	✓	Part A - Organisational Performance; Part B - Programme of regulation/inspection Part C - Reviews from the relevant year of the published Three Year Review Programme ✓	

Business Services Organisation	✓	✓
Patient and Client Council	✓	✓
Northern Ireland Blood Transfusion Service (Special Agency)	✓	✓
Northern Ireland Guardian Ad Litem Agency	✓	✓
Northern Ireland Medical and Dental Training Agency	✓	✓
NI Practice and Education Council for Nursing and Midwifery	✓	✓
NI Social Care Council	✓	✓
NI Fire and Rescue Service	✓	✓

Role of the ALB Board.

3.25 The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated by the Department rests with its board.

3.26 Within the board the balance of this responsibility sits with the Chair and Non-Executive Directors. The responsibilities of the Chair, Non-Executive Directors and Board as a whole are set out in a number of documents including MPMNI; the Codes of Conduct & Accountability for Board members (updated June 2012); the Management Statement

for each ALB; and the Department Accounting Officer letters of appointment to the Chief Executive of each ALB.

3.27 The role which the board of an ALB is expected to play is reflected within this framework in the way in which:

a) priorities, objectives, targets and other requirements are set and communicated by the Department to the ALB;
b) the ALB is performance managed by the Department including the escalation of issues and the application of Special Measures; and
c) Accounting Officer sponsored Assurance and Accountability meetings between the Department and the ALB are structured and conducted.

3.28 Department priorities to be reflected in ALB Business Plans will be communicated to ALB Chairs in writing. These communications will cover both expected organisational and service/programme delivery performance and be in a timely fashion, in line with the planning cycle set out in a Departmental calendar.

3.29 The priorities etc. communicated to ALB Chairs will be supported on an ongoing basis by a range of communications, to the Chair and/or Senior Management in the ALB, from policy, operational and professional leads setting out additional detail and requirements designed to support Ministerial priorities, Departmental policy and strategy and statutory requirements.

4. Departmental Roles and Responsibilities

4.1 Good governance in the sponsorship of ALBs requires that all Department staff understand their own and each other's roles and responsibilities. Good communication between these staff is essential to ensure that the Department collectively discharges its role effectively in line with the requirements of MPMNI and other relevant guidance.

4.2 All Departmental policy areas and professional groups have a role to play within the assurance and accountability framework for the sponsorship of all ALBs.

4.3 The roles of key stakeholders and staff in the delivery of this framework are set out below covering the:

a) Minister for Health Social Services and Public Safety
b) Permanent Secretary/Accounting Officer
c) Departmental Board
d) Executive Board Member Sponsors (EBM)
e) Members of the Top Management Group
f) Senior Civil Servants and Professional Leads
g) Sponsor Branch
h) Central ALB Governance Unit

<u>Minister for Health Social Services and Public Safety</u>

4.4 The Minister for Health & Social Services has responsibility for, and is accountable to the Northern Ireland Assembly for, the exercise of all the powers in his/her portfolio. Supported by officials, the Minister is responsible for :

- setting the priorities and directions within which the HSC and NIFRS must operate;
- issuing letters of strategic guidance to the ALB;

- agreeing in the Assembly, as part of collective discussion, the overall resource framework for the HSC and NIFRS;
- communicating to Chairs of ALBs key priorities and requirements for the year ahead;
- keeping the Assembly informed about the ALB's performance, as appropriate;
- fulfilling any responsibilities specified in the founding legislation, including appointments to the board (including its Chairman) and laying of the annual report and accounts before the Assembly;
- making the final determination for the introduction of Special Measures to an underperforming ALB;
- approving the terms, conditions and remuneration scheme of the Chair and Non-Executive Board members and setting the annual pay increase each year under these arrangements;
- annually approving a Commissioning Plan Direction and Indicators of Performance Direction for issue to the HSCB Chair;
- approving an annual HSCB Commissioning Plan;
- delegating authority to the Permanent Secretary or EBM Sponsor to communicate priorities to ALBs and approve ALB Corporate and Business Plans (Except for the HSCB Commissioning Plan);
- delegating to the Permanent Secretary or EBM Sponsors the responsibility for completing Chairs' end-year appraisals;
- if required, issuing a formal direction to an ALB requiring it to take a particular action; and
- holding the HSC and NIFRS Chairs to account.

Permanent Secretary/Accounting Officer

4.5 The DHSSPS Permanent Secretary is designated as the Accounting Officer for the HSC and NIFRS. The Permanent Secretary is accountable to the Minister for the HSC and the NIFRS and is responsible for providing the Minister with policy advice and exercising strategic leadership and management of the HSC and NIFRS.

4.6 The Permanent Secretary chairs the Department's Board. He also chairs the Top Management Group which develops policy, plans the development of and oversees delivery of services with regard to the Minister's priorities and directions.

4.7 Supported by the Departmental Board and Top Management Group, and subject to Ministerial approval/authority, the Permanent Secretary is responsible for ensuring;

- that the ALB is adequately briefed about the Minister's policies and priorities and to monitor the ALBs activities on behalf of the Minister;
- that each year the Department develops and communicates its specific requirements, objectives and targets for the year ahead to each of its ALBs;
- all ALB Corporate and Business plans support the Department's wider strategic aims and contribute, as appropriate, to the achievement of PfG and Ministerial priorities;
- that the Department Board and Minister are provided with regular reports and advice on the governance and performance of each ALB;
- that significant problems in ALBs are addressed, making such interventions as are judged necessary;
- that the Department periodically carry out assessments of the risks both to the Department's and the ALBs' objectives and activities;
- that ALBs are informed of relevant Government policy in a timely manner;
- that financial and other management controls applied by the Department to the ALBs are appropriate and sufficient to safeguard public funds, and that compliance with those controls is effectively monitored;
- that internal controls applied by the ALBs conform to the requirements of regularity, propriety and good financial management;

- the initiation, at his personal direction, of twice yearly (mid and end year) accountability meetings with each ALB Chair and Chief executive;
    - the AO issues a memo to each EBM Sponsor setting out the timetable, key steps and process for these meetings;
    - the AO agrees the key issues and standard agenda items for these meetings; and
    - the AO chairs all end year accountability meetings; mid year accountability meetings with the HSCB, PHA and HSC Trusts; and mid year accountability meetings with other ALBs, based on a recommendation from the EBM Sponsor;

- the annual planning process is initiated by;
    - issuing a memo to EBM Sponsors, TMG,SCS, and professional leads setting out the timetable, key steps and processes for the planning process and their roles;
    - approving Departmental Corporate and service Strategic Priorities for each ALB and recommending to the Minister that he issues same to ALB Chairs;
    - delegating to EBM Sponsors authority to approve targets and objectives for named ALBs to be communicated to the ALB Chairs as appropriate;
    - approving (except for the commissioning plan and indicators of performance direction) detailed targets and objectives for each ALB to be communicated to ALB Chairs; and
    - signing off or delegating to EBM Sponsors the authority to sign off on ALB Business and Corporate plans (except for the HSCB commissioning plan).
- that any concerns about the activities of an ALBs are communicated to the ALB's Chair and Board, requiring explanations and assurances that appropriate action has been taken.

Departmental Board

4.8 The Departmental Board role is to scrutinize the governance and performance of ALBs and the implementation of the assurance and accountability framework within the Department. Specifically, the board will receive and examine at regular intervals reports on:

- service/programme delivery of each ALB against Departmental requirements;
- the organizational performance of each ALB against Departmental requirements; and
- the effectiveness with which the Department discharges its sponsorship role.

Executive Board Member Sponsors

4.9 The Executive Board Member Sponsor is responsible for supporting the Permanent Secretary and for;

- ensuring sponsorship is applied systematically based on the management statement, financial memorandum and ALB Checklist;
- managing the ALB planning process by:
  - ensuring other TMG members are consulted when setting the Service/Programme Delivery objectives for the ALB;
  - communicating to ALB's, on behalf of Permanent Secretary, their specific Service/Programme Delivery objectives and organisational objectives (except where this is actioned by Minister/AO);
  - ensuring TMG members and professionals have an opportunity to comment on the ALB's draft business and corporate plan, as appropriate;
  - approving or making recommendation to the Permanent Secretary on the signing off of ALB Business and Corporate Plans; and

- monitoring ALB's compliance against Departmental requirements, priorities etc.

- ensuring significant internal control issues are escalated to TMG, the Board or Minister as appropriate;
- providing updates to TMG or the Board on the performance of the ALB against service/programme delivery requirements;
- supporting the accountability process by:
  - undertaking, on behalf of the Minister, Chair end-year appraisals prior to end-year accountability meetings;
  - ensuring the end-year and mid-year meetings take place on time;
  - consulting TMG members on the issues to be addressed at end-year and mid-year assurance and accountability meetings;
  - making recommendations to the Permanent Secretary on the agenda and issues to be addressed at end and mid-year assurance and accountability meetings;
  - providing briefing for end and mid-year assurance and accountability meetings;
  - supporting the Permanent Secretary at Part A of the accountability meetings; and
  - providing regular/periodic reports to the Department Board on service/programme deliver of the ALBs
- assessing, through consultation with colleagues, ALBs against the four domains and making a recommendation to Permanent Secretary on the ALB's performance rating.

4.10 The current allocation of ALBs to each EBM Sponsor is shown at Table 4a below.

Table 4a – ALB Executive Board Member Sponsors

Departmental ALB	Executive Board Member Sponsor
Public Health Agency	Dr Michael McBride
Health and Social Care Regulation and Quality Improvement Authority (RQIA)	Dr Michael McBride
Business Services Organisation	Julie Thompson
NI Fire and Rescue Service	Julie Thompson
Health and Social Care Board	Catherine Daly
Health and Social Care Trusts	Catherine Daly
Patient and Client Council	Catherine Daly
Northern Ireland Blood Transfusion Service	Catherine Daly
Northern Ireland Medical and Dental Training Agency	Catherine Daly
NI Practice and Education Council for Nursing and Midwifery	Catherine Daly
Northern Ireland Guardian Ad Litem Agency	Sean Holland
NI Social Care Council	Sean Holland

Top Management Group

4.11 The Top Management Group are responsible for ensuring that they;

- contribute to the ALB planning process by;
  - consulting with their team on their contribution to objective setting;
  - providing input to the setting of the organisational and Service/Programme Delivery objectives for the ALB; and
  - providing EBM Sponsor s with feedback on the draft plans.
- contribute to the accountability process by;
  - consulting with their teams on issues that need to be raised at the end-year/mid year assurance and accountability meetings;
  - providing agenda items and briefing for the end-year/ mid-year accountability meeting; and
  - monitoring ongoing assurance of issues raised.
- Provide reports to TMG and Departmental Board on policy and professional matters which may include performance of some or all ALBs.

Senior Civil Servants and Professional Leads

4.12 The Senior Civil Servants and Professional leads are responsible for;

- ensuring arrangements to monitor and report on policy and strategy within their area of responsibility are in place;
- ensuring priorities specific to their area of expertise are communicated to the Sponsor Branch and ALB;
- communicating other priorities on an ongoing basis as part of the normal business of the Department and sponsorship of ALBs
- taking the lead on issues of assurance with regard to professional disciplines
- supporting the AO, EBM Sponsor s and TMG members in decision making on priorities for ALB's plans and agenda items for mid and end year accountability meetings;
- responding to requests for input to Departmental consideration of other aspects of ALB Governance e.g. Serious Adverse Incidents, Governance Statements, compliance with Controls Assurance Standards;

- Contributing to the ALB planning process by:
  - providing input to the setting of the organisational and Service/Programme Delivery objectives for the ALB;
  - providing EBM Sponsors with feedback on the draft plans.
- contributing to the accountability process by providing agenda items and briefing for the end-year/ mid-year accountability meeting;
- consulting with IAD on the setting of targets and indicators for ALBs relevant to their policy or professional area;
- monitoring the ALBs compliance with policy or professional standards for which they have responsibility; and
- submitting or providing advice and input to reports to TMG, Department Board and the AO on ALB performance.

Sponsor Branch

4.13 Sponsor branches are the ALBs primary point of contact with the Department on non-financial management and performance. They are responsible for:

- everyday sponsorship of the ALB in line with the Sponsor branch checklist;
- monitoring the ALB's compliance with control and risk management obligations;
- managing the ALB into compliance where obligations are not being met;
- escalating concerns or issues to the EBM Sponsor ;
- liaising with TMG members, policy and professional leads;
- implementing the ALB planning process by:
  - drafting the Service/Programme Delivery objectives for the ALB taking onboard colleagues contributions;
  - providing recommendations to EBM Sponsor on the draft ALB Business and Corporate plans taking onboard feedback from colleagues; and

- providing feedback to the EBM Sponsor on the performance of the ALB against the objectives.

- implementing the accountability process by:
  - reviewing the ALB's Governance and Mid-year Statement and making recommendations to the EBM Sponsor on issues that need escalated to TMG;
  - arranging the end-year and mid-year meetings;
  - drafting agendas for end-year and mid-year assurance and accountability meetings taking account of contributions made by colleagues;
  - drafting briefing for end and mid-year assurance and accountability meetings taking account of the contributions made by colleagues; and
  - taking the minutes at the end and mid-year assurance and accountability meetings.
- providing the EBM Sponsor with assurance on the governance of ALBs.

Central ALB Governance Unit (CAGU)

4.14 CAGU are responsible for:

- drafting Departmental guidance in relation to governance of ALBs;
- drafting of Permanent Secretary's memos to TMG/EBM Sponsors initiating planning process to set requirements for year ahead for each ALB;
- communicating to ALBS new policies or guidance on Governance/sponsorship;
- liaising with Sponsor Branches on governance as required;
- providing advice on corporate control issues within the ALBs (eg Governance Statement and Mid-year Assurance Statement);
- monitoring of assurances on control (eg Controls Assurance Standards, Governance Statement);

- advising and updating the Departmental Board, Departmental Audit & Risk Committee and TMG on governance and related issues (e.g. biannual paper on Governance of ALBs);
- drafting of Permanent Secretary's memos to EBM Sponsors initiating end-year and mid-year accountability process;
- providing input to the Governance Statement guidance drafted annually by Finance;
- drafting of Mid-year assurance statement guidance; and
- co-ordinating the drafting of the ALB organisational targets or objective by liaising with HR, Finance and HEIG etc.

5. Assurance and Accountability Domains

5.1 Performance of ALBs will be reviewed under the following Assurance and Accountability domains:

- Corporate;
- Quality;
- Resources (Finance, HR, Estates);
- Service Delivery/Improvement; and
- Other significant operational issues and risks.

5.2 These domains are not mutually exclusive and issues can and will feature under more than one domain. Any single issue may impact across all of the domains.

Corporate

5.3 This Domain encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the ALB is fulfilling its essential obligations as a public body.

5.4 Specifically the Department will seek assurance from all ALBs on the existence of effective corporate control arrangements e.g. existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance thereon.

Quality

5.5 The ‘Quality’ domain covers the duty of each ALB to put and keep in place arrangements for the purpose of monitoring and improving the quality of programmes/services provided by and for that ALB.

5.6 The safety of services being provided is implicitly addressed under the quality domain as is the quality of professional practice and the personal responsibility of every individual for the quality services they provide.

5.7 The Department will seek assurance from ALBs on their ability;

- to understand the relative quality of services they provide;
- to ensure that practice is safe and the safety of clients;
- to identify and manage risks to quality;
- to act against poor performance; and
- to implement plans to drive continuous improvement.

Resources

5.8 The 'Resources' domain refers to the arrangements ALBs have in place for ensuring that resources, e.g. finance, allocated by the Minister/Department are deployed fully in achievement of agreed outcomes and for ensuring value for money and that other resources e.g. Human Resources and Estate, are managed effectively.

5.9 Specifically the Department will ensure that appropriate resource accountability mechanisms are in place to:

- ensure that the optimum resources are secured from the Executive for Health and Social Care;
- ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;
- deliver and maintain workforce and financial stability
- facilitate the delivery of economic, effective and efficient services; and
- facilitate the development of innovative and effective models of care.

Service/Programme Delivery

5.10 The domain of 'Service/Programme Delivery' refers to the arrangements the ALB has in place for ensuring the delivery of programmes and services with particular reference to meeting PfG commitments, Ministerial targets, Departmental priorities, required service improvements and any other relevant objectives/ targets/ commitments/ policies/ strategies developed by the Department.

6. Evidence based Assurance and Accountability

6.1 The Department relies on evidence when:

- seeking assurance from ALBs;
- holding ALBs to account;
- discharging its sponsorship role; and
- providing assurance to the Minister with regard to the performance of its ALBs.

6.2 In practice the Department discharges its sponsorship responsibility through:

- multiple formal and informal meetings where the Department is represented by policy staff, professional staff or sponsor branches;
- the exchange and scrutiny of formal planning, assurance, performance and other documentation; and
- ongoing exchanges by TMG members, policy and professional leads and by sponsor branches through a variety of media with each ALB.

6.3 The existence of formal documentation including records of meetings and other engagements with ALB representatives enables the Department to provide assurance on the effectiveness of its sponsorship of ALBs and to discharge the role itself effectively.

6.4 Assurance and accountability are ongoing and are not confined to the twice yearly Department Accounting Officer sponsored assurance and accountability meetings

6.5 All engagements or meetings with one or more ALB and attended by Department policy or professional staff contribute to the Departments discharge of it sponsorship role within this framework. It is therefore

important that there must be clarity about when and how these meetings take place.

ALB Information Streams

6.6 The Department has access to and can request from each ALB or from Independent sources information necessary and appropriate to discharge its sponsorship role. Sponsor Branches, Policy and Professional leads all play a key role in identifying and specifying the Departments information needs whether that be data downloads (primarily collected through IAD) or information presented in other forms including but not limited to:

- published reports;
- ALB plans submitted to the Department for approval;
- papers submitted to the Department;
- monitoring reports;
- Minutes and papers from ALB board and board sub-committee meetings; and
- other reports and minutes.

6.7 Information flows to the Department through attendance of staff at meetings/workshops etc, where ALB staff are also present. Information is also shared with the Department in response to specific requests related to Assembly business; progress with delivery of particular polices and strategies; adverse incident reporting; and compliance with legislation and guidance etc.

6.8 Information with regard to the implementation of, and ALB compliance with:

- departmental policy;
- strategy;

- legislation;
- guidance; and
- in connection with professional practice,

flows directly from ALBs to Department Policy and Professional Leads.

6.9 Analysis of information in the context of assurance and accountability arrangements should be informed by:

- Executive Priorities and PFG Commitments;
- statutory and governance requirements which emanate from the UN, EU, UK as well as NI;
- Department Priorities, Policies and Strategies;
- the functions of the ALB;
- ALB Corporate and Business Plans approved by the Department;
- Department legislation, Guidance and Governance requirements;
- statutory, licensing and regulatory requirements; and
- Professional Practice requirements.

6.10 Assessments of information provided by ALBs must take account of 'How', 'Why' and 'When' the ALB has acted as well as the event or activity which is being reported. It should routinely be assessed in terms of what assurance the Department can derive about the effectiveness of the ALB's Systems of Internal Control and the way in which the specific responsibilities of the Chair, Non-Executive Directors, Chief Executive, Board, Professional leads and other members of the Senior Management Team within the ALB are being discharged.

Information Streams External to ALBs

6.11 The Department has access to a range of externally or independently sourced information streams which informs its sponsorship of ALBs

within the assurance and accountability framework. These information streams include, but are not limited to:

- external audit reports provided by NIAO;
- reports of audits conducted by Department Internal Audit;
- individual audit reports and the Head of Internal Audit overall assessment of each ALB;
- reports from inspections and reviews conducted by regulators of services(including the RQIA) and of professions;
- reports from education providers;
- reports prepared by external Licensing Authorities such as the MHRA;
- reports from Committees of the Assembly; and
- reports from Inquiries and Coroners Inquests.

6.12 The Department also receives relevant information from ad hoc communications with;

- public representatives;
- members of the public;
- key stakeholder groups including patient and client representatives;
- other Departments and their Agencies;
- the Judiciary;
- Non-DHSSPS Regulatory Bodies such as the Criminal Justice Inspectorate;
- Organisations representing staff; and
- Regulatory bodies covering services and professional disciplines;

6.13 Alongside IAD, advice from policy and professionally led business areas, these independent sources may provide the Department with some of the necessary assurance as to the quality of information being provided by ALBs.

The Role of IAD

6.14 Whilst the primary flow of service delivery data (as opposed to information) from ALBs to the Department is through Information and Analysis Directorate there are also significant flows of data (particularly on organizational performance) from ALBs to a number of policy and professional groups within the Department including for example Financial Management Directorate (FMD), CAGU, Health Estates, Human Resources Directorate (HRD), Information Management branch, Corporate Services Directorate, and safety, Quality and Standards Directorate.

6.15 IAD bring significant expertise in the interpretation and presentation of data as information but also rely on policy and professional colleagues to set the context for and provide advice on the interpretation of data provided to them by ALBs.

Escalation within the Department

6.16 A basic principle underpinning the exchange of information between ALBs and the Department is that there are no artificial barriers to the communication of information within the Department. ALB staff must be clear that information imparted to any member of Department staff is being imparted to the Department.

6.17 Departmental staff are required to consider, respond to, share and escalate as appropriate within the Department information provided to them by an ALB.

6.18 ALB staff must understand the context in which they are providing information including:

- their role and whether it explicitly enables/requires them to share the information with the Department;

- what action they should also have taken to escalate or share information within their own organisation;
- what approval they should have sought to share information with the Department if this was required or if approval is already in place; and
- If none of the above apply, the basis on which they are sharing information e.g. whistle blowing.

Proportionality

6.19 Whilst a lot of information is provided to the Department on a planned basis through routinely established mechanisms, information is routinely also required on an unplanned ad hoc basis. It is important that the Department avoids placing unnecessary burdens on ALBs to provide data and that account is taken of the cost to ALBs in providing data and other information.

6.20 The role of the Regional Information Group is pivotal in ensuring that the Department has access to the data which it needs but also that the Department's requests for data and the frequency with which it is collected is proportionate.

7. Planning, Assurance and Accountability Cycle

7.1 The Department must exercise oversight of its ALBs on an ongoing basis throughout the year. ALBs must provide regular performance reports and documentation demonstrating progress against Department priorities and assurance as to the ongoing effectiveness of their systems on internal control.

7.2 In support of discharging its ALB sponsorship role there are a number of underpinning and time critical events which occur on a cyclical basis. These include:

- Business Planning including:
  - the development and communication of Departmental priorities for the year ahead (for PFG for four years ahead) to ALBs; and
  - the subsequent approval process for ALB Corporate and Business Plans to ensure that plans are approved and in place by the 1st April of the first year to which they refer;

- Annual Accounts including:
  - an end year report;
  - a Statement on Internal Control/Governance statement;
  - a Statement of Comprehensive Nett Expenditure; and
  - a statement of Financial Position;

  .

- Department Accounting Officer Sponsored Assurance and Accountability meetings which:
  - take place mid year (October-November) and end year (May-June);
  - take account of ALB performance against the PFG and Department requirements, priorities, objectives and targets;

- address the performance and governance of each ALB under the four Domains – Corporate, Quality, Resources and Service/Programme Delivery.

7.3 The cyclical nature of these events means that they can be planned for and that the timetable for compliance by ALBs, with other assurance and accountability requirements, can be aligned where appropriate with these key events.

Calendar of Key Events

7.4 The Department will prepare an annual Calendar of Key Events (Appendix B for initial first draft). The key events initially covered are:

- priority setting and business planning;
- Departmental AO sponsored mid and end year assurance and accountability meetings;
- submission of end year accounts; and
- performance assessments of ALBs.

7.5 The Calendar will reflect the key steps necessary to ensure that all relevant policy and professionally led business areas have adequate time to play a full role in assurance and accountability processes.

7.6 It will be the responsibility of Executive Board Member Sponsors to agree ALB specific reporting arrangements for performance against service/programme delivery priorities and requirements set by the Department.

7.7 The steps set out for each of the key events covered by the Calendar will recognize and support the Minister's role and the pivotal role of the Accounting Officer in the sponsorship of ALBs.

7.8 The steps set out in the Calendar will assist the Accounting Officer in providing assurance to the Department Board and the Minister as to the effectiveness of Departmental assurance and accountability arrangements for all and individual ALBs.

7.9 The Calendar of Key Events is internal to the Department but is informed by and informs timetables for actions by ALBs. The Calendar assigns tasks to key stakeholders and staff in sequential order, taking account of roles and responsibilities and the end date by which key events should have occurred.

7.10 The initial calendar covers a small number of key events but may be added to over time to include key dates for the reporting on ALB performance and the Departments' discharge of its sponsorship role to TMG, the Departmental Board and Minister.

7.11 The Calendar will:

- describe the various arrangements which cover all 17 ALBs;
- ensure that work to set Departmental Strategic priorities is initiated earlier in the financial year;
- facilitate and support engagement by all relevant business areas in the setting of organisational and service delivery objectives and targets for each ALB;
- facilitate and support engagement by all relevant business areas in the performance management and holding to account of each ALB;
- strengthen the focus on communication of strategic priorities to the Board of each ALB;
- facilitate improved communication within the Department with regard to sponsorship and performance management of ALBs; and

- help ensure that ALB Business, Commissioning and Delivery Plans are approved and in place by end March prior to the financial year to which they refer.

7.12 Progress in meeting the timetable set out in this calendar will be monitored and reported on to TMG and escalated as appropriate to the Department Board and to Minister.

8. Accounting Officer Sponsored Assurance and Accountability Meetings

8.1 The Department will ensure a consistent approach to the format and structure of the Accountability Officer (Permanent Secretary) sponsored twice yearly assurance and accountability meetings with Chairs and Chief Executives of each Arms Length Body.

8.2 The purpose of these meetings is both to seek **assurance** focusing particularly on ALB systems on internal control and to hold ALBs to **account** for their performance against PFG and Departmental priorities.

Standard Agenda

8.3 All sponsor branches must broadly follow the same assurance and accountability review agenda to ensure a consistent approach across the Department. While the detail may vary slightly from ALB to ALB, and while there will be slight differences between the mid year and end year agendas, each assurance and accountability review should follow the same basic structure.

8.4 The agenda for these assurance and accountability review meetings will be split into two sections.

8.5 **Part A** is to be attended by only the Chair and Chief Executive from the ALB. Also in attendance will be the TMG sponsor and the Permanent Secretary (and anyone else requested by Permanent Secretary) and a minute taker. This part of the Agenda will cover:

- Strategic Issues and Direction – led by the Permanent Secretary; and

- Specific issues or concerns relevant to the ALB raised through TMG Leads.

8.6 Part A of the meeting is intended to cover specific issues and concerns by exploring key aspects of the Governance and Systems of Internal Control of the ALB. Issues/topics which could feature in this section of the accountability meeting include:

- how the performance of the ALB is being reported to and scrutinized by the board of the ALB;
- the availability and quality of performance information within the ALB and the availability and quality of performance information being reported to the HSCB (in the case of HSC Trusts) and to the Department;
- the effectiveness of the ALBs Governance arrangements in general or around the delivery of specific objectives and plans;
- the relationship between the ALB Board and Chief Executive;
- the functioning of the ALB Board and the Audit Committee;
- the effectiveness of the ALBs systems for dealing with and learning from adverse incidents; and
- the procedures followed to prepare and approve the ALBs Corporate and Business plans, SIC and mid-year assurance statements.

8.7 **Part B** is to be attended by relevant parties based on the agenda for the meeting, drawn from ALB Chair, ALB Chief Executive, ALB Executive Directors, Permanent Secretary, Department Policy Leads, Chief Professionals and in the case of HSC Trusts representatives of the HSCB/PHA. It is proposed that this part of the agenda will address performance of the ALB under the Assurance and Accountability domains:

a) Corporate
b) Quality including safety;
c) Resources (Finance, HR, Estates)
d) Service Delivery/Improvement
e) Other significant operational issues and risks

8.8 Briefing guidance for the Permanent Secretary sponsored accountability meeting has been developed by CAGU. This guidance is aimed at both sponsor branches and policy/professional colleagues who may be asked to provide briefing for these meetings.

8.9 Uniformity at these meetings will strengthen the assurance the Department can provide to the Department Board and Minister as to the effectiveness with which it discharges its sponsorship role as well as giving the Department increased assurance as to the actual effectiveness of individual ALBs. CAGU will compile a summary report to TMG and to the Department Board on the conduct and outcome of these end year assurance and accountability meetings.

Performance Assessment

8.10 Existing arrangements provide for individual assessments to be carried out on Chairs; Non-Executive Directors; and Chief Executives and other ALB staff. Within assurance and accountability arrangements there are also ongoing exchanges and assessments of the performance of each ALB with regard to delivery of Departmental policy and strategy; achievement of targets and other Departmental requirements; compliance with statutory requirements and Departmental standards and guidance; and ALB responses to specific events and issues.

8.11 The Department will continue to develop new arrangements around the assessment of the overall performance of each ALB, escalation and the application of Special Measures.

9. Assurance and Performance Reporting

9.1 Regular and periodic Reports will be produced for TMG, the Departmental Board and for Minister under the assurance and accountability framework

9.2 The content of these reports will be to:

a) Provide assurance information about the performance of the individual ALB; and

b) Provide assurance information about the effectiveness of the Department's arrangements for the sponsorship of its ALBs.

Reports on Performance of ALBs

9.3 CAGU will provide update reports to TMG, the Departmental Board and OFMDFM on progress against PfG commitments and milestones. CAGU will also co-ordinate the production of two reports each year on the organizational performance of ALBs.

9.4 EBM Sponsors will produce reports to TMG and Departmental Board focusing on service delivery of the ALBs which they sponsor. CAGU will liaise with EBM Sponsors on the frequency with which these reports should be produced which should then be agreed with TMG and the Department Board. In addition Policy and Professionally led business areas, including IAD, will continue to produce regular/periodic reports within which they provide information about the performance of ALBs and the Department's sponsorship of them focusing on specific areas of Departmental policy and strategy and on professional practice. These reports are part of the normal business of the Department with reports provided to all levels including Heads of Branch, Director, Head of Group, TMG, AO, Board and Minister.

9.5 CAGU will report annually to TMG and DARC on compliance by ALBs with controls assurance standards for the previous year; on any follow-

up action being taken; and to secure agreement to the compliance requirements for the following year.

Reports on Department's Sponsorship of ALBs

9.6 CAGU will report biannually, September and January, to the Departmental Board on the Department's sponsorship of ALBs. These reports will include an overview of the Department's conduct in relation to the Mid-year and End-year accountability review process.

9.7 CAGU will report biannually, June and December, to the Departmental Audit and Risk Committee on governance in our ALBs and the discharge of departmental responsibilities in that regard. These reports will focus on the mid or end-year accountability process and provide updates on departmental work on governance policy, strategy and standards.

9.8 The Department's Internal Audit will annually audit a rolling selection of sponsor branches and provide a summary report to the Departmental Board on its findings.

Appendix A - Key Documents, References and Legislation

Managing Public Money NI

1. Managing Public Money NI (MPMNI) sets out the main principles for dealing with resources used by public sector organisations in Northern Ireland (NI). See http://www.dfpni.gov.uk/index/finance/afmd/afmd-key-guidance/afmd-mpmni.htm for the latest version of MPMNI.

Programme for Government

2. The Programme for Government (PFG) sets the strategic context for the Budget, Investment Strategy and Economic Strategy for Northern Ireland. The Programme for Government (PFG) highlights the key goals and actions the Executive will take to drive forward the priority areas.

See http://www.northernireland.gov.uk/index/programme-for-government-and-budget-v1.htm for the final version of PFG.

Management Statement /Financial Memorandum (MS/FM)

3. The MS/FM sets out the strategic control framework within which an ALB is required to operate, including the conditions under which any government funds are provided to the public body. Each ALB has a specific MS/FM agreed with the Department. The MS/FM must be periodically reviewed by the Department and the ALB.

The template for MS/FMs can be found at http://www.dfpni.gov.uk/index/finance/afmd/afmd-key-guidance/afmd-mpmni/df1_11_490848__a.7.4_model_management_statement_financial_memorandum_for_executive_ndpbs.pdf

Appointment Letter / Accounting Officer Memorandum

4. The appointment letter sets out the Accounting Officer duties and the capacity in which the AO is responsible for safeguarding public funds in

their charge. In addition, ensuring that the funds are applied only to the purposes for which they were voted and, more generally, for efficient and economical administration. Chapter 3 of Managing Public Money Northern Ireland (MPMNI), Accounting Officer Memorandum, sets out the responsibilities of accounting officers and can be accessed using the link http://www.dfpni.gov.uk/index/finance/afmd/afmd-corporate-governance/afmd-accounting-officer-appointments-roles/manging_public_money_-_chapter_03.pdf

Accounting officer letters also briefly details the circumstances in which AO status can be withdrawn from a Chief executive by the Departmental AO.

Framework Document

5. The Health and Social Care (Reform) Act (NI) 2009, Section 5(1), required the Department of Health, Social Services & Public Safety ('the Department') to produce a 'Framework Document'. The document sets out, in relation to each health and social care body:

    a) the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;
    b) the matters for which the body is responsible;
    c) the manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and
    d) the arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The

Northern Ireland Fire and Rescue Service is outside the scope of the Framework Document.

The Framework Document can be found at:
http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf

Departmental Business Plan

6. The Departmental Business Plan is concerned primarily with the objectives for the Department itself and therefore focuses on the Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 to:

- Develop policies;
- Determine priorities;
- Secure and allocate resources;
- Set standards and guidelines;
- Secure the commissioning of relevant programmes and initiatives;
- Monitor and hold to account its ALBs; and
- Promote a whole system approach.

It sets out the key objectives for the Department in the discharge of those responsibilities, against which its performance is measured.

The Departmental Business Plan 2012-15 can be found at TRIM DH1/12/165103.

HSC Performance and Assurance roles and Responsibilities

7 This paper sets out performance and assurance roles and responsibilities in relation to four key HSC domains and identifies the key functions to be undertaken and the associated roles and responsibilities of the Department, the Health and Social Care Board (the Board), the Public Health Agency (the Agency), the Business Services Organisation (BSO),

the Trusts and the other Arm's Length Bodies (ALBs) post-1 April 2009. This paper can be found at http://www.dhsspsni.gov.uk/mipb-74-09.pdf

Establishing an Assurance Framework

8. In April 2009 the Department issued a revised version of '*Establishing an Assurance Framework'*. The framework is designed to help ALBs map out its principal business objectives, the risks to their achievement, and related controls whose effectiveness could be genuinely tested and assured. The guidance is an important aid to management boards in their handling of risks to business objectives and, by extension, to the production of a balanced SIC.

The Establishing a Framework document can be found at TRIM DH1/09/61784

Business Planning, Risk Management and Assurance in the Department of Health, Social Services and Public Safety - A Framework

9. The Framework for Business Planning, Risk management and Assurance is designed to provide management with a clear and common understanding of how these processes will work in DHSSPS and, at the same time, provide a standard against which independent assurance of our internal control mechanism may be measured.

This Framework can be found at TRIM DH1/12/158293.

Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies

10. The Codes of Conduct & Accountability set out the principles by which the ALB board must operate including the role of the Chairman and their relationship with the Chief Executive and the role of Non-Executive board members. These document the key functions for which DHSSPS holds boards accountable. They also list specific instructions for boards as they fulfil these functions and make a number of other requirements for boards. The Codes of Conduct & Accountability state that on appointment all

board members must subscribe to the Codes of Conduct and that all staff must subscribe to the principles of the Codes of Conduct.

These codes can be found at TRIM DH1/12/128365. For NIFRS TRIM DH/12/158754

Guidance on Accounting Officer Sponsored Mid and End Year Assurance and Accountability meetings

11. Briefing guidance for the Permanent Secretary sponsored is issued by CAGU. This guidance is aimed at both sponsor branches and policy/professional colleagues who may be asked to provide briefing for these meetings.

This guidance can be found on TRIM DH1/12/111229

Guidance on Preparation and Content of ALB Corporate and Business Plans

12. Guidance on the content and approval of ALB Corporate and Business Plans is issued by CAGU. The guidance is designed to ensure that these plans are produced by all DHSSPS sponsored ALBs on a consistent basis.

This consistent approach will strengthen the Department's ability to seek assurance and to hold ALBs to account. The guidance will explain the linkage between the Commissioning Plan, Delivery Plans, Corporate and Business Plans. The guidance will also explain the process whereby key organizational and service delivery objectives and targets are set by the Department for each of the 17 main Arms Length Bodies sponsored by DHSSPS.

This guidance can be found at TRIM DH1….[DN Under development].

Escalation of Risk within and between Health and Social Care organisations

13. Guidance was issued by the Department to all Chief Executives of HSC Organisations on the need :

- for robust processes within organisations to escalate concerns and risk adequately, including to Board Level as appropriate; and
- to consider the wider impact of any identified risks across the HSC and Department and the resultant duty to address these adequately.

This guidance can be found on TRIM DH1/11/224512

Guidance on Governance Statements

14. Guidance on the new Governance Statement for ALBs is issued by FMD. The Governance Statement brings together the material previously covered by Statements on Internal Control and the requirement to publish a comprehensive explanation of how the internal governance of an ALB/Department should work.

This guidance can be found at TRIM DH1/13/38890
DH1/13/97620

Sponsor Branch Checklist

15. Arm's Length Bodies (ALBs) checklist details the key actions that must be undertaken by Sponsor Branches to ensure that:

- in their capacity as sponsors of ALBs, branches are discharging their responsibilities; and
- ALBs themselves are meeting their corporate governance obligations.

The latest checklist can be found at TRIM DH1/14/23132

NAO Audit Committee self-assessment tool

16. The NAO checklist's prime purpose is to assist organisations in assessing their effectiveness by reference to five broad areas:

- the role of the audit committee;
- the membership, independence, objectivity and understanding of the audit committee;
- the mix of skills within or available to the committee;
- the scope of the committee's work; and
- the effectiveness of the audit committee's arrangements for engagement and communication.

The latest version of the checklist can be found at: http://www.nao.org.uk/help_for_public_services/financial_management/audit_committees.aspx.

ALB Board self-assessment tool

17. Guidance on a self assessment checklist for ALB Boards is issued by CAGU. The self assessment checklist will enable board members to identify strengths and weaknesses and implement a development programme to address any issues or concerns. The checklist's prime purpose is to assist each ALB Board in assessing their effectiveness under four key areas:

- board composition & commitment;
- board evaluation, development & learning;
- board insight and foresight; and
- Board engagement and involvement.

This guidance can be found at TRIM DH1/13/280475

ALB Performance Governance self-assessment tool

18. Guidance on ALB Performance Governance self-assessment tool is issued by CAGU. The purpose of the guidance is to enable ALB Boards to assess the appropriateness, quality and relevance of performance information being presented to the Board by the Chief Executive and Senior Management team.

This guidance can be found at TRIM DH1/13/280475

Whistleblowing

19. Circular HSS (F) 07/09 "Whistleblowing" provides good practice and advice and makes Accounting Officers aware of a template which was drawn up for use in developing organisational specific arrangements. The circular can be found at http://www.dhsspsni.gov.uk/hss___f___07_-_2009_whistleblowing.pdf

Departmental representatives on the Boards of NDPBs and other sponsored bodies

20. This paper sets out principles which Departments should consider when considering whether to have officials in attendance at board meetings of public bodies, either in a representative capacity or sometimes as full board members. It recommends that Department officials should only attend:
    - if there are special circumstances;
    - to assess the performance of board members so that Ministers can be advised on re-appointments;
    - for discussion of a particular issue, or where the sponsor department wants to ensure that a particular issue or concern is brought to the attention of the full board;
    - to bring specialist knowledge to a particular issue and where it is clear to all the parties that they are attending for that reason only; or
    - to provide guidance, during the setting up of a new body, or during periods of major organisational or strategic change.

This paper can be found at

http://www.dfpni.gov.uk/index/finance/afmd/afmd-public-bodies/afmd-public_bodies_to_include_on-board_guide_and_public_bodies_guide/fd0305att.pdf

DHSSPS Arms Length Bodies – Indicative ALB Priorities and Business Planning Calendar **APPENDIX B**

	Length Bodies	Indicative Dates
SEPTEMBER	AO issues memo to EBM Sponsors, TMG,SCS, and professional leads setting out the timetable, key steps and processes for the planning process and their roles;	**Week Beginning 3rd September**
	AO issues memo to ALB Chairs setting out the timetable, key steps and processes for the planning process and their roles;	**Week Beginning 3rd September**
	AO issues sub to Minister seeking agreement to delegating authority to the Permanent Secretary or EBM Sponsor to communicate priorities to some ALBs and approve ALB Corporate and Business Plans (Except for the HSCB Commissioning Plan);	**Week Beginning 3rd September**
	TMG Members supported by SCS begin consultation with own teams on their proposals for relevant and appropriate objectives, targets, priorities and requirements which should be communicated to one or more ALBs (including to HSCB as part of either the Commissioning Plan or Indicators of Performance Direction). The focus should be on 'service' objectives etc. which TMG leads consider should be reflected in the ALBs business plans. This work should be undertaken in liaison as appropriate with business areas and professional advisers in other groups who may be able to help, advise or provide other input to	**Week Beginning 3rd September** **TMG members to submit their proposals to each of the relevant EBM Sponsors for each ALB by 28th September**

	their deliberations. (IAD to support EBMs etc. on target wording/data availability)	
	CAGU to co-ordinate development of proposals on organisational objectives for all ALBs	**Week Beginning 3rd September**
OCTOBER	Executive Board Member sponsors to submit proposals for 'service' priorities(including proposed content of Commissioning Plan and Indicators of Performance Direction) etc. to TMG	**Week Beginning 15st October**
	Head of RPMG to submit collated proposals for organizational priorities etc. for all ALBs to TMG	**Week Beginning 15st October**
	AO issues sub to Minister on proposed organizational priorities and service priorities etc.(excluding proposals for Content of Commissioning Plan and Indicators of Performance Direction)	**Week Beginning 22nd October**
	AO issues sub to Minister on proposals for Content of Commissioning Plan and Indicators of Performance Direction.	**Week Beginning 22nd October**
NOVEMBER	Departmental Organisational and Service Business Plan Priorities Communicated to ALB Chairs by AO/EBM Sponsors (except Commissioning Plan and Indicators of Performance Directions)	**Week Beginning 5th November**
	Commissioning Plan Direction and IOP direction issued to HSCB by Minister	**Week Beginning 19th November**
JANUARY	ALB Business Plans (including Commissioning Plan) submitted to Department	**Week Beginning 14th January**

	ALB Business plans (including Commissioning Plan) circulated by EBM Sponsor to Executive Board Members for comment by 4h February	
FEBRUARY	EBM Sponsors submits papers to TMG on approval of ALB Business Plans (including Commissioning Plan, excluding Trust Delivery Plans)	**Week Beginning 11th February**
	AO issues sub to Minister on approval of ALB Business Plans(excluding Commissioning Plan)	**Week Beginning 18th February**
	AO issues sub to Minister on approval of Commissioning Plan	**Week Beginning 18th February**
MARCH	ALB Business Plans (excluding Commissioning Plan and Trust Delivery Plans) to be approved in writing to ALB by Department (AO or EBM)	**Week Beginning 4d March**
	Commissioning Plan to be approved in writing to HSCB by Minister	**Week Beginning 4d March**

Notes:

1. EBM Sponsors to be supported by own SCS team and Sponsor Branches
2. IAD to advise EBM Sponsors on availability of data to monitor proposed targets
3. Commissioning Plan Direction and Indicators of Performance Direction to be issued under signature of Minister. Organisational priorities for all ALBs and service priorities for all ALBs other than HSCB to be issued under signature of AO and EBM Sponsors
4. Proposed priorities to be aligned with ALB Functions, Statutory requirements and Executive/Departmental policy, strategy and priorities

5. Departmental priorities to align with Departmental business plan
6. CAGU to co-ordinate development of Organizational priorities for all ALBs
7. ALB priorities to be included in paper to departmental Board
8. ALB Business plans to be benchmarked against Departmental priorities

DHSSPS Arms Length Bodies – Mid Year Accountability Calendar **APPENDIX C**

		Indicative Dates	ACTION
SEPTEMBER	Deputy Secretary to issue commissioning memo to Executive Board Member (EBM) Sponsors, TMG, SCS, professional leads and sponsor branches setting out the roles and responsibilities, timetable, key steps and processes for the accountability meetings TMG Members and professional leads, supported by SCS, consult with own teams on their proposed agenda items/issues CAGU to reissue Controls Assurance Scores and previous years Statement on internal control to TMG members, Professionals, EBMs and sponsor branches Note: TMG members and Professionals should consider the mid/ end-year Head of Internal Audit report, Audit reports, Controls Assurance Scores and Statement on internal control when identifying topics/issues to be raised	**Week Beginning 10th September**	**Deputy Secretary** **TMG, Professional Leads & SCS** **CAGU**

	CAGU to organise a meeting with Sponsor Branch leads to explain the arrangements for the mid-year permanent secretary lead accountability reviews.	**Week Beginning 10th September**	**CAGU**
	Sponsor Branches to review and circulate to TMG/SCS as appropriate minutes of most recent accountability meetings to follow up on action points. Sponsor Branch to contact TMG members and SCS Policy and Professional leads to ensure action points followed up	**Week Beginning 10th September**	**Sponsor Branches** **Sponsor Branches**
	TMG leads to respond to requirements of commissioning note by (after discussion with their teams) identifying and communicating to EBM sponsors cc CAGU: a) key risks from within their areas of responsibility which they believe mean the timing of the meeting for a particular ALB or ALBs should be prioritised; b) any other timing issues which they believe should be factored in to discussions about the timing of a particular ALBs meeting e.g. timing of another event, publication of a report or availability of other relevant evidence; and c) whether the meeting is to be chaired by the Permanent Secretary	**17th September**	**TMG**

	EBM Sponsors to forward a priority list for accountability meetings in liaison with CAGU, to Permanent Secretary and to confirm which meetings are to be Chaired by Permanent Secretary. Sponsor Branches to arrange dates for mid-year accountability meetings and to notify CAGU of the time, date and location of meetings The timing of mid-year meetings with ALBs to be scheduled to prioritise a) the HSCB, b) the PHA and c) ALBs where the EBM has identified significant issues of control and/or performance which need to be prioritised by the Department. Meetings at risk of delay or postponement beyond end November to be scheduled for evening (5-5.30) start time Dates in December to be held as contingencies for postponed/delayed accountability meetings	**Week beginning 17th September**	**Sponsor Branches**
	CAGU paper provided to TMG on priority list for accountability meetings and Chairing arrangements	**Week beginning 24h September**	**CAGU**
	TMG leads to respond to EBM sponsors by (after discussion with their teams) identifying and communicating possible agenda items/issues from their areas of responsibility (Part A and/or Part B of the meetings) for each ALB's mid-year accountability meeting	**26th September**	**TMG**

	CAGU to organise a meeting with Sponsor Branch leads to discuss the outcome of planning process for mid-year permanent secretary led accountability reviews and identify blockages	**Week Beginning 24th September**	**CAGU**
OCTOBER	EBM Sponsor/Sponsor Branch issues memo to TMG members copied to Policy Leads, Professionals, Finance, Information Governance, Human Resources, and Health Estates and Investment group requesting briefing against proposed agenda items, and nominees to attend to speak to items at the meetings	**Week Beginning 1st October**	**EBM Sponsor/ Sponsor Branch**
	EBM sponsor/ Sponsor Branch issues memo to ALB Chairs and Chief Executives detailing the draft agenda and asking them if there are any specific issues that they wish to raise	**Week Beginning 1st October**	**EBM Sponsor/ Sponsor Branch**
	TMG members and Professional leads to provide briefing to Sponsor Branch at least 2 weeks prior to the meeting	**Week Beginning 15th October**	**TMG & professional leads**
	CAGU receives Mid-year Assurance Statements from ALBS on 19th October which are forwarded immediately to EBMs and sponsor branches If required Sponsor Branch to revise agenda and notify AO, TMG, other professionals, CAGU and ALB in line with issues identified in the mid-year statement	**Week Beginning 22nd October**	**CAGU** **Sponsor Branches** **Sponsor**

	Sponsor Branches and Policy and professional leads to liaise on provision of any additional briefing required TMG members and Professionals to provide additional briefing ASAP		**Branches and Policy and professional leads** **TMG members & Professionals**
	Sponsor Branches to pull together all the relevant briefing and to issue this briefing, 5 working days prior to the meeting, to the AO and Departmental representatives who will be in attendance at the meetings	**Week beginning 29th October onwards**	**Sponsor Branches**
	If EBM sponsors are aware of particular significant issues with an ALB , Pre-briefs should take place three working days prior to the meeting to allow for briefing to be revised if required Pre- briefs to be attended by AO (if Chairing), EBM, sponsor branch and other TMG members, depending on items being raised at meeting and chairing recommendation Sponsor Branch to revise briefing in line with recommendations made at	**Week Beginning 5th November onwards**	**AO, EBM, sponsor branch & other TMG members (who will be attending meeting)**

	pre-brief		
	AO chairs the mid-year accountability meetings with the HSCB, PHA and HSC Trusts, and others, based on recommendations received from the EBM sponsor EBMs support the AO at Part A of the meetings depending on items to be raised and chairing recommendation Part B of the meeting is attended by AO, EBM and other TMG members, depending on items to be raised and chairing recommendation Sponsor Branch takes the minutes of the meeting (Part A & Part B)	**Week Beginning 5th November onwards**	**AO** **EBM** **AO, EBM and other TMG members** **Sponsor Branch**
	Sponsor Branch to draft and issue minutes to Department representatives within two weeks of the meeting. Department Representatives to provide feedback on minutes to Sponsor branches Sponsor Branch to issue revised draft minutes to ALB for comment Sponsor Branch to revise minutes in line with comments received back		**Sponsor Branch** **Department Representatives** **Sponsor Branch**

	from ALB and issue final minutes to Department and ALB within 4 weeks of meeting		**Sponsor Branch**
	TMG members and professional leads to follow up action points with ALB Sponsor Branch to ensure TMG members and professional leads are following up action points by issuing a reminder and asking for update on action point 3 months after meeting		**TMG & Professional leads** **Sponsor Branches**
	CAGU to produce a report for the Department Board on the effectiveness of Departmental arrangements for sponsorship of ALBs which will includes mid-year accountability process		**CAGU**

DHSSPS Arms Length Bodies – End Year Accountability Calendar **APPENDIX D**

		Indicative Dates
MARCH	Accounting Officer to issue commissioning memo to Executive Board Member (EBM) Sponsors, TMG, SCS, professional leads and sponsor branches setting out the roles and responsibilities, timetable, key steps and processes for the accountability meetings TMG Members and professional leads, supported by SCS, consult with own teams on their proposed agenda items/issues CAGU to reissue Controls Assurance Scores, previous years Statement on internal control and Mid-year Assurance Statement to TMG members, Professionals, EBMs and sponsor branches Note: TMG members and Professionals should consider the mid/ end-year Head of Internal Audit report, Audit	**Week Beginning 4th March**

	reports, Controls Assurance Scores and Statement on internal control when identifying topics/issues to be raised	
	CAGU to organise a meeting with Sponsor Branch leads to explain the arrangements for the end-year permanent secretary lead accountability reviews.	**Week Beginning 4th March**
	Sponsor Branches to review and circulate to TMG/SCS as appropriate minutes of most recent accountability meetings to follow up on action points. Sponsor Branch to contact TMG members and SCS Policy and Professional leads to ensure action points followed up	**Week Beginning 4th March**
	TMG leads to respond to requirements of AO commissioning note by (after discussion with their teams) identifying and communicating to EBM sponsors: d) key risks from within their areas of responsibility which they believe mean the timing of the meeting for a particular ALB or ALBs should be prioritised;	**Week Beginning 11th March**

	e) any other timing issues which they believe should be factored in to discussions about the timing of a particular ALBs meeting e.g. timing of another event, publication of a report or availability of other relevant evidence.	
	EBM Sponsors to identify priority list for accountability meetings to CAGU EBM Sponsors to confirm to CAGU which meetings are to be Chaired by Permanent Secretary;	**Week Beginning 18th March**
	Sponsor Branches arrange dates for end-year accountability meetings The timing of end-year meetings with ALBs to be scheduled to prioritise a) the HSCB, b) the PHA and c) ALBs where the EBM has identified significant issues of control and/or performance which need to be prioritised by the Department. Meetings at risk of delay or postponement beyond end June to be scheduled for evening (5-5.30) start time	**Week Beginning 18th March**

	Dates in July to be held as contingencies for postponed/delayed accountability meetings	
	Sponsor Branch to notify CAGU of the time, date and location of meetings	**Week Beginning 18th March**
	CAGU paper provided to TMG on priority list for accountability meetings and Chairing arrangements	**Week Beginning 25th March**
	TMG leads to respond to requirements of AO commissioning note by (after discussion with their teams) identifying and communicating to EBM sponsors: a) possible agenda items/issues from their areas of responsibility (Part A and/or Part B meetings) for each ALB's end- year accountability meeting;	**Week Beginning 25th March**
	EBM Sponsors table draft agendas and specific issues for each assurance and accountability meeting to TMG for agreement/information.	**Week Beginning 25th March**
	CAGU to organise a meeting with Sponsor Branch leads to discuss the outcome of planning process for end-	**Week Beginning 25th March**

	year permanent secretary lead accountability reviews and identify blockages	
APRIL	EBM Sponsor/Sponsor Branch issues memo to TMG members, Policy Leads, Professionals, Finance, Information Governance, Human Resources, and Health Estates and Investment group requesting briefing against proposed agenda items, and nominees to attend to speak to items at the meetings	**Week Beginning 1st April**
	AO issues memo to ALB Chairs and Chief Executives detailing the draft agenda and asking them if there are any specific issues that they wish to raise	**Week Beginning 1st April**
	TMG members and Professional leads to provide briefing to Sponsor Branch at least 2 weeks prior to the meeting	**Week Beginning 15th April**
	CAGU receives Governance Statement from ALBS on ??? which are forwarded immediately to EBMs and sponsor branches If required Sponsor Branch to revise agenda and notify AO, TMG, other professionals, CAGU and ALB in line with issues identified in the Governance statement Sponsor Branches and Policy and professional leads to	**Week Beginning 29th April**

	liaise on provision of any additional briefing required TMG members and Professionals to provide additional briefing ASAP	
	Sponsor Branches to pull together all the relevant briefing and to issue this briefing, 5 working days prior to the meeting, to the AO and Departmental representatives who will be in attendance at the meetings	**Week beginning 29th April onwards**
	Pre-briefs to ideally take place three working days prior to the meeting to allow for briefing to be revised if required Pre- briefs to be attended by AO, EBM, sponsor branch and other TMG members, depending on items being raised at meeting and chairing recommendation Sponsor Branch to revise briefing in line with recommendations made at pre-brief	**Week Beginning 13th May onwards**
	AO chairs the end-year accountability meetings with the HSCB, PHA and HSC Trusts, and others, based on recommendations received from the EBM sponsor EBMs support the AO at Part A of the meetings depending	**Week Beginning 13th May onwards**

	on items to be raised and chairing recommendation Part B of the meeting is attended by AO, EBM and other TMG members, depending on items to be raised and chairing recommendation Sponsor Branch takes the minutes of the meeting	

DHSSPS Arms Length Bodies – Assurance and Accountability Calendar **APPENDIX E**

	Accountability Meetings	**Governance Statement**	**Business Planning Performance Monitoring**	**Mid-Year Assurance Statements**	**Controls Assurance Standards**	**Board, Audit Committee & Sponsor Branch Checklists**
APRIL	End Year process begins with Commissioning letter – see calendar for further details		Sponsor Branch request update on RAG status of all Departmental requirements Policy Leads to verify RAG status		CAGU publish revised Standards on website CAGU to Receive Controls Assurance Scores from ALBs	Sponsor Branch checklist updated by CAGU and issued to Sponsor Brances SB to analyse ALB Board checklist returns and inform CAGU. CAGU prepare a paper for TMG and Departmental Board. CAGU to issue guidance regarding an Independent Evaluation for 14/15
MAY	End-year Permanent Secretary	Receive Statements from all ALBs	CAGU to prepare paper reporting the End year position on all		CAGU to analyse ALB Scores and prepare a Summary paper on the	Sponsor Branch checklists returned to CAGU

	sponsored accountability meeting with ALB (Permanent Secretary Chairs all meetings)	Sponsor Branches and CAGU to analyse and review statements to inform Accountability review Finance Branch to provide input to Departmental Governance Statement	Departmental requirements to Dept Board		CAS process for the June Departmental Board Scores used to inform End Year briefing	Selection to NI Audit Office
JUNE	End-year Permanent Secretary sponsored accountability meeting with ALB (Permanent Secretary Chairs all meetings)	CAGU to prepare a paper on Governance for DARC June meeting			Determine additional Standards to be audited at year end and issue letter to ALBs Paper to Departmental Board	Sponsor Branch to continually update checklist
JULY						Sponsor Branch to

						continually update checklist
AUGUST						Sponsor Branch to continually update checklist
SEPTEMBER	Mid Year Accountability process begins		Department commences work on Corporate and Service Strategic priorities for following year			Sponsor Branch to continually update checklist Receive completed NAO Checklists from ALBs
OCTOBER			Departmental Corporate and Service strategic Priorities Communicated to ALB Chairs	Receive Mid- year assurance statements from all ALBs		Sponsor Branch to continually update checklist CAGU to analyse ALB NAO checklist returns and prepare a paper for DARC December meeting CAGU issue Board Governance Self Assessment checklist to ALBs for completion by

						end of March
NOVEMBER	Mid- year Permanent Secretary sponsored accountability meeting with ALB (Permanent Secretary Chairs meetings with HSCB, PHA, HSC Trusts and other ALBs by exception based on assessment of performance of ALB – otherwise other ALB meetings chaired by TMG lead)		Commissioning Plan Direction and Specific Corporate and Service Priorities issued to Chief Executives	Sponsor Branches & CAGU to analyse and review Mid-year assurance statements to inform Account-ability review CAGU to prepare a paper on Governance for DARC December meeting		Sponsor Branch to continually update checklist
DECEMBER	Mid- year Permanent Secretary sponsored accountability meeting with ALB		HSCB to submit draft Commissioning Plan to Department.			Sponsor Branch to continually update checklist

	(Permanent Secretary Chairs meetings with HSCB, PHA, HSC Trusts and other ALBs by exception based on assessment of performance of ALB – otherwise other ALB meetings chaired by TMG lead)					
JANUARY	Arrange date for End Year Accountability meetings	Finance with input from CAGU to draft Governance statement guidance	All ALBs to submit draft Business Plan for year ahead to the Department. Commissioning Plan to be agreed by Department			Sponsor Branch to continually update checklist
FEBRUARY		Finance to issue guidance to ALBS on the governance statement			CAGU to commission Review of Standards from policy leads	Sponsor Branch to continually update checklist
MARCH			ALB Business Plans		Publish revised	Sponsor Branch to

			(excluding Trust Delivery Plans) to be approved by Department		Standards on website	continually update checklist