BELFAST HSC TRUST 2010/11 YEAR END PERFORMANCE AND ACCOUNTABILITY REVIEW MEETING

Thursday 11 August 2011, Castle Buildings

Attendees

DHSSPS	Belfast HSC Trust
Andrew McCormick	Colm Donaghy
Catherine Daly	Marie Mallon
Liz Mitchell	Martin Dillon
Sean Holland	Bernie McNally
Jim Livingstone	Jennifer Welsh
Eugene Rooney	Brian Barry
Peter Toogood	June Champion
Donncha O'Carolan	Brenda Creaney
Kathy Fodey	Tony Stevens
John McKeown	Catherine McNicholl

HSCB

John Compton
Paul Cummings
Sloan Harper
Jeff Featherstone

PHA

Mary Hinds

1. Welcome and Opening Remarks

1.1 Andrew McCormick welcomed those present to the Trust's year end Performance and Accountability Review meeting for 2010/11.

1.2 Andrew McCormick placed the meeting in the context of the need for robust accountability and assurance processes to be in place for all ALBs. He emphasised that the Accountability Review meetings formed an important part of the process of governance and accountability, and that it was essential that organisations can provide assurance that the relevant processes are in place and that they are continually looking to see how these processes could be improved.

1.3 Andrew McCormick acknowledged that the Belfast Trust has a range of very challenging issues and this demonstrated the need for these Accountability meetings in order to work together to solve problems and identify root causes. He confirmed that the framework document was close to completion. **Action: DHSSPS**

1.4 Colm Donaghy welcomed the process and recognised the accountability framework within which the Trust needs to operate, particularly with the tremendous challenges that lie ahead.

2. Governance – Corporate (2010/11)

(i) Statement on Internal Control(SIC)

2.1 Andrew McCormick reminded the Trust Accounting Officer of the requirement that the SIC must be properly completed and fully compliant with Departmental guidance before submission to the Department. He stated that the SIC is a fundamental part of the assurance process and enables the DHSSPS Accounting Officer to attest to the continuing robustness of the organisation's system of internal control. He emphasised the need to ensure that issues are dealt with through existing systems and in a sensible and transparent manner.

2.2 Colm Donaghy confirmed that he was content that the action plans being implemented to address the five identified internal control problems in the redrafted SIC are adequate to tackle the issues. He confirmed that the Trust considered internal audit priority 1 findings along with the contents of the

Assurance Framework and Risk Register when identifying possible control issues for inclusion in the SIC.

2.3 In relation to significant licensing/accreditation requirements, Tony Stevens confirmed that the Trust has a Licences Manager in place, and that a register is maintained of those licences which have the potential for significant impact on the services provided by the Trust. He stated that there were some challenges around licences but that there were no significant control issues in this area.

2.4 Eugene Rooney reminded the Trust of the need to comply with the Department's documentary requirements as set out in Appendix 1 of the Management Statement.

2.5 Colm Donaghy confirmed that he was satisfied that the Trust's approach to risk management, internal control and corporate governance will highlight any significant internal control weaknesses that exist. He also confirmed that there are no other significant internal control issues that needed to be explicitly mentioned in the statement but advised that the Trust were now finding it difficult to sustain three A&E sites because of staff shortages. Mr Donaghy referred to the possibility of restrictions at the City Hospital from October 2011.

2.6 Andrew McCormick stated that there had been a range of meetings to discuss various issues around A&E and referring to the recent report by NIMDTA, requested assurance from the Trust in respect of the identification and management of risks.

2.7 Colm Donaghy advised that A&E is the first risk in the Trust's risk register. He said that NIMDTA report received last week did refer to "unsafe training environment" and that the Trust was working with NIMDTA to mitigate the risks identified and was trying to address staff shortages. **Action: BHSCT**

2.8 Tony Stevens stated that the Trust had agreed an action plan with NIMDTA to address the training issues identified. He advised that there were particular issues in respect of junior doctors at the Belfast City A&E site adding that the Trust's Human Resources Directorate were investigating these issues including reviewing levels of supervision and induction. **Action: BHSCT**

2.9 John Compton stated that the current level of performance in respect of A&E was a matter of concern and that the restrictions on an A&E facility at this stage would affect performance further. He said the HSCB was working with the Trust to mitigate risks and address capacity issues. **Action: HSCB and BHSCT**

Oral Medicine Service

2.10 Donncha O'Carolan provided some background to one of the five significant control problems included in the Trusts' SIC, the Oral Medicine Service. He advised that a regional review of consultant-led dental services, chaired by CDO, commenced in March 2011 and a report is due for consultation in October 2011. The Belfast Trust, SEHSCT and WHSCT are represented on the project Board along with HSCB, PHA and QUB.

2.11 He advised that the Dental Inquiry report was submitted to the Minister on 24 June 2011, who made a Statement to the Assembly on 28 June 2011 and that the executive report of the Inquiry was published on 6 July 2011. The report makes 45 recommendations and a working group has been established to develop an action plan by the end of August to take forward these recommendations. Belfast Trust is represented on this group. He requested an update from the Trust on the Oral Medicine Service including any further issues emanating from the recall of patients.

2.12 Andrew McCormick advised of the status of the Inquiry report and the need to act on its recommendations. **Action: BHSCT**

2.13 Tony Stevens advised that it has emerged that one further patient may have received a late diagnosis of oral cancer and that 2 experts were now reviewing the history of this case. He advised that an SAI was completed in

this case. He stated that during 2010 there were around 2000 cases where there was not direct supervision and these are in the review cycle. There were around 600 patients discharged where it was difficult to determine what the level of supervision was. He stated that the Trust was inclined to offer a review to all of these patients in line with the recommendation of the Inquiry. Dr Stevens added that this was a big task with significant resource implications and that the Trust would welcome assistance on this front. John Compton agreed that the HSCB would look at the resource issue but emphasised the need to fulfil the recommendations of the Review. **Action: BHSCT and HSCB.**

2.14 It was agreed that the Clinical Governance Group established by the Trust which includes representatives from the PHA and HSCB would be the appropriate forum to decide on the recall of these patients rather than the Inquiry Action Plan working group of the Department.

2.15 Donncha O'Carolan noted that the issue of the oral medicine service was not raised at the last accountability meeting on 2 December 2010 and sought the views of the meeting as to whether this was the appropriate forum for such matters. Andrew McCormick stated that it was imperative that such matters are raised at these meetings and Colm Donaghy agreed that this will be case in future.

2.16 Donncha O'Carolan welcomed the fact that the SAI process relating to the most recent case worked well with the proper procedures being followed.

Dental Hospital Inquiry

2.17 Brian Barry confirmed that the recommendation arising from the Dental Hospital Inquiry, to establish a local governance committee, is being addressed and that the local governance committee of the School of Dentistry is part of the overall BHSCT assurance scheme.

Ombudsman's Case

2.18 Brian Barry also referred to an ongoing Ombudsman's case in respect of a dental issue where a consolatory payment was recommended which the Trust had been advised it was unable to pay. This had been referred to FPAU in the Department for guidance but was not yet resolved. Other consolatory payments were referred to and the Trust advised that CMO had asked for a meeting with the Ombudsman to discuss consolatory payments. **Action: DHSSPS**

Information Governance - Belvoir Park

2.19 Catherine McNicholl stated that the Trust has had a series of meetings with the Information Commissioners Office (ICO) which has advised that it will take several months before a decision is reached with the potential of a fine up to £0.5m. She advised that the ICO believed this was a significant breach, particularly because of the numbers and types of documents involved.

(ii) Audit Priority 1 Findings

2.20 Peter Toogood welcomed the overall opinion of the head of Internal Audit that, for the year ended 31 March 2011, there is a satisfactory system of internal control designed to meet the Trust's objectives.

2.21 Martin Dillon confirmed that action plans are in place to address all Priority 1 findings and that substantial progress has been made in respect of implementing Priority 1 recommendations.

(iii) Controls Assurance Standards

2.22 Eugene Rooney noted that the Trust achieved substantive compliance in all applicable controls assurance standards but highlighted a few areas of concern in individual criterion scores in Buildings, Medical devices and equipment and Medicines Management. Tony Stevens said that action plans were in place to address any deficiencies and that regular reports on controls assurance standards are provided to the Assurance Committee and Audit Committee.

3. Governance – Quality (2010/11)

(i) Statutory Duty of Quality

3.1 Jim Livingstone explained that, although responsibility for arrangements around managing and reporting serious adverse incidents (SAI) transferred to the HSCB in 2010, the Department will continue to wish to be assured that lessons emerging from investigation and analysis of such incidents are being identified and disseminated in a timely and consistent manner with the overall aim of minimising the risk of occurrence. He stated that the Department will also seek assurances that Trusts are learning from other adverse incidents and near misses recorded within the Trust.

3.2 Colm Donaghy explained that the SAI process within the Trust is followed very closely and that there is a clear method for dealing with incidents with the serious ones included in the principal risk document while those less serious included in the directorate risk register. He said that learning is formally reported to the Assurance Committee in order to inform the organisation and the wider system. He advised of a split function for dealing with SAIs with the Medical Director overseeing the reporting process while the Director of Nursing chairs an SAI review responsible for learning lessons.

3.3 Brenda Creaney advised that a lessons learned flyer which brings together particular themes or issues, distributed to all staff, was well received. She said that this was believed to be very helpful for staff and local governance arrangements. She also said that the Trusts' SAI Review Board identify if current methodology is being used. Brian Barry stated that the learning from all complaints incidents is integrated throughout the organisation.

3.4 Jim Livingstone enquired as to the barriers for implementing Patient Safety Alerts pointing out that of 17 alerts issued, 6 had been fully implemented with 11 partially implemented.

3.5 Tony Stevens set out the procedure for dealing with Patient Safety Alerts (PSA) within the Trust advising that they are allocated to the appropriate directorate, tracked and reported back. He explained that a significant number have a regional dimension and require simultaneous implementation across all Trusts. He confirmed that the Trust takes PSAs very seriously and that all of them are on a register and monitored on a regular basis.

(ii) Statutory Duty of Involvement/Personal and Public Involvement

3.6 Colm Donaghy confirmed that he was satisfied that in general, that the Trust has established sufficiently effective governance arrangements to ensure that it is compliant with the statutory duty of involvement across the full range of its business, and that these arrangements are sufficiently robust to withstand any potential legal challenge.

(iii) Statutory Duty on Health and Wellbeing

3.7 Liz Mitchell asked how the Trust Board assures itself that it is meeting its statutory duty to exercise its functions with the aim of improving health and social well being and reducing health inequalities. Colm Donaghy stated that the improvement of health and social wellbeing is integrated throughout the Trust. He advised that a strategy has been approved by the Trust Board and regular update reports are provided to the Board. He agreed to provide the Department with the latest update report. **Action BHSCT.**

4. Governance – Finance (2010/11) [Agenda item 3]

(i) Procurement

4.1 Andrew McCormick stressed that there was a range of procurement guidance which the Trust must ensure that it complies with and emphasised the

importance of Service Level Agreements (SLAs) with the relevant Centres of Procurement Expertise (COPEs).

4.2 Peter Toogood reminded the Trust that poor procurement practice can lead to Accounts qualification, Assembly criticism and, in particular cases, litigation and court fines. He stated that Trust procurement policies must reflect the NI Executive's overarching public procurement policy and must also comply with all relevant DFP, national and EU guidance. He stressed that any procurement outside the two Centres of Procurement Expertise (BSO PaLS for goods & services and DHSSPS Health Estates Investment Group (HEIG) for major capital works) should be highly exceptional and fully justified.

4.3 Peter Toogood emphasised that Trusts should ensure they comply with the relevant guidance setting out the exceptional circumstances when single tender action may be used and that all single tender actions should be subject to Accounting Officer approval.

4.4 Colm Donaghy provided assurance that proper processes would be followed in respect of single tender action and will report back to the Department on those single tender actions already taken to demonstrate that they were the only available provider. He stated that the Trust wished to migrate as far as possible to a position where procurement is made through a COPE or influenced by a COPE. **Action BHSCT.**

4.5 Martin Dillon pointed out that the Trust takes its responsibility for procurement very seriously and believed that the organisation is making very good progress in this area. He very much welcomed the Department's Review of Arrangements for the Control of Procurement Expenditure as he believed some of the service and maintenance contract guidance was falling between the two COPEs (PALs and HEIG).

4.6 Andrew McCormick agreed that the Review gave the opportunity to make a positive difference in respect of procurement.

4.7 Peter Toogood reminded the Trust that as stated in the Financial Memorandum it must undertake periodic reviews of its procurement activity and share the results of such reviews with the Department. **Action: BHSCT**

(ii) Financial Management

4.8 Peter Toogood commended the Trust in reporting a surplus of £64k in its 2010/11 final Accounts. He noted that whilst the Trust had achieved its CSR efficiencies target, the efficiencies needed to be secured on a wholly recurrent basis. There was also a need to ensure that forecasts of the year-end financial position were as robust as possible from the outset of the year. The Trust confirmed that there were no concerns regarding the Trust's financial governance to report. The Trust confirmed that freehold and leasehold information for the HSC estate would be provided to the department by 31 August. **Action: BHSCT**

4.9 Colm Donaghy commented that the Trust had benefited from a system-wide financial plan in 2010/11: previously each organisation had operated in silos. Within the system-wide plan for 2011/12, Belfast Trust was playing its part in pursuing savings. The Trust was in dialogue with the HSCB on the implications for this year. The challenges are even greater to budgets for 2012/13. It was noted that the savings made and the difficulties faced were relevant issues to raise with the PEDU Review.

4.10 Peter Toogood reminded the Trust on the requirements for identifying expenditure on art in capital projects. The Department had written to the Chief Executive on 16 June on this matter. **Action: BHSCT**

5. Performance against Objectives

(i) Corporate/Business Plans Objectives

5.1 Catherine Daly advised that the Department is aware that some of the Trusts have concerns about the requirements for Corporate/Business plans as set out in the Management Statement. She said the Department is therefore

preparing guidance with a view to specifying clearly what needs to be included in the corporate/business plan going forward in order to achieve a measure of uniformity between the various plans.

(ii) Progress against PfA targets for 2010/11

5.2 John Compton provided a summary of performance across the 76 PfA standards and targets applicable to the Belfast Trust that are monitored by the HSCB. He stated that 55% of targets/standards had been substantially or partly achieved with the remaining 45% not achieved. He advised that there were major issues in respect of elective care particularly around the 9/9/13 weeks target which were not achieved but stated that the agreed backstop positions had been substantially achieved. He advised that the HSCB was working with the Trust to ensure that, although not ideal, the position did not get any worse than 31 March 2011. He advised that the A&E performance continued to be a difficult area and confirmed that the HSCB was working with the Trust on this issue. **Action: HSCB and BHSCT**

5.3 John Compton stated that performance in the arena of childrens targets/standards was generally good although Family Support (initial assessment) was an area of concern. He stated that performance for the year in respect of HCAI and Autism targets was also good. He advised that the numbers in terms of cardiac surgery were satisfactory, informed of a £1.8m investment in Urology and that it was pressing on the Trust to deliver in this area.

5.4 He highlighted a problem with endoscopy waiting times and confirmed that the HSCB was in discussion with the Trust for additional clinics with the objective to get within the 13 weeks arrangement.

5.5 John Compton advised that overall, his main concerns were that the position of 31 March 2011 has drifted out for a number of areas and although not ideal the Trust has provided an assurance that it will pull back to that position.

5.6 Colm Donaghy advised that the Trust was not comfortable with the current position in respect of elective care standards/targets but stressed that it was working hard with clinicians to improve the position and at least hold the 31 March position. He advised that the organisation was looking at how performance can be improved in respect of A&E and in particular how to improve the interface between community and unscheduled care. He advised of the Unscheduled Care Project which he hoped would bear fruit on the performance of A&E and the Trust as a whole.

5.7 Catherine McNicholl confirmed that Mr Compton's assessment was a fair reflection on the Trusts' performance and that the Trust would continue to work with the Board to address any outstanding commissioning issues with regard to demand/capacity.

5.8 Andrew McCormick acknowledged those areas of good performance but stressed that the Trust must ensure the best possible approach is taken to address issues and improve performance. He stated that this performance assessment highlighted a number of areas of concern and that the Department would be wishing to discuss the root causes at the forthcoming HSCB Accountability meeting.

6. Governance, operational and financial issues and risks for 2011/12 and beyond

(i) Strategic Direction

6.1 Andrew McCormick advised that the Minister has initiated the HSC Review to tackle the issues of a changing demographic, an ageing population, advances in medicine, rising public expectations and financial resources constraints. He said the review is to report back to the Minister by 30th November 2011 and will enable the Minister to plan and ensure that resources are used in the right way and money is spent on the right things. For the medium to long term, decisions on reconfiguring health and social care will be based on the outcome of this review and longer-term priorities

and objectives for HSC will be informed by this review. He stated that there was also further work to do with the PEDU which was expected to be completed by October 2011.

6.2 Colm Donaghy agreed that there is a need to look fundamentally at how the HSC is delivered in the future and hoped that the Review would set out a roadmap for the HSC.

(ii) Financial Position

6.3 Peter Toogood highlighted the significant financial challenges facing the HSC as a whole and reminded the Trust of the need to take all possible actions to live within the available resources.

(iii)Bowel Screening Programme

6.4 Liz Mitchell relayed the Department's concerns about the delay in rolling out the bowel cancer screening programme to the Belfast Trust and requested an assurance that the Trust will commence the screening programme before the end of the year. John Compton stated that this was a big priority for the HSCB, PHA and the Trust and that discussions were ongoing in order to take this forward more quickly. **Action: Trust to provide a commencement date.**

7. Any Other Business

7.1 Andrew McCormick thanked the Belfast Health and Social Care Trust representatives for their contributions to the meeting. He commented that the department would continue to work with the Trust to strengthen the relationships in the interests of ensuring that accountability arrangements operate continuously and effectively throughout the year.

Performance Management Unit
October 2011

MAHI - STM - 089 - 6392

CHECKLIST FOR ARM'S LENGTH BODY (ALB) SPONSOR BRANCHES

Version control: 1.9 updated June 2021

Name of ALB:

Name of Sponsorship branch:

Checklist completed by:

Checked by G7:

Cleared by EBM Sponsor: **Date:**

Statement of Purpose

- The purpose of this checklist is to provide a guide for Sponsor Branches in terms of assessing the extent to which they are operating within departmental guidelines and good practice.
- Completion of the checklist will assist the Executive Board Member Sponsor in providing assurance to the Accounting Officer on the adequacy of existing accountability arrangements.
- This is an internal tool to assist sponsor branches. The evidence section allows sponsor branches to record timely and proportionate evidence in support of the checklist. This is not intended to be exhaustive and in line with good practice, sponsor branches should ensure that accurate and timely records are maintained on CM.
- The checklist is supported by the Sponsorship Handbook and is underpinned by the 'comply or explain' principle.

1. Board minutes

1.1	Yes	No	Partly
Can you confirm that: a) As part of the induction process, new sponsor branch staff familiarise themselves with the ALB's founding legislation. b) an approved Management Statement/Financial Memorandum (MS/FM) or partnership agreement between Department and ALB is in place c) the MS/FM or partnership agreement is reviewed and updated at least every 5 years (MSFM)/3 years (partnership agreement); and d) the MS/FM or partnership agreement is publically available through the ALB (e.g. on the ALB website)? e) Documentation is provided to the Department by the ALB as set out in the Management Statement/partnership agreement – annual engagement plan. f) If partnership agreement has been initiated, annual engagement plan has been completed as required			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

1.2	Yes	No	Partly
Can you confirm that: a) all operational staff in the sponsor branch have attended a training course in relation to sponsored bodies, to aid their full understanding of roles and responsibilities; and b) A representative from sponsor branch attends the majority of Sponsor Branch Forums			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

1.3 (a) to (c) only required if new Chief Executive 1.4 (d) required if a Chief Executive has been in post over 6 years.	Yes	No	Partly
Can you confirm: a) The ALB Chief Executive has acknowledged in writing receipt of a formal letter of designation as Accounting Officer defining the role and responsibilities of this position; b) The clerk to PAC has been informed of the appointment; and c) The ALB Chief Executive has, within six months and preferably within three months of appointment, attended an accounting officer training course run by Chief Executives Forum d) Refresher Accounting Officer Training is undertaken at least every six years.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

2.0 ALB Board Governance

2.1 To be completed by Public Appointments Unit	Yes	No	Partly
Can you confirm that: a) Appointments to the Board of the ALB are in line with the 'Code of the Commissioner for Public Appointments NI' b) Appointments and tenure periods of Board members are monitored to ensure that appointment competitions are run on a timely bases c) Board appointments are sufficiently staggered to ensure that there is appropriate retention of experienced Board members balanced by the influx of new members bringing fresh challenges			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

2.2 To be completed with input from Public Appointments Unit	Yes	No	Partly
Can you confirm that a) All newly appointed ALB Board Members have attended an appropriate training course preferably within 6 months of appointment. This training course (which is provided by either CIPFA or ON BOARD TRAINING) is in addition to any Induction training provided by the Chair and the ALB and increases their effectiveness in discharging their roles and responsibilities b) an approved, publicly available, Code of Practice for ALB board members setting out the standard of conduct to which they are expected to adhere is available; c) a senior Departmental representative conducts an annual appraisal of the ALB board Chair; and d) the ALB board Chair conducts annual appraisals of all Non-Executive Directors. This appraisal includes consideration of performance as a committee member (as appropriate)?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

2.3 Board Meetings	Yes	No	Partly
Can you confirm that the ALB; a) holds open board meetings; b) advises the public of board meetings; c) makes minutes publicly available and d) has a register of board members/ALB Senior Staff interests that is available publicly.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

2.4 Board Agenda	Yes	No	Partly
Can you confirm that the Board of the ALB a) receives and reviews regular updates on the ALBs performance (both non-financial and financial performance); b) considers the risks facing the organisation including reviewing the Body's corporate risk register; c) receives reports from the Board's committees (as specified in the ToR) on the work they are undertaking; and Can you confirm that the Board Chair: d) completes an annual review of board effectiveness using the DOH Board Self-assessment tool which is discussed with the EBM/Lead official; and e) Undertakes an externally facilitated review of Board effectiveness at least once every three years			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

2.5 Board Minutes	Yes	No	Partly
Can you confirm that: a) the sponsor branch receives copies of the minutes of ALB board meetings as soon as these are available and that these are reviewed in a timely manner? b) If concerns are identified, assurance is sought from the ALB that appropriate action is being taken to address issues? c) any unresolved issues arising from the areas covered by Section 2 of this template are escalated in the Department as appropriate?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

3. Business Planning and Risk Management

3.1	Yes	No	Partly
Can you confirm that: a) ALB collaborates with the Department on development of corporate and business plans b) the ALB has a corporate plan in place in line with the Assembly budget process c) the ALB has a more detailed business plan for the year developed by the ALB on an annual basis; d) ALB plans are reviewed and approved by the Department before the start of the reporting year; and e) appropriate processes are in place in the Department to monitor the performance against approved business plans.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

3.2	Yes	No	Partly
Can you confirm that: a) the ALB has a Board approved Corporate Governance Framework in place; b) the ALB has a clear risk management strategy in place that is kept up to date; and c) Compliance with risk management policies and procedures is subject to regular internal audit review.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

3.3	Yes	No	Partly
Can you confirm that the ALB Risk Register: a) is linked to key strategic/annual objectives to ensure that risks to their achievement have been identified and are being actively managed; b) contains the required information i.e. the ALB's assessment of the level of risk (likelihood/impact), key controls and any action required; c) is approved by the Audit/Governance Committee and/or ALB board; and d) is a 'live' document i.e. is there evidence of: • text being updated, risks moving on and off register over time, rating of risks changing, action points being added and removed as addressed; • regular reports to the Audit/Governance Committee and ALB board on risks; and • it being reviewed by ALB internal Audit?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

3.4	Yes	No	Partly
Can you confirm that: a) the ALB's risk registers are provided at least biannually to the Department; b) the risk registers are considered by sponsor branch to ensure that they include mitigating measures and actions to address identified risks; and c) Significant ALB risks are considered by the sponsor branch (with input from policy leads as required) for possible escalation within the department.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

4. Governance arrangements

4.1	Yes	No	Partly
Can you confirm that the ALB's mid-year assurance statement and Governance Statement each: a) details significant internal control divergences; b) reflects the outcomes of any adverse Internal Audit reports; c) provides the necessary assurance that appropriate action is being taken to address the control/risk issues identified; and d) provides for the mid-year and end-year accountability reviews, due assurance that all significant control issues are identified and that there is effective management of risk? Does Sponsor Branch escalate through Finance significant control divergences for consideration for inclusion in Department's Governance Statement?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
<u>Supporting evidence</u>			

4.2	Yes	No	Partly
Can you confirm that a) a ground clearing meeting at senior departmental level is held with the ALB at least biannually; b) an accountability meeting chaired by the Permanent Secretary (or appropriate deputy by exception) is held with the ALB at least annually; c) governance, resources, quality and service delivery issues are considered as agenda items as appropriate; d) Minutes for both meetings should be drafted and circulated as promptly as possible after the meeting, ideally within 2 weeks; e) outside the formal accountability process, the sponsor branch engages with the ALB as regularly as appropriate; f) the EBM provides annual assurance to the AO that the level of sponsorship for the ALB is proportionate.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and			

associated timeframes:
Supporting evidence

4.3	Yes	No	Partly
Can you confirm that the ALB has in place an Audit Committee which fully complies with the requirements of DAO (DOF) 03/18 Audit and Risk Assurance Committee Handbook (NI) that it: a) is chaired by a suitably experienced non-executive; b) has a wholly non-executive membership with a minimum of three members; c) has a least one member with recent financial experience; d) has a TOR approved by Board and publicly available; e) provides a report to the Board after each meeting and produces an annual report to support the Governance Statement; f) has a membership which, preferably within six months of appointment, attended appropriate training courses on their respective roles and responsibilities; Can you confirm that a departmental representative has attended at least one audit committee meeting in the course of the financial year?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

4.4	Yes	No	Partly
Can you confirm that: a) The ALB has a Business Continuity Plan in place; and b) The Business Continuity Plan is reviewed annually.			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			

Supporting evidence

4.5	Yes	No	Partly
If the ALB is subject to regular inspection by an external body (e.g. MHRA), can you confirm that: a) the sponsor branch receives copies of any adverse inspection reports; b) the ALB has an action plan in place to address the recommendations therein; and c) satisfactory progress is being made in implementing the recommendations (*this excludes RQIA inspection reports)			
Supporting evidence			

4.6	Yes	No	Partly
Can you confirm that the ALB has in place: a) robust anti-fraud measures, as set out in Appendix A.4.7 of MPMNI, and that these are formally considered by the ALB Audit committee; b) A whistle blowing policy; c) A gifts and hospitality policy; d) A complaints procedure covering both ALB staff and Board members			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

5. Internal audit

5.1	Yes	No	Partly
Can you confirm that the sponsor branch: a) has an annual meeting with the ALB's internal audit to discuss issues and topics for consideration for inclusion in ALBs audit plan and audit strategy?			

b) Receives regular, periodic self-assessments of the internal audit function in line with Public Sector Internal Audit Standards; and c) External Quality Assessment of the Internal Audit function is conducted at least every 5 years by a qualified independent assessor			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

5.2	Yes	No	Partly
Can you confirm that the sponsor branch receives and reviews on a timely basis; a) the Internal Audit workplan; (timeframe for Audit work) b) HIA annual and mid-year assurance statements; c) Internal audit assignment reports where satisfactory assurance is not received d) all Audit Committee minutes; and e) copies of Reports To Those Charged With Governance sent to the ALB Can you confirm that the sponsor branch provides copies of HIA mid year and annual reports to departmental HIA?			
If the response is 'No or 'Partly', please confirm what action is being taken to address issues and associated timeframes:			
Supporting evidence			

Summary of any issues identified during completion for checklist that require follow-up action or consideration for escalation.

Chapter 1 – Governance Statement

1. What does the Governance Statement tell us?

The Governance Statement is the means by which the Accounting Officer provides a comprehensive explanation on the Arms Length Bodies' (ALBs') approach to governance, risk management, internal control and how they operate in practice. The Statement also provides an account of the ALB's Board and Committees, including reference to the board's performance and effectiveness.

In addition, it represents a medium for the Accounting Officer to highlight significant control issues which have been identified during the reporting period and those previously reported control issues which are continuing within the ALB.

The Governance Statement forms an integral component of the Annual Report and Accounts.

2. Why do we have a Governance Statement?

Public bodies must provide assurance that they are appropriately managing and controlling the resources of ALBs for which they are responsible. The Statement is an important accountability document in communicating these assurances to the Assembly and the public.

The Statement is a mandatory disclosure for all central government entities that comply with the Financial Reporting Manual (FReM). It is a primary accountability document. The external auditors do not provide an explicit audit opinion on the content, but it is subject to external audit review to ensure that it has been prepared in accordance with Government guidance and that it is consistent with the auditors' knowledge of the entity.

3. Roles and Responsibilities

Accounting Officer

Accounting Officers are required to make an annual statement – the Governance Statement (the Statement) – alongside the accounts of the body and in accordance with this guidance using the template at Appendix x. It should be noted that the Statement covers the accounting period and the period up to the date of signature. The Accounting Officer is charged with signing the Statement; maintaining a sound system of internal governance that supports the achievement of the department's policies, aims and objectives; and regularly reviewing the effectiveness of that system.

The Statement must be physically signed by the Accounting Officer of the Arm's Length Body (ALB) prior to submission.

ALBs should note that where the Accounting Officer has changed during the period covered by the Statement, or between the end of the period and the date of signature, the Accounting Officer in post on the date of signature is the person who should sign the Statement.

The ALBs' Board

The Board is ultimately responsible for the ALB's internal governance. Boards will normally delegate the task of establishing, operating and monitoring the governance framework to management, but they cannot delegate their responsibility for it. Reviewing the effectiveness of internal governance is an essential part of the Board's responsibilities.

The Board must satisfy itself as to the adequacy of the Statement and must ensure their knowledge is detailed enough for it to concur with the proposed Statement. The Board must ensure that the Statement takes account of all significant events or issues.

Audit Committee

The Audit Committee plays a key role in the production of the Statement. It supports the Board and Accounting Officer by reviewing the comprehensiveness of assurances the Board and Accounting Officer receives, and reviewing the reliability and integrity of the assurances. The Audit Committee also advises the Board and Accounting Officer of any

control issues that could or should be considered significant and are therefore appropriate for disclosure in the Statement.

Internal Audit

Internal Audit provides the Accounting Officer with an objective evaluation of, and opinion on, the overall adequacy and effectiveness of the ALB's framework of governance.

4. What does a Governance Statement disclose?

The Governance Statement Template sets out the expected form and content of the statement. This is a mix of prescribed text and sections where Accounting Officers are expected to describe the particular arrangements in their ALBs.

The Statement should contain disclosures under the following headings:

1. Introduction/ Scope of responsibility
2. Compliance with Corporate Governance Best Practice
3. Governance Framework
4. Framework for Business Planning and Risk Management
5. Information Risk
6. Public Stakeholder Involvement
7. Assurance
8. Sources of Independent Assurance
9. Review of Effectiveness of the System of Internal Governance
10. Internal Governance Divergences
11. Conclusion

Chapter 2 – Guidance on completion of proforma

1. Introduction / Scope of Responsibility

This reports the Accounting Officer's responsibility for maintaining a sound system of internal governance and should provide an explanation of the accountability arrangements surrounding their role. In particular, it should include an account of the

- processes in place by which the ALB works with the Health and Social Care Board and (other) partner organisations; and
- inter-relationships with the Department or other ALBs.

2. Compliance with Corporate Governance Best Practice

This is a high level statement which describes the ALBs assessment of the board's compliance with the principles of good practice in Corporate Governance, with explanations of any departures.

3. Governance Framework

This describes the governance framework of the ALB including information about

- the Board/Council's committee structure, its attendance records, role and performance;
- the Audit Committee's role and performance;
- other relevant committee's role and performance e.g. Governance.

4. Business Planning and Risk Management

Business Planning

This describes the key elements in the business planning process, including how objectives are identified, managed and reviewed. This section must explicitly include

how the ALB's business planning process ensures statutory obligations and ministerial priorities are met.

Risk Management

This describes the key elements in risk management process, including how risk is identified, evaluated and controlled. This section must explicitly describe how risk appetites are determined; the ALB's risk profile; explain how risk management is embedded within the ALB; and describe how public stakeholders are involved in managing risks which affect them (where appropriate).

Once a body has the appropriate risk management and review processes in place, it is important that they are maintained and developed to ensure their continuing effectiveness. The Statement should record the key elements of the way in which this is done, whether as part of a "planned maintenance" programme or in response to problems or significant external developments (for example, machinery of government changes) and the evidence used to assess effectiveness.

This section should also describe how leadership is given to the risk management process, how staff are trained or equipped to manage risk and how the ALB learns from good practice.

Changes to business planning or risk management in year should be highlighted. Disclosure should cover how quickly and effectively the ALB embedded these changes within the day to day operations of the ALB.

5. Information Risk

This section must describe the management and control of information risk. This must explicitly include how the ALB ensures that information used for operational purposes and reporting purposes is handled appropriately, particularly where it is used by third parties or other parts of government.

In addition, it should also describe how the Accounting Officer and Board receive assurances that the processes are being managed effectively, and that these assurances are obtained from managers, Internal Audit or other assurance providers.

6. Public Stakeholder Involvement

This section describes the key elements of the way in which the ALB ensures the involvement of service users and other stakeholders in identifying and managing risks. (This section should only be inserted by those bodies to which it is relevant).

7. Assurance

This section describes the key elements of the way in which the ALB receives assurances including information about the quality of the assurances received.

Controls Assurance Standards

Each ALB should show its compliance against the applicable Controls Assurance Standards which are defined by the Department and against which a degree of progress is expected in the year.

8. Sources of Independent Assurance

This section should list and describe the sources from which the ALB receives Independent Assurance e.g.

- Internal Audit;
- Northern Ireland Audit Office;
- RQIA; and
- any other relevant Licensing/Regulatory authorities.

Internal Audit

This section describes the internal audit function in place within the ALB. It should identify the systems which have been reviewed during the year and the relevant

ratings given. It should specifically identify areas of limited assurance and priority 1 findings and confirm that recommendations to address these control weaknesses have been or are being implemented.

9. Review of Effectiveness of the System of Internal Governance

This section confirms that the Accounting Officer has responsibility for reviewing the effectiveness of the system of internal control. It should provide assurance that the review has been informed by relevant parties e.g. internal audit, executive directors and that implications resulting from the review have been highlighted by relevant internal mechanisms e.g. Board/Council, Audit Committee, Governance Committee, Clinical Governance Committee, Risk Committee etc. In addition it should provide assurance that plans to address weaknesses and ensure continuous improvement to the system are in place.

10. Internal Governance Divergences

ALBs should report on all significant control issues identified and continuing during the reporting period. It is imperative that control issues raised internally and through sponsor branches are reported in the Statement. It is the responsibility of the Accounting Officer to consider the impact of all significant issues arising and consider their impact on the Statement, ensuring it is complete, comprehensive and transparent.

When completing the ‘Significant Internal Control Issue’ section of the Statement, Accounting Officers must ensure that the actual internal control issue is identified and not only the consequence, outcome or event which occurred as a result of a weakness in internal control arrangements. Disclosure of internal control issues should be comprehensively detail;

- the internal control issue or the processes in place to identify the issue;
- how the issue arose;
- remedial action taken or proposed to prevent recurrence; and
- timescales involved (This should include explanations for any variation against original timescales).

Significant internal control issues should be reported under 3 headings;

- an update on prior year control issues which have now been resolved and are no longer considered to be control issues;
- an update on prior year control issues which continue to be considered control issues; and
- identification of new issues in the current year, including issues identified in the mid-year assurance statement, and anticipated future issues.

The purpose of this disclosure is to deliver assurance that significant internal control issues have been, or are being, addressed and that the Statement is a balanced reflection of the actual control position.

There is no single definition of a "significant internal control issue". Accounting Officers will need to exercise judgement in deciding whether or not particular issues or events should be considered for inclusion into their Statement. Factors which may be helpful in exercising that judgement include:

- the issue could or has seriously prejudiced or prevented achievement of a key business target or other priorities;
- the issue could or has put a significant programme or project at risk;
- it could or has resulted in a need to seek additional funding from the DFP (Department of Finance and Personnel) / the sponsoring department to allow it to be resolved, or has resulted in significant diversion of resources from another aspect of the business;
- the Audit or Governance and Risk Committee advises it should be considered significant for the purposes of the Statement;
- Internal Audit reports on it as having significant influence in their annual report on risk and governance;
- the issue, or its impact, has attracted or has the potential attract significant public interest/concern;
- the issue, or its impact, has attracted or has the potential to impact on the reputation of the body or operating sector;

- the business areas external auditor regards it as having a material impact on the accounts;
- the issue could or has had a material impact on the accounts;
- the issue has been escalated to the Departmental Accounting officer or Chief Professional Officer during the year; or
- the issue has been accepted by the Northern Ireland Commissioner for Complaints ombudsman for investigation.

Other considerations when identifying possible significant internal control issues for inclusion in the Statement;

- the contents of both the ALB's Assurance Framework and Risk Register;
- Internal Audit priority 1 findings;
- External Audit Findings; and
- compliance with the licences, other legislation, and regulatory bodies.

The Board of the ALB should ensure that all potential control issues have been fully explored by the Accounting Officer.

It is important that all issues identified by senior staff as being relevant or having an impact on the Statement are provided for potential inclusion in the Departments Resource Accounts pack.

At the time of preparing the Statement for a particular year, disclosure of information about a significant internal control issue might prejudice the outcome of a special investigation (possibly preventing successful prosecution in a case of fraud, or inhibiting a disciplinary case against members of staff). In such circumstances, the Statement should record that there are issues which cannot be disclosed because to do so would prejudice the outcome of an investigation. In such cases, the external auditors should be made aware of the background.

Issues identified up to and including the day of signature should, where appropriate, be included in the Statement.

11. Conclusion

MAHI - STM - 089 - 6414

This section gives the Accounting Officers overall conclusion on the operation of system of internal governance within the ALB.

MAHI - STM - 089 - 6415

PRO FORMA GOVERNANCE STATEMENT

The wording shown below which is not in *italic* script or highlighted in ***bold/italic*** in this pro forma should be replicated in each Arms Length Bodies' individual Governance Statement. The wording in *italic* script should be amended as appropriate to refer to the Arms Length Bodies (ALB) in question. ***Bold/italic*** script indicates a section which should be completed to reflect the actual/specific processes in place in the ALB to which the Statement relates.

ALBs must develop the model wording to suit their own circumstances and explain:

a) what has been done to date;
b) anything that remains to be done; and
c) the action planned for the coming year with a proposed timetable.

The Statement should be signed by the Accounting Officer of the ALB.

MODEL ALB GOVERNANCE STATEMENT

1. Introduction / Scope of Responsibility

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

(Accounting Officers should add to this paragraph to provide an explanation of the accountability arrangements surrounding their role. In particular, they should comment on:

- ***processes in place by which they work with the Health and Social Care Board and (other) partner organisations; and***
- ***inter-relationship with the Department or other ALBs .*)**

2. Compliance with Corporate Governance Best Practice

[*ALB*] applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. The [*ALB*] does this by undertaking continuous assessment of its compliance with Corporate Governance best practice by ***(include the [Board/Council]'s assessment of its compliance with best practice Corporate Governance with explanations of any departures.)***

3. Governance Framework

(The ALB should provide an account of the governance framework of the organisation, including information about

- ***the [Board/Council['s committee structure, its attendance records, role and performance***
- ***the Audit Committee's role and performance;***
- ***other relevant committee's role and performance e.g. Governance.)***

4. Business Planning and Risk Management

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

(Describe the key elements of the Business planning process, including how objectives are identified, managed and reviewed.

Describe the key elements of the risk management strategy, including the way in which risk (or change in risk) is identified, evaluated, and controlled.

Describe key ways in which risk management is embedded in the activity of the organisation.

Describe the key ways in which leadership is given to the risk management process and staff are trained or equipped to manage risk in a way appropriate

to their authority and duties. Include comment on guidance provided to them and ways in which you seek to learn from good and poor practice.)

5. Information Risk

(Describe the key ways in which risks to information are being managed and controlled as part of this process.)

6. Public Stakeholder Involvement

(Describe the key elements of the way in which the ALB ensures the involvement of service users and other stakeholders in identifying and managing risks.)(This section should only be inserted by those bodies to which it is relevant).

7. Assurance

(Describe the key elements of the way in which the ALB receives much of its assurance including information about the quality of the assurance received by the [Board/Council], and why the [Board/Council] finds it acceptable.)

Controls Assurance Standards

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

The Organisation achieved the following levels of compliance for [*2012/13*].

Standard	DHSS&PS Expected Level of Compliance	Trust Level of Compliance	Audited by XXX
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)		
Decontamination of medical devices	75% - 99% (Substantive)		

Emergency Planning	75% - 99% (Substantive)		
Environmental Cleanliness	75% - 99% (Substantive)		
Environment Management	75% - 99% (Substantive)		
Financial Management ***(Core Standard)***	75% - 99% (Substantive)		
Fire safety	75% - 99% (Substantive)		
Fleet and Transport Management	75% - 99% (Substantive)		
Food Hygiene	75% - 99% (Substantive)		
Governance ***(Core Standard)***	75% - 99% (Substantive)		
Health & Safety	75% - 99% (Substantive)		
Human Resources	75% - 99% (Substantive)		
Infection Control	75% - 99% (Substantive)		
Information Communication Technology	75% - 99% (Substantive)		
Management of Purchasing and Supply	75% - 99% (Substantive)		
Medical Devices and Equipment Management	75% - 99% (Substantive)		
Medicines Management	75% - 99% (Substantive)		
Records Management *[2012/13].* *[From 2013/14 this*	75% - 99% (Substantive)		

standard will be Information Management].			
Research Governance	75% - 99% (Substantive)		
Risk Management *(Core Standard)*	75% - 99% (Substantive)		
Security Management	75% - 99% (Substantive)		
Waste Management	75% - 99% (Substantive)		

8. Sources of Independent Assurance

The *[ALB]* obtains Independent Assurance from the following sources:

(List and Describe these sources e.g.

- ***Internal Audit;***
- ***Northern Ireland Audit Office;***
- ***RQIA***
- ***Add Other relevant Licensing/Regulatory authorities as appropriate etc.)***

Internal Audit

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

In *2012-13* Internal Audit reviewed the following systems **(specify the systems and assurance received)**.

In his annual report, the Internal Auditor reported that the [*ALB*] system of internal control was adequate and effective [or otherwise as concluded by auditors]. However, ***(number)*** weaknesses in control were identified in a **([*small*] *number [be specific] of areas detailed as appropriate)*** Recommendations to address these control weaknesses have been or are being implemented.

9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the *[ALB]* who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the [detail the relevant internal mechanisms e.g. *[Board/Council]*, Audit Committee, Governance Committee, Clinical Governance Committee, Risk Committee etc], and a plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

(Disclosure of internal control issues should be comprehensive; covering how the issue arose; remedial actions taken / proposed to prevent recurrence and the timescales involved. This should include explanations for any variation against original timescales.

Internal control issues should be reported under 3 headings:

- ***an update on prior year control issues which have now been resolved and are no longer considered to be control issues;***
- ***an update on prior year control issues which continue to be considered control issues; and***
- ***identification of new issues in the current year (including issues identified in the mid-year assurance statement) and anticipated future issues.)***

11. Conclusion

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

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

Department of Health

ARM'S LENGTH BODIES

SPONSORSHIP HANDBOOK

November 2016

1.0 Introduction

1.1 The purpose of the handbook is to set out the Department's approach to sponsorship of its ALBs to ensure as far as possible that there is consistency of approach and proportionality of application.

Definition of an Arm's Length Body (ALB)

1.2 For the purposes of this handbook, an Arm's Length Body is defined as:

- a Body which has a role in the process of government but is not a Government Department, or part of one, and which accordingly operates to a greater or lesser extent at arm's length from Ministers; and

- a Body for which the Department has designated Accounting Officer status to an individual within the organisation – normally the Chief Executive.

1.3 The ALBs covered by this handbook are therefore:

- The Health and Social Care Board;
- Belfast Health and Social Care Trust;
- Northern Health and Social Care Trust;
- South Eastern Health and Social Care Trust;
- Southern Health and Social Care Trust;
- Western Health and Social Care Trust;
- Northern Ireland Ambulance Service;
- Northern Ireland Blood Transfusion Service;
- Regulation, Quality Improvement Authority;
- Business Services Organisation;
- Northern Ireland Social Care Council;
- Northern Ireland Guardian Ad Litem Agency;
- Northern Ireland Medical Dental Training Agency;
- Northern Ireland Practice Education Council;

- Patient and Client Council;
- Public Health Agency; and
- Northern Ireland Fire and Rescue Service.

2.0 Assurance and Accountability

2.1 Accountability is the process by which public sector bodies and the individuals within them are held to account for their decisions and actions, including their stewardships of public funds and all aspects of performance.

2.2 The Department must be able to provide assurance to the Minister and the Accounting Officer that public funds allocated to our ALBs are being used to deliver intended objectives.

2.3 At the heart of assurance and accountability arrangements are the following fundamental principles which should be embedded at all levels within the Department's culture and ethos:

- Principle 1: An ALB is sponsored by the Department as a whole.

- Principle 2: The Department must discharge its sponsorship responsibility (assurance and accountability) on an ongoing basis.

- Principle 3: The concept of openness and transparency should guide the approach to sponsorship.

- Principle 4: The primary responsibility for the performance of an ALB rests with its Board.

- Principle 5: An ALB will be held to account for the delivery of its prescribed functions and its compliance with other statutory responsibilities.

- Principle 6: 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.

- Principle 7: 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 8: The Departmental Board will have oversight of the discharge of the Department's ALB sponsorship role within a planned and managed set of arrangements.

3.0 Other Guidance

3.1 The sponsorship guidance contained within this handbook is not intended to replicate existing guidance and instructions. This handbook is not a standalone document and should be read in conjunction with relevant DoF and departmental guidance. In particular, 'Managing Public Money Northern Ireland' (MPMNI) and 'Public Bodies: A Guide for NI Departments' are useful reference documents.

3.2 This handbook supersedes the ALB Assurance and Accountability Framework (2012).

4.0 Roles and Responsibilities of a Sponsor Department

4.1 The roles and responsibilities of a Sponsor Department in terms of the: Minister; Departmental Accounting Officer; Executive Board Member Sponsor; and Sponsor Branch are set out in Annex 7.4 of Managing Public Money NI in the Management Statement and Financial Memorandum template.

Minister of Health

4.2 The Minister 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:

- delegating authority to the Permanent Secretary or Executive Board Member (EBM) Sponsor to communicate priorities to ALBs and approve ALB Corporate and Business Plans;
- keeping the Assembly informed about the ALB's performance;
- 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;
- approving the terms, conditions and remuneration scheme of the Chair and Non-Executive Board members;
- 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 ALB Chairs to account.

Permanent Secretary/Accounting Officer

4.3 The Permanent Secretary/Departmental Accounting Officer designates the Chief Executive of the ALB as the ALB's Accounting Officer, and may

withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

4.4 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's strategic aims and objectives support the Minister's policies and priorities;
- that any significant problems in the ALB are addressed, making such interventions as are judged necessary including making any changes to the baseline sponsor control and accountability arrangements;
- 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;
- accountability meetings take place as required with each ALB Chair and Chief Executive;
- sign off, or delegation to EBM Sponsors the authority to sign off, on MS/FMs, ALB Business and Corporate plans; and
- that any concerns about the activities of an ALB are communicated to the Departmental Board and to the ALB's Chair and Board, requiring explanations and assurances that appropriate action has been taken.

Departmental Board

4.5 As per its Terms of Reference, the Departmental Board's role is to scrutinise the governance and performance of ALBs and the implementation of the ALB assurance and accountability arrangements within the Department. The Board will receive and examine biannual reports on the governance and accountability of the Department's ALBs. The reports will be prepared by Governance Unit at the conclusion of the mid year and end year

accountability process and will summarise the governance and accountability process and highlight emerging issues. The Board will consider and note as appropriate any changes to the baseline sponsor control and accountability arrangements.

4.6 In addition, other business areas including Finance Directorate, Information Analysis Directorate and Service Delivery Directorate, will continue to produce regular/periodic reports for the Departmental Board within which they provide information about the performance of ALBs. These reports are part of the normal business of the Department and policy leads, in liaison with the relevant Sponsor Branch, are responsible for ensuring that any issues feed into the accountability process as appropriate.

4.7 As the custodian of the Departmental Risk Register, the Departmental Board, on the advice of the EBM sponsor, can approve the escalation of any significant risks associated with the ALBs to the Departmental Risk Register as appropriate.

4.8 The Departmental Audit and Risk Assurance Committee (DARAC) is a committee of the Departmental Board. It advises the Accounting Officer, through the Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. This includes examining regular reports on the accountability and assurance processes and advising on any system deficiencies that this brings to light.

Executive Board Member (EBM) Sponsor

4.9 The EBM Sponsor is responsible for supporting the Permanent Secretary and for:

- ensuring sponsorship is applied systematically based on the founding legislation, MS/FM and Sponsor Branch Checklist;

- providing assurance to the Permanent Secretary (and Departmental Board as appropriate) that a proportionate approach to governance, assurance and accountability is in place and making recommendations for any required adjustments;
- managing the ALB planning process;
- ensuring significant issues of a governance, risk management, internal control or other nature are escalated to the Directorate Risk Register, TMG, the Board or Minister as appropriate; and
- supporting the accountability process by:
    - undertaking, on behalf of the Minister, end-year appraisals for ALB Chairs;
    - chairing Ground Clearing meetings (or delegating to Grade 5 sponsor lead in specific circumstances); and
    - making recommendations to the Permanent Secretary on the agenda and issues to be addressed at accountability meetings.

Sponsor Branch

4.10 Sponsor Branches are the ALB's primary point of contact within the Department on assurance and accountability. They are responsible for:

- everyday sponsorship of the ALB in line with the MS/FM and Sponsor Branch Checklist with input from policy leads as required;
- providing feedback to the EBM Sponsor on performance of ALB against Sponsor Branch Checklist;
- timely engagement with ALB seeking resolution of issues arising from the Sponsor Branch Checklist;
- escalating concerns or issues to the EBM Sponsor;
- oversight of the ALB governance arrangements and making recommendations to the EBM Sponsor to strengthen these arrangements if necessary;
- implementing the ALB planning process by:

- issuing an appropriate framework of objectives and targets in light of the Department's wider strategic aims (except where this is actioned by Minister/AO);
- 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 assurance and accountability process by:
  - reviewing the ALB's Governance and Mid-Year Assurance Statement and making recommendations to the EBM Sponsor on issues that require escalation;
  - arranging the Ground Clearing and Accountability meetings; coordinating briefing, attending and minuting meetings; and
  - monitoring and follow-up of any issues raised in conjunction with policy leads as required.
- providing input to Governance Unit's regular reports to the Departmental Board/DARAC on assurance and accountability issues emerging from the mid/end year accountability process and any other relevant ALB governance issues.

Policy and Professional Leads

4.11 Policy and Professional leads are responsible for:

- ensuring arrangements are in place to monitor and report on policy and strategy within their area of responsibility;
- taking the lead on issues of assurance with regard to professional disciplines;
- responding to requests for input to departmental consideration of other aspects of ALB Governance e.g. Serious Adverse Incidents, Governance Statements;
- contributing to the ALB planning process by:

  - ensuring priorities specific to their area of expertise are communicated to the Sponsor Branch and ALB; and
  - providing EBM Sponsors with feedback on the draft plans;
- contributing to the accountability process by providing agenda items and briefing for the Ground Clearing and Accountability meetings;
- monitoring the ALB's compliance with policy or professional standards for which they have responsibility (including controls assurance standards);
- escalating concerns or issues to the EBM Sponsor; and
- providing reports, or input to reports to TMG and Departmental Board on policy and professional matters which may include performance of some or all ALBs.

Governance Unit

4.12 Governance Unit is responsible for:

- reviewing and coordinating the update of ALB assurance and accountability arrangements;
- drafting, updating and disseminating departmental guidance in relation to governance of ALBs (e.g. guidance on corporate/business plans, guidance on accountability process);
- regular liaison with Sponsor Branches and sharing of best practice;
- providing advice to Sponsor Branches on governance issues on an ad hoc basis and as part of the formal accountability processes;
- monitoring of assurances on control from a governance perspective (e.g. Controls Assurance Standard Scores, Governance Statement, mid year assurance statement);
- regular updates to the Departmental Board, Departmental Audit & Risk Committee and TMG on governance and related issues; and
- developing a sponsorship handbook and induction material for new Sponsor Branch staff.

Roles and Responsibilities of ALBs

4.13 The roles and responsibilities of ALBs as they relate to the: Board of the ALB; Board Chair; and Chief Executive (who is normally designated as Accounting Officer for the ALB) are also set out in Managing Public Money NI and MS/FMs.

5.0 Sponsorship Context

5.1 The starting point for staff in the Department is the context within which the ALB operates, and Sponsor Branches should be familiar with the framework that exists. This will include -

Legislation

5.2 At a strategic level the operating framework for the ALB is generally set out in the ALB's founding legislation.

5.3 Sponsor Branches need to:

- identify what legislation exists;
- familiarise themselves with its contents and requirements;
- ensure that it remains appropriate; and
- review and update the legislation as and when required (with input from departmental colleagues as appropriate).

Other Statutory Responsibilities

5.4 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.

5.5 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.

Management Statement and Financial Memorandum (MS/FM)

5.6 The framework document in place between the Department and the ALB is generally referred to as the Management Statement and Financial Memorandum (MS/FM). This document should set out a clear framework of strategic control within which the ALB will operate, taking account of the legislation applicable to the ALB. Managing Public Money NI, Annex 7.4 provides a model MS/FM template. This template is kept under review by Governance Unit and Finance Directorate to ensure it remains relevant to the ALBs.

5.7 Sponsor Branches need to ensure that an MS/FM is in place and that:-

- it meets the needs of the Department;
- it is signed by the Permanent Secretary (or EBM Sponsor if delegated), and the Chief Executive of the ALB and approved by the Department of Finance;
- the conditions within the document are known and understood within the Sponsor Branch and it forms the basis of the assurance and accountability process; and
- it is regularly discussed with the ALB and that its terms are subject to formal review at least every 5 years.

5.8 In liaison with DoF, Finance Directorate and policy leads as appropriate, Governance Unit will co-ordinate and disseminate any guidance or advice on the updating of MS/FMs to Sponsor Branches.

6.0 Boards of ALBs

6.1 Given the important role which ALB Boards play in providing constructive challenge to executive staff within the ALB and ensuring that set objectives are achieved, it is important that the Department has the correct processes in place for:-

- the appointment of Board Members and Board Chairs with the required skills sets;

- ensuring Board Member training and development needs are appropriately identified and addressed by the ALB (and the Department); and

- commissioning the performance appraisal of Board Chairs and Board Members and monitoring appraisal completion.

6.2 These functions are dealt with by Appointments and Business Unit in the Department.

Board Appointments

6.3 Appointments to the Boards of the Department's ALBs must be made in line with the 'Code of Practice for Ministerial Public Appointments in NI' and the 'The Executive Office, Central Appointments Unit guidance'.

6.4 Appointments and Business Unit in the Department ensures that:-

- through monitoring the appointment and tenure periods of Board Members that appointment, competitions are run on a timely basis;

- Board appointments are sufficiently staggered to ensure that there is an appropriate retention of experienced Board Members balanced by the influx of new Members bringing fresh challenge;

- the skills required are formally identified (e.g. sectoral knowledge, finance, governance) and adequately detailed in candidate specifications etc;

- where possible the Chair of the ALB is involved in the appointment process of new Members; and

- applicants are probed both at application and interview stage regarding conflict of interest issues.

Induction and Training

6.5 Included in the standard letter of appointment for Board Members should be a mandatory requirement that new Board Members should attend an induction course recognised by the Department.

6.6 Board Chairs are responsible for ensuring that new Board appointees are provided with sufficient induction into their role. Within 6 months of appointment (preferably) all ALB Board members should have attended an appropriate training course to provide them with a clear understanding of their roles and responsibilities.

Board Appraisal

6.7 All ALB Boards are required to complete an annual Board Governance Self Assessment Tool (BGSAT). The tool is intended to help ALBs improve the effectiveness of their Board and provide the Board Members with assurance that it is conducting its business in accordance with best practice.

6.8 ALBs are asked to provide assurance, through their mid-year assurance statement, that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department. For assurance

purposes the Department may, at any stage, request copies of the completed BGSAT pro-forma and/or supporting documentation.

6.9 Governance Unit will periodically review and update the BGSAT in line with good practice.

Board Chair and Member Appraisals

6.10 The Board Chair completes a self-assessment which must then be sent to the appropriate EBM Sponsor in the Department who completes the appraisal. The appraisal is then countersigned by the Permanent Secretary.

6.11 The Non-Executive Board Member completes a self-assessment which must then go to the Board Chair who completes the appraisal. The appraisal is then countersigned by the appropriate Grade 5 Sponsor Lead in the Department.

6.12 Appointments and Business Unit is responsible for co-ordinating the appraisal process which includes issuing appraisal reminders and templates and maintaining records.

Code of Conduct and Accountability for Board Members

6.13 A Code of Conduct and a Code of Accountability should be issued to all newly appointed Board Members. All Board Members should subscribe to these codes and should be judged on the way the codes are observed.

Board Meetings

6.14 Boards of ALBs should meet on a regular basis. Public board meetings should take place regularly with the time and place advertised.

6.15 Although there is not an exhaustive list of business for the Boards to consider, and the agenda of most Boards will be driven by their own business activities, Sponsor Branches should scrutinise the agenda for evidence that the Board is:

- receiving and reviewing regular updates and information on the ALB's performance (both non-financial and financial);

- considering the risks facing the organisation including reviewing the ALB's corporate risk register; and

- receiving regular reports from the Board's committees on the work they are undertaking, including an annual report.

6.16 The Sponsor Branch should take a targeted and proportionate approach to the scrutiny of Board papers. Any identified issues regarding the conduct of the ALB Board should be raised with the ALB in the first instance. Any unresolved issues should be raised at the relevant Ground Clearing meeting and escalated to the AO Accountability Meeting if required.

Attendance at ALB Board Meetings by the Sponsor Department

6.17 In general officials should not attend such meetings as a matter of routine. Officials may attend in an advisory capacity if this is helpful but should not influence, or give an impression that they are party to, any decisions taken. If officials are attending Board meetings, they should ensure that the capacity in which they are attending (observer etc.) is conveyed and recorded in the minutes. This may include notifying the ALB that any views expressed should not be taken by the ALB as departmental approval having been given but that proper approval should still be sought in the normal way.

Board Minutes

6.18 A good source of information for the Sponsor Branch, on how effectively the Board is operating and to gain an insight into key issues, are the minutes of Board Meetings.

6.19 Sponsor Branches should ensure that:-

- they put in place appropriate arrangements to receive Board minutes on a timely basis;
- Board minutes are published on the ALB's website;
- responsibility for reading and reviewing minutes is allocated within the Sponsor Branch and the outcome documented and reported;
- if concerns are identified, assurance is sought from the ALB that appropriate action is being taken to address issues; and
- any unresolved issues regarding the conduct of the ALB Board are escalated within the Department.

6.20 Sponsor Branches should also agree arrangements with the ALB for receipt of Board papers on a monthly basis. The Sponsor Branch should review the agenda for the ALB Board meeting and take a targeted and proportionate approach to the scrutiny of Board papers. If necessary any issues raised in the papers should be communicated to the EBM Sponsor.

6.21 Where a departmental representative has attended a Board meeting this individual should specifically consider whether the minutes represent an accurate record of proceedings.

7.0 Financial Management

7.1 On financial matters, the primary point of contact for ALBs is Finance Directorate. Finance Directorate is responsible for the following functions:

- Scrutinising HSC savings plans;
- Allocating programme money including grant aid payments;
- In-year financial monitoring and challenge;
- Managing cash draw downs by ALBs;
- Preparing departmental annual accounts and Governance Statement;
- Reviewing business cases in liaison with Capital Investment Directorate to ensure compliance with NIGEAE;
- Providing advice and guidance to ALBs on revenue business cases and external consultancy and carrying out test drilling;
- Setting annual charges for HSC bodies;
- Discharging counter fraud responsibilities; and
- Overseeing application of procurement policy.

7.2 In carrying out these functions, Finance Directorate liaises closely with Sponsor Branches. Finance Directorate plays an important role in the mid and end year accountability process. Each business area within the Department has an assigned business partner from Finance Directorate. Sponsor Branches can engage with their finance business partner for financial advice and guidance.

Procurement

7.3 Finance Directorate monitors progress against strategic initiatives around procurement within ALBs and issues DoF procurement guidance and operational procurement guidance to ALBs.

7.4 Finance Directorate will provide input and data on procurement matters to sponsors and policy branches as required and signpost staff to appropriate

written or professional guidance. There is a long list of exceptions where procurement regulations do not apply - e.g. employment contracts and most public sector to public sector relationships - but as a general rule of thumb, formal professional advice on conducting procurements or entering contracts without competition must be sought from a Centre of Procurement Expertise (CoPE) where the expenditure is over £5k in total.

7.5 Finance (and not sponsors) will process all direct award contract requests from ALBs above their delegated limit for direct awards to the point of consideration by the Accounting Officer, with input from policy and sponsor colleagues as appropriate. Sponsors will be copied into above delegated limit direct award requests by private office when they are received, as they may evidence wider problems in the organisation.

8.0 Corporate and Annual Business Plans

8.1 All of the Department's ALBs should have in place a Corporate Plan that is aligned with the NI Executive's Programme for Government (PfG) and an annual Business Plan. Corporate and business plans will be formally approved by the Department.

8.2 Planning arrangements in Trusts are unique. Trusts currently prepare annual Trust Delivery Plans which are approved by the Health and Social Care Board. Future planning arrangements in Trusts will be an important consideration in the ongoing work on HSC restructuring.

Corporate Plan

8.3 The requirements of a Corporate Plan are typically reflected in ALB Management Statements and can be supplemented by specific departmental and ALB requirements.

8.4 The Corporate Plan will reflect the ALB's statutory duties and functions, and within those duties and functions, the priorities set by the Minister. In particular, the plan will demonstrate how the ALB contributes to the achievement of the Department's strategic aims and objectives and the Executive's PfG in the context of the current and forecast financial environment.

Annual Business Plan

8.5 The business planning process sets out in detail the framework through which the ALB contributes to the Department's strategic aims, objectives and targets arising from the Executive's PfG. The annual Business Plan will include key objectives, targets, actions and milestones, as appropriate.

8.6 Governance Unit will provide annual advice and guidance on the development of plans and Sponsor Branches should liaise with ALBs on the content of the plans and timeframe for submission.

8.7 On receipt of the Business Plan Sponsor Branches should:

- review the plan and circulate to departmental colleagues for comment;

- collate comments from departmental colleagues and communicate them to the ALB if change/clarification is required; and,

- make a recommendation to the EBM Sponsor on whether the Department should approve the business plan.

8.8 In reviewing the plan, Sponsor Branches, in liaison with Policy Leads as appropriate, should ensure that Plans:-

- support the delivery of Programme for Government outcomes;
- support the delivery of departmental policy and strategy;
- deliver on the functions etc. specified in the ALBs founding legislation setting out the purposes for which the ALB was created and the functions/services it is to deliver; and
- address known areas of underperformance, the findings of inquiries etc. and respond to particular events, serious adverse incidents and near misses.

8.9 As the objectives and targets set as part of the business planning process are those against which the Department will hold the ALB to account for delivering throughout the year, it is important that they are robust and measurable. Monitoring of performance will form a key strand of the Ground Clearing meetings.

9.0 Risk Management

9.1 All of the Department's ALBs should have in place a risk management process which identifies, assesses, evaluates, reviews and reports on key risks relevant to the ALB. ALBs are also required to have an assurance framework in place that maps out business objectives, the risks to their achievement, and related controls.

9.2 ALB risk registers should be submitted to Sponsor Branch at least twice a year and this should align with the mid year and end year accountability process.

9.3 Sponsor Branches should ensure that:

- the ALB risk register is a 'live' document i.e. is there evidence of:
    - text being updated, risks moving on and off register over time, rating of risks changing, action points being added and removed as addressed;
    - regular reports to the Audit/Governance Committee and ALB Board on risks; and
    - it being reviewed by ALB internal Audit.
- the register includes mitigating measures and actions to address identified risks; and
- the risk register is considered by the Audit Committee and approved by the ALB Board.

9.4 Sponsor Branches should review ALB risk registers bearing in mind other supporting information that the Department has available on the ALB's business e.g. evidence obtained from accountability meetings, mid year assurance Statements and Governance Statement and internal/external audit reports etc. The Sponsor Branch should challenge the ALB if they feel that the risk register does not adequately reflect known risks.

9.5 In considering the risk register it is reasonable that Sponsor Branches may need to seek input from the relevant Policy Lead on a specific risk. Depending on the nature of the issue or risk, it may be appropriate for the Policy Lead to engage with the ALB directly to seek clarity. Sponsor Branch must be kept informed of the outcome of this engagement and must liaise with the Policy Lead to ensure that any unresolved issues are factored in to the accountability process as appropriate (Ground Clearing, Assurance/Governance Statement, Accountability Meeting).

9.6 Where a significant ALB risk has been identified, the Sponsor Branch in conjunction with the Policy Lead should consider the need for escalation within the Department. The process for escalation is set out in the Framework for Business Planning, Risk Management and Assurance. The standing agendas of formal management meetings such as the Departmental Board and the Top Management Group provide opportunities for the EBM Sponsor or EBM Policy Lead to highlight potential issues for escalation. If appropriate, the Departmental Risk Register should be updated, subject to approval of the Departmental Board.

9.7 Governance Unit is responsible for maintaining and updating central guidance to ALBs on risk management and associated processes.

10.0 Assurance Reporting

Mid Year Assurance Statement

10.1 All ALBs are required to submit a Mid-Year Assurance Statement to the Department. The function of this Statement is to enable ALB Accounting Officer's to attest to the continuing robustness of their organisation's system of internal governance. The Statement should provide a balanced appraisal, capable of substantiation, of the state of the organisation's internal governance.

10.2 Governance Unit commissions the Mid-Year Assurance Statements directly from ALBs in September each year. Governance Unit will receive the Mid-Year Assurance Statement from each ALB and will send to the relevant Sponsor Branch. Governance Unit will review each statement from a governance perspective and provide comments and/or briefing to Sponsor Branches if required. Ground Clearing and Accountability meetings allow for issues to be identified and escalated if necessary.

10.3 Sponsor Branches should:-

- critically review and evaluate the Mid-Year Assurance Statement to determine if the information provided is in line with the Department's knowledge of the ALB and any particular risks or issues facing the organisation;

- consider any information provided by the ALB Accounting Officer which indicates that there are issues emerging of which the Department was perhaps previously unaware, or which the Department needs to consider further;

- circulate the statement to EBMs and Policy and Professional Leads, as appropriate, for comment. If Policy or Professional leads decide that issues identified within the statement should be escalated to the Ground

Clearing/Accountability meeting they should provide appropriate briefing/input to the meeting.

- co-ordinate briefing for Ground Clearing and Accountability meetings ensuring that issues arising from the consideration of the Mid-Year Assurance Statement are included as appropriate.

Governance Statement

10.4 All ALBs are required to produce an annual Governance Statement signed off by their Accounting Officer. The statements are commissioned by and submitted to the Department's Finance Directorate. Finance Directorate review the draft Governance Statements to identify issues for inclusion in the Department's own Governance Statement and forward the statements to Sponsor Branches.

10.5 Sponsor Branches should review their ALB statement/s to determine if the information provided is in line with the Department's knowledge of the ALB and any particular risks or issues facing the organisation and to ensure they have been completed in line with departmental guidance. The statements should also be reviewed by relevant policy and professional areas (as identified by the Sponsor Branch) and by Governance Unit and Finance Directorate and relevant issues should be identified for potential inclusion in the Department's Governance Statement. A departmental response is prepared by the Sponsor Branch and signed by the Sponsor EBM or Grade 5 Sponsor Lead.

10.6 Sponsor Branches should also consider whether any issues identified in the Governance Statement should be discussed further with the ALB at the Ground Clearing or AO Accountability meetings.

10.7 Further guidance on the Governance Statement is available at DH1/16/11331.

11.0 Controls Assurance Standards

11.1 The Controls Assurance regime forms a sub-set of the wider ALB assurance system. Controls Assurance is a process that aims to provide evidence that ALBs are doing their reasonable best to manage themselves in meeting their objectives and managing risks.

11.2 There are 22 Controls Assurance Standards comprising:

- The three core standards of governance, risk management and financial management with which (because they apply to every organisation's business) compliance is mandatory; and
- 19 more operationally specific standards whose applicability depends on the nature and scope of the organization's business.

11.3 Compliance reporting on controls assurance standards is based on self-assessment. A "substantive compliance" entails scoring at least 75.

11.4 Each standard has a lead author, who is the Policy Lead within the Department. The Policy Lead is responsible for reviewing the standard on a yearly basis. The updates and changes are then relayed to the ALBs and the current standard is posted on to the Department's website.

11.5 Each year the Internal Audit Team within the Business Services Organisation (BSO) complete an internal audit of compliance levels against a number of the CAS. The three core standards, Finance, Risk Management and Governance are audited every year for every organisation. A further two standards are also audited. These will change year to year and are decided on by the Department, in conjunction with BSO Audit.

11.6 On an annual basis, ALBs submit their CAS scores to the Governance Unit in the Department. Scores are shared with policy leads and Sponsor Branches. They are considered as part of the formal accountability process and feature

in each ALB's Governance Statement as an indicator of the strength of control systems.

12.0 Audit Committees

12.1 Each ALB with responsibility for administering public funds is required to have an Audit Committee. The Audit Committee is a committee of the Board, and its purpose is to advise the Board and the ALB's Accounting Officer on the risk management, control and governance arrangements within the body. While the role of the ALB's Audit Committee is primarily to provide assurance to the ALB's Accounting Officer and Board, an effective ALB Audit Committee will also assist the Department meet its oversight and sponsorship responsibilities.

12.2 One of the main Audit Committee principles is that it should be independent of executive management. This means that the Audit Committee in an ALB will be made up of the Non-Executive Board Members with one of these Members acting as Audit Committee Chair.

12.3 The primary source of guidance on Audit Committees including a suggested work programme is contained within the Audit and Risk Assurance Committee Handbook. The Audit Committee work programme should be approved by the ALB Board. The Chair of the Audit Committee should provide a report to the Board after each meeting and produce an annual report to support the Governance Statement.

12.4 A departmental representative should attend at least one audit committee meeting, in an observer capacity, in the course of the financial year. This may be a representative from Sponsor Branch or Finance Directorate. Through such attendance the Department is able to assess how effectively the Audit Committee is discharging its challenge function and to gain a good insight into the governance arrangements within the ALB. It also helps to gain a greater understanding of the ALB's business and the key risks and issues facing the organisation. A short report should be prepared for the EBM sponsor by the departmental representative following the meeting. Any identified issues must be brought to the attention of the Sponsor Branch.

National Audit Office (NAO) Checklist

12.5 It is best practice that Audit Committees should periodically review the overall effectiveness of the Committee. Since 2009 the Department has required ALBs to complete the NAO checklist annually. The ALB provides assurance on completion of the checklist through their Mid-Year Assurance Statement and should report any exception issues to the Department.

12.6 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.

Role of Internal Audit

12.7 ALBs are required to have an Internal Audit function which complies with Public Sector Internal Audit Standards (PSIAS). The role of Internal Audit within an ALB is to provide the ALB Accounting Officer with an opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The internal audit function for each ALB is provided by BSO Internal Audit.

12.8 In line with PSIAS an ALB's internal audit function should prepare its audit strategy and annual audit plans on a risk based approach. The Sponsor

Branch and the ALB internal auditor should engage with each other at an early stage in the audit planning process. Sponsor Branches should also make arrangements to ensure they are kept informed on the progress of the ALB's internal audit plan and to formally agree with the ALB the procedures through which they wish to receive copies of internal audit assignment reports (where satisfactory assurance is not received) and the Head of Internal Audit's (HIA's) interim and annual reports on a timely basis. The Sponsor Branch should also act as the channel for providing departmental Internal Audit with assignment, interim and annual reports etc.

13.0 Performance Review

13.1 Ground Clearing and Accountability meetings are held at mid and end year. The purpose of Ground Clearing and Accountability meetings is both to seek assurance (focusing particularly on systems of internal control) and to hold ALBs to account for their performance against organisational and service delivery priorities which should be reflected in each ALB business plan.

13.2 Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues should be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the ALB.

Ground Clearing Meetings

13.3 The Executive Board Member (EBM) sponsor of the ALB should chair the Ground Clearing meetings. In specific circumstances this may be delegated to the Grade 5 Sponsor Lead. Depending on the circumstances of the ALB, a representative from Finance Directorate may also be required to attend. When commissioning briefing from Finance Directorate for the Ground Clearing meeting, Sponsor Branch should therefore seek Finance Directorate's advice as to whether a finance representative is required to attend the meeting. Beyond this the attendance of other senior officials is at their own discretion and will depend on the agenda items.

13.4 The Ground Clearing meeting should be attended by relevant parties from the ALBs. It is at the discretion of each ALB to decide which Directors should attend these meetings.

13.5 All end-year and mid-year Ground Clearing meetings should follow a broadly standard agenda to ensure a consistent approach across the Department. The agenda will address performance of the ALB under the Assurance and Accountability domains:

- Corporate Governance – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;
- Quality – the arrangements for monitoring and improving the quality of programmes/services provided by and for the ALB. Ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;
- Resources – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources (incl HR and Estates) are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;
- Service delivery/improvement – the arrangements for ensuring the delivery of PfG outcomes, ministerial targets, other targets/priorities and required service improvements; and
- Other significant operational issues and risks.

13.6 Briefing for Ground Clearing meetings is co-ordinated by Sponsor Branches with timely input from policy/professional leads.

Accountability Meetings

13.7 For all 17 ALBs, the Accounting Officer Accountability meetings will normally be led by the Permanent Secretary, supported by the EBM sponsor and a note-taker. These meetings are attended by only the Chair and Chief Executive of the ALB.

13.8 Following the Ground Clearing meeting the EBM Sponsor will be required to provide the Permanent Secretary with a note outlining the issues which they feel need to be escalated to the accountability meeting and enclosing a proposed agenda. The sponsor EBM also documents a provisional assessment on whether any adjustment is required to the baseline level of sponsorship and control and provides a rationale for such an assessment.

13.9 Briefing for accountability meetings is co-ordinated by Sponsor Branches with timely input from policy/professional leads.

13.10 If there are no issues arising from Ground Clearing meeting, the EBM sponsor should provide assurance to the Permanent Secretary that there are no issues for escalation. In such instances, the Permanent Secretary may decide to meet with the ALB Chair and Chief Executive on a more informal basis.

Minutes and Action Points

13.11 Minutes for both meetings should be drafted and circulated as promptly as possible after the meeting, ideally within 2 weeks. Minutes should be agreed by all parties and finalised as soon as possible, ideally within 4 weeks of the meeting.

13.12 Detailed guidance on the accountability process is available at DH1/16/13177.

13.13 Assurance and accountability is ongoing and not confined to formal process. Outside the formal accountability meetings, Sponsor Branches should engage (meetings, emails etc) regularly with the ALB through-out the year. This engagement should be timely, pitched at the correct level and appropriate to the circumstances.

Reports to Top Management Group (TMG), Departmental Board etc

13.14 As part of the routine business of the Department, EBM sponsors and policy/professional leads are responsible for providing updates to TMG and the Departmental Board, as required, on specific aspects of ALB performance.

13.15 Governance Unit will provide biannual update reports on ALB Governance to the Departmental Board and the Departmental Audit and Risk Assurance

Committee (DARAC). These reports will include an overview of the mid and end year accountability process including completion of the sponsor branch checklists and any significant issues or common emerging themes. Sponsor Branches and policy/professional leads will provide input to these reports.

13.16 The Department's Internal Audit will carry out a rolling programme of sponsorship audits and will report to DARAC on its findings.

14.0 Policies

Fraud

14.1 It is important that each of the Department's ALBs has in place adequate and effective anti-fraud arrangements in order to ensure that public funds are adequately safeguarded and protected.

14.2 Sponsor Branches should ensure that each ALB has made satisfactory arrangements in terms of having robust anti-fraud measures in place in line with Appendix A.4.7 of MPMNI and has a bespoke whistleblowing policy in place. These should be considered by the ALB Audit Committee and approved by the ALB Board.

Acceptance and Provision of Gifts and Hospitality

14.3 Acceptance and Provision of Gifts and Hospitality Policy should set out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made in line with Department of Finance guidance.

15.0 Information

Information flows

15.1 In discharging its sponsorship role the Department must ensure appropriate record keeping. Clear and sufficient audit trails are important for supporting the evidence based assurance and accountability process.

15.2 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.

Sponsor branches

15.3 The Department has access to and can request from each ALB or from independent sources information necessary and appropriate to discharge its sponsorship role e.g.

- 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.

Information Streams External to ALBs

15.4 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 Medicines and Healthcare products Regulatory Agency (MHRA);
- reports from Committees of the Assembly; and
- reports from Inquiries and Coroners Inquests.

16.0 Sponsor Branch Staff

Training

16.1 Sponsorship training should be provided to staff who are involved in the sponsorship of the Department's ALBs. Attendance at relevant Centre for Applied Learning courses on Arm's Length Body sponsorship may be useful in, at least partly, addressing this need. Other training needs for sponsor staff, such as that on finance, governance, policy development, etc. should also be considered.

16.2 Governance Unit will arrange an induction session with staff who are new to sponsorship to discuss the assurance and accountability arrangement set out in this handbook.

Sponsor Branch Forum

16.3 A Sponsor Branch Forum, chaired by Governance Unit, has been established to discuss generic sponsorship issues and to identify and disseminate best practice in sponsorship arrangements across Sponsor Branch staff. The Forum, which meets every few months, allows Sponsor staff within the Department to contribute to the agenda; provide supporting papers where appropriate; share experiences and lessons learned; and contribute to discussions and work undertaken to improve the Department's sponsorship practices.

16.4 Governance Unit can be contacted for further advice as necessary on any aspect of this handbook which will be reviewed annually to ensure that it remains valid and up-to-date.

Department of Health

ARM'S LENGTH BODIES

SPONSORSHIP HANDBOOK

April 2018

1.0 Introduction

1.1 The purpose of the handbook is to set out the Department's approach to sponsorship of its ALBs to ensure as far as possible that there is consistency of approach and proportionality of application. The handbook is supported by a Sponsor Branch Checklist which acts as guide for Sponsor Branches in terms of assessing the extent to which they are operating within departmental guidelines and good practice and to confirm that ALBs themselves are meeting their corporate governance obligations (section 6).

1.2 The handbook is underpinned by the 'comply or explain' principle. Where it is necessary to deviate from the handbook the rationale should be explained along with any mitigating action required to address any associated risk.

Definition of an Arm's Length Body (ALB)

1.3 For the purposes of this handbook, an Arm's Length Body is defined as:

- a Body which has a role in the process of government but is not a Government Department, or part of one, and which accordingly operates to a greater or lesser extent at arm's length from Ministers; and

- a Body for which the Department has designated Accounting Officer status to an individual within the organisation – normally the Chief Executive.

1.4 The ALBs covered by this handbook are therefore:

- The Health and Social Care Board;
- Belfast Health and Social Care Trust;
- Northern Health and Social Care Trust;
- South Eastern Health and Social Care Trust;
- Southern Health and Social Care Trust;
- Western Health and Social Care Trust;

- Northern Ireland Ambulance Service;
- Northern Ireland Blood Transfusion Service;
- Regulation, Quality Improvement Authority;
- Business Services Organisation;
- Northern Ireland Social Care Council;
- Northern Ireland Guardian Ad Litem Agency;
- Northern Ireland Medical Dental Training Agency;
- Northern Ireland Practice Education Council;
- Patient and Client Council;
- Public Health Agency; and
- Northern Ireland Fire and Rescue Service.

2.0 Assurance and Accountability

2.1 Accountability is the process by which public sector bodies and the individuals within them are held to account for their decisions and actions, including their stewardships of public funds and all aspects of performance.

2.2 The Department must be able to provide assurance to the Minister and the Accounting Officer that public funds allocated to our ALBs are being used to deliver intended objectives.

2.3 At the heart of assurance and accountability arrangements are the following fundamental principles which should be embedded at all levels within the Department's culture and ethos:

- Principle 1: An ALB is sponsored by the Department as a whole.

- Principle 2: The Department must discharge its sponsorship responsibility (assurance and accountability) on an ongoing basis.

- Principle 3: The concept of openness and transparency should guide the approach to sponsorship.

- Principle 4: The primary responsibility for the performance of an ALB rests with its Board.

- Principle 5: An ALB will be held to account for the delivery of its prescribed functions and its compliance with other statutory responsibilities.

- Principle 6: 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.

- Principle 7: 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 8: The Departmental Board will have oversight of the discharge of the Department's ALB sponsorship role within a planned and managed set of arrangements.

3.0 Other Guidance

3.1 The sponsorship guidance contained within this handbook is not intended to replicate existing guidance and instructions. This handbook is not a standalone document and should be read in conjunction with relevant DoF and departmental guidance. In particular, 'Managing Public Money Northern Ireland' (MPMNI) and 'Public Bodies: A Guide for NI Departments' are useful reference documents. The handbook is supported by a Sponsor Branch Checklist which acts as guide for Sponsor Branches.

3.2 This handbook supersedes the ALB Assurance and Accountability Framework (2012).

4.0 Roles and Responsibilities of a Sponsor Department

4.1 The roles and responsibilities of a Sponsor Department in terms of the: Minister; Departmental Accounting Officer; Executive Board Member Sponsor; and Sponsor Branch are set out in Annex 7.4 of Managing Public Money NI in the Management Statement and Financial Memorandum template.

Minister of Health

4.2 The Minister 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:

- delegating authority to the Permanent Secretary or Executive Board Member (EBM) Sponsor to communicate priorities to ALBs and approve ALB Corporate and Business Plans;
- keeping the Assembly informed about the ALB's performance;
- 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;
- approving the terms, conditions and remuneration scheme of the Chair and Non-Executive Board members;
- 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 ALB Chairs to account.

Permanent Secretary/Accounting Officer

4.3 The Permanent Secretary/Departmental Accounting Officer designates the Chief Executive of the ALB as the ALB's Accounting Officer, and may

withdraw the Accounting Officer designation if he/she believes that the incumbent is no longer suitable for the role.

4.4 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's strategic aims and objectives support the Minister's policies and priorities;
- that any significant problems in the ALB are addressed, making such interventions as are judged necessary including making any changes to the baseline sponsor control and accountability arrangements;
- 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;
- accountability meetings take place as required with each ALB Chair and Chief Executive;
- sign off, or delegation to EBM Sponsors the authority to sign off, on MS/FMs, ALB Business and Corporate plans; and
- that any concerns about the activities of an ALB are communicated to the Departmental Board and to the ALB's Chair and Board, requiring explanations and assurances that appropriate action has been taken.

Departmental Board

4.5 As per its Terms of Reference, the Departmental Board's role is to scrutinise the governance and performance of ALBs and the implementation of the ALB assurance and accountability arrangements within the Department. The Board will receive and examine biannual reports on the governance and accountability of the Department's ALBs. The reports will be prepared by Governance Unit at the conclusion of the mid year and end year

accountability process and will summarise the governance and accountability process and highlight emerging issues. The Board will consider and note as appropriate any changes to the baseline sponsor control and accountability arrangements.

4.6 In addition, other business areas including Resources and Performance Management Group, will continue to produce regular/periodic reports for Top Management Group and the Departmental Board within which they provide information about the performance of ALBs. These reports are part of the normal business of the Department and policy leads, in liaison with the relevant Sponsor Branch, are responsible for ensuring that any issues feed into the accountability process as appropriate.

4.7 As the custodian of the Departmental Risk Register, the Departmental Board, on the advice of the EBM sponsor, can approve the escalation of any significant risks associated with the ALBs to the Departmental Risk Register as appropriate.

4.8 The Departmental Audit and Risk Assurance Committee (DARAC) is a committee of the Departmental Board. It advises the Accounting Officer, through the Board, on the quality of assurances they receive about strategic processes for risk management, governance, internal control and the integrity of financial statements. This includes examining regular reports on the accountability and assurance processes and advising on any system deficiencies that this brings to light.

Executive Board Member (EBM) Sponsor

4.9 The EBM Sponsor is responsible for supporting the Permanent Secretary and for:

- ensuring sponsorship is applied systematically based on the founding legislation, MS/FM and Sponsor Branch Checklist;

- providing assurance to the Permanent Secretary (and Departmental Board as appropriate) that a proportionate approach to governance, assurance and accountability is in place and making recommendations for any required adjustments;
- managing the ALB planning process;
- ensuring significant issues of a governance, risk management, internal control or other nature are escalated to the Directorate Risk Register, TMG, the Board or Minister as appropriate; and
- supporting the accountability process by:
    - undertaking, on behalf of the Minister, end-year appraisals for ALB Chairs;
    - chairing Ground Clearing meetings (or delegating to Grade 5 sponsor lead in specific circumstances); and
    - making recommendations to the Permanent Secretary on the agenda and issues to be addressed at accountability meetings.

Sponsor Branch

4.10 Although ALBs are sponsored by the Department as a whole, Sponsor Branches are the ALB's primary point of contact within the Department on assurance and accountability. They are responsible for:

- everyday sponsorship of the ALB in line with the MS/FM and Sponsor Branch Checklist with input from policy leads as required;
- providing feedback to the EBM Sponsor on performance of ALB against Sponsor Branch Checklist;
- timely engagement with ALB seeking resolution of issues arising from the Sponsor Branch Checklist;
- escalating concerns or issues to the EBM Sponsor;
- oversight of the ALB governance arrangements and making recommendations to the EBM Sponsor to strengthen these arrangements if necessary;
- implementing the ALB planning process by:

- issuing an appropriate framework of objectives and targets in light of the Department's wider strategic aims (except where this is actioned by Minister/AO);
- providing recommendations to EBM Sponsor on the draft ALB Business and Corporate plans taking on board feedback from colleagues (section 9); and
- providing feedback to the EBM Sponsor on the performance of the ALB against the objectives.

- implementing the assurance and accountability process by:
  - reviewing the ALB's Governance and Mid-Year Assurance Statement and making recommendations to the EBM Sponsor on issues that require escalation;
  - arranging the Ground Clearing and Accountability meetings; coordinating briefing, attending and minuting meetings; and
  - monitoring and follow-up of any issues raised in conjunction with policy leads as required.
- providing input to Governance Unit's regular reports to the Departmental Board/DARAC on assurance and accountability issues emerging from the mid/end year accountability process and any other relevant ALB governance issues; and
- drafting Accounting Officer letters for new ALB Chief Executives.

Policy and Professional Leads

4.11 Policy and Professional leads are responsible for:

- ensuring arrangements are in place to monitor and report on policy and strategy within their area of responsibility, including the areas formerly covered by the Controls Assurance Standards;
- taking the lead on issues of assurance with regard to professional disciplines;

- responding to requests for input to departmental consideration of other aspects of ALB Governance e.g. Serious Adverse Incidents, Governance Statements, Risk Registers;
- contributing to the ALB planning process by:
    - ensuring priorities specific to their area of expertise are communicated to the Sponsor Branch and ALB; and
    - providing EBM Sponsors with feedback on the draft plans;
- contributing to the accountability process by providing agenda items and briefing for the Ground Clearing and Accountability meetings;
- monitoring the ALB's compliance with policy or professional standards for which they have responsibility (including controls assurance standards);
- escalating concerns or issues to the EBM Sponsor; and
- providing reports, or input to reports to TMG and Departmental Board on policy and professional matters which may include performance of some or all ALBs.

Governance Unit

4.12 Governance Unit is responsible for:

- reviewing and coordinating the update of ALB assurance and accountability arrangements;
- drafting, updating and disseminating departmental guidance in relation to governance of ALBs (e.g. guidance on corporate/business plans, guidance on accountability process);
- regular liaison with Sponsor Branches and sharing of best practice;
- providing advice to Sponsor Branches on governance issues on an ad hoc basis and as part of the formal accountability processes;
- monitoring of assurances on control from a governance perspective (e.g. Governance Statement, mid-year assurance statement);
- regular updates to the Departmental Board, Departmental Audit & Risk Committee and TMG on governance and related issues; and

- developing a sponsorship handbook and induction material for new Sponsor Branch staff.

Roles and Responsibilities of ALBs

4.13 The roles and responsibilities of ALBs as they relate to the: Board of the ALB; Board Chair; and Chief Executive (who is normally designated as Accounting Officer for the ALB) are also set out in Managing Public Money NI and MS/FMs.

5.0 Sponsorship Context

5.1 The starting point for staff in the Department is the context within which the ALB operates, and Sponsor Branches should be familiar with the framework that exists. This will include:

Legislation

5.2 At a strategic level the operating framework for the ALB is generally set out in the ALB's founding legislation.

5.3 Sponsor Branches need to:

- identify what legislation exists;
- familiarise themselves with its contents and requirements;
- ensure that it remains appropriate; and
- review and update the legislation as and when required (with input from departmental colleagues as appropriate).

Other Statutory Responsibilities

5.4 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.

5.5 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.

Management Statement and Financial Memorandum (MS/FM)

5.6 The framework document in place between the Department and the ALB is generally referred to as the Management Statement and Financial Memorandum (MS/FM). This document should set out a clear framework of strategic control within which the ALB will operate, taking account of the legislation applicable to the ALB. Managing Public Money NI, Annex 7.4 provides a model MS/FM template. This template is kept under review by Governance Unit and Finance Directorate to ensure it remains relevant to the ALBs.

5.7 Sponsor Branches need to ensure that an MS/FM is in place and that:-

- it meets the needs of the Department;
- it is signed by the Permanent Secretary (or EBM Sponsor if delegated), and the Chief Executive of the ALB and approved by the Department of Finance (if significant changes made to the DoF approved format/content);
- the conditions within the document are known and understood within the Sponsor Branch and it forms the basis of the assurance and accountability process;
- it is regularly discussed with the ALB and that its terms are subject to formal review at least every 5 years;
- Consideration is given to the need to review/resign the MS/FM when a new Chief Executive is appointed; and
- the MS/FM is available to the public through the ALB (e.g. on the ALB website).

5.8 In liaison with DoF, Finance Directorate and policy leads as appropriate, Governance Unit will co-ordinate and disseminate any guidance or advice on the updating of MS/FMs to Sponsor Branches.

Reviewing an ALB

5.9 The ALB shall be reviewed as required, in accordance with the business needs of the sponsor Department and the ALB.

5.10 A consolidated record is maintained of the dates of completion of ALBs effectiveness reviews and anticipated dates of the next reviews. This is reported to the Board in the biannual ALB Governance Report.

6.0 Sponsor branch checklist

6.1 The checklist is an internal tool that is issued to Sponsor Branches by Governance Unit at the start of the financial year. The purpose of this checklist is to provide a guide for Sponsor Branches in terms of assessing the extent to which they are operating within departmental guidelines and good practice and to confirm that ALBs themselves are meeting their corporate governance obligations.

6.2 The checklist is underpinned by the 'comply or explain' principle. Where it is necessary to deviate from the handbook the rationale should be explained along with any mitigating action required to address any associated risk.

6.3 The checklist consists of a series of assurance and accountability statements that the sponsor branch is required to confirm (Yes, No or Partly). If the response is 'No or 'Partly' sponsor branches are required to confirm what action is being taken to address issues and associated timeframes. An evidence section allows sponsor branches to record timely and proportionate evidence in support of the checklist. This is not intended to be exhaustive and in line with good practice, sponsor branches should ensure that accurate and timely records are maintained on TRIM. These records will be subject to scrutiny by Internal Audit in the completion of sponsorship audits.

6.4 The checklist is a living document that is completed by sponsor branches on an ongoing basis throughout the year and is signed off by the Executive Board Member Sponsor as part of the end year accountability process. The checklist will feed in to the accountability process and will assist the Executive Board Member Sponsor in providing assurance to the Accounting Officer on the adequacy of existing accountability arrangements. Governance Unit receives and reviews copies of completed checklists to identify any common emerging issues.

6.5 The timing of submission of completed checklists has historically been dictated by NIAO. Often this is in advance of the end year accountability process and Governance Unit is keeping this under review.

6.6 The checklist template can be updated at any stage throughout the year by Governance Unit in response to emerging governance or transformation issues.

7.0 Boards of ALBs

7.1 Given the important role which ALB Boards play in providing constructive challenge to executive staff within the ALB and ensuring that set objectives are achieved, it is important that the Department has the correct processes in place for:-

- the appointment of Board Members and Board Chairs with the required skills sets;
- ensuring Board Member training and development needs are appropriately identified and addressed by the ALB (and the Department); and
- commissioning the performance appraisal of Board Chairs and Board Members and monitoring appraisal completion.

7.2 These functions are dealt with by Appointments and Business Unit in the Department.

Board Appointments

7.3 Appointments to the Boards of the Department's ALBs must be made in line with the 'Code of Practice for Ministerial Public Appointments in NI' and the 'The Executive Office, Central Appointments Unit guidance'.

7.4 Appointments and Business Unit in the Department ensures that:-

- through monitoring the appointment and tenure periods of Board Members that appointment, competitions are run on a timely basis;
- Board appointments are sufficiently staggered to ensure that there is an appropriate retention of experienced Board Members balanced by the influx of new Members bringing fresh challenge;
- the skills required are formally identified (e.g. sectoral knowledge, finance, governance) and adequately detailed in candidate specifications etc;

- where possible the Chair of the ALB is involved in the appointment process of new Members; and
- applicants are probed both at application and interview stage regarding conflict of interest issues.

Induction and Training

7.5 Included in the standard letter of appointment for Board Members should be a mandatory requirement that new Board Members should attend an induction course recognised by the Department.

7.6 Board Chairs are responsible for ensuring that new Board appointees are provided with sufficient induction into their role. Within 6 months of appointment (preferably) all ALB Board members should have attended an appropriate training course to provide them with a clear understanding of their roles and responsibilities.

Board Appraisal

7.7 All ALB Boards are required to complete an annual Board Governance Self Assessment Tool (BGSAT). The tool is intended to help ALBs improve the effectiveness of their Board and provide the Board Members with assurance that it is conducting its business in accordance with best practice.

7.8 ALBs are asked to provide assurance, through their mid-year assurance statement, that the tool is being completed, actions are being addressed and that any exception issues will be raised with the Department. For assurance purposes the Department may, at any stage, request copies of the completed BGSAT pro-forma and/or supporting documentation.

7.9 Governance Unit will periodically review and update the BGSAT in line with good practice.

Board Chair and Member Appraisals

7.10 The Board Chair completes a self-assessment which must then be sent to the appropriate EBM Sponsor in the Department who completes the appraisal. The appraisal is then countersigned by the Permanent Secretary.

7.11 The Non-Executive Board Member completes a self-assessment which must then go to the Board Chair who completes the appraisal. The appraisal is then countersigned by the appropriate Grade 5 Sponsor Lead in the Department.

7.12 Appointments and Business Unit is responsible for co-ordinating the appraisal process which includes issuing appraisal reminders and templates and maintaining records.

Code of Conduct and Accountability for Board Members

7.13 A Code of Conduct and a Code of Accountability should be issued to all newly appointed Board Members. All Board Members should subscribe to these codes and should be judged on the way the codes are observed.

Board Meetings

7.14 Boards of ALBs should meet on a regular basis. Public board meetings should take place regularly with the time and place advertised.

7.15 Although there is not an exhaustive list of business for the Boards to consider, and the agenda of most Boards will be driven by their own business activities, Sponsor Branches should scrutinise the agenda for evidence that the Board is:

- receiving and reviewing regular updates and information on the ALB's performance (both non-financial and financial);

- considering the risks facing the organisation including reviewing the ALB's corporate risk register; and
- receiving regular reports from the Board's committees on the work they are undertaking, including an annual report.

7.16 The Sponsor Branch should take a targeted and proportionate approach to the scrutiny of Board papers informed by consideration of the Board Agenda. Any identified issues regarding the conduct of the ALB Board should be raised with the ALB in the first instance. Any unresolved issues should be raised at the relevant Ground Clearing meeting and escalated to the AO Accountability Meeting if required.

Attendance at ALB Board Meetings by the Sponsor Department

7.17 In general officials should not attend such meetings as a matter of routine. Officials may attend in an advisory capacity if this is helpful but should not influence, or give an impression that they are party to, any decisions taken. If officials are attending Board meetings, they should ensure that the capacity in which they are attending (observer etc.) is conveyed and recorded in the minutes. This may include notifying the ALB that any views expressed should not be taken by the ALB as departmental approval having been given but that proper approval should still be sought in the normal way.

Board Minutes

7.18 A good source of information for the Sponsor Branch, on how effectively the Board is operating and to gain an insight into key issues, are the minutes of Board Meetings.

7.19 Sponsor Branches should ensure that:-

- they put in place appropriate arrangements to receive Board minutes on a timely basis;

- Board minutes are published on the ALB's website;
- responsibility for reading and reviewing minutes is allocated within the Sponsor Branch and the outcome documented and reported;
- if concerns are identified, assurance is sought from the ALB (by the Sponsor Branch or relevant Policy Branch) that appropriate action is being taken to address issues; and
- any unresolved issues regarding the conduct of the ALB Board are escalated within the Department.

7.20 Sponsor Branches should also agree arrangements with the ALB for receipt of Board papers on a monthly basis. The Sponsor Branch should review the agenda for the ALB Board meeting and take a targeted and proportionate approach to the scrutiny of Board papers. If necessary any issues raised in the papers should be communicated to the appropriate Policy Lead and EBM Sponsor.

7.21 Where a departmental representative has attended a Board meeting this individual should specifically consider whether the minutes represent an accurate record of proceedings.

8.0 Financial Management

8.1 On financial matters, the primary point of contact for ALBs is Finance Directorate. Finance Directorate is responsible for the following functions:

- Scrutinising HSC savings plans;
- Allocating programme money including grant aid payments;
- In-year financial monitoring and challenge;
- Managing cash draw downs by ALBs;
- Preparing departmental annual accounts and Governance Statement;
- Reviewing business cases in liaison with Capital Investment Directorate to ensure compliance with NIGEAE;
- Providing advice and guidance to ALBs on revenue business cases and external consultancy and carrying out test drilling;
- Setting annual charges for HSC bodies;
- Discharging counter fraud responsibilities; and
- Overseeing application of procurement policy.

8.2 In carrying out these functions, Finance Directorate liaises closely with Sponsor Branches. Finance Directorate plays an important role in the mid and end year accountability process. Each business area within the Department has an assigned business partner from Finance Directorate. Sponsor Branches can engage with their finance business partner for financial advice and guidance.

Procurement

8.3 Finance Directorate monitors progress against strategic initiatives around procurement within ALBs and issues DoF procurement guidance and operational procurement guidance to ALBs.

8.4 Finance Directorate will provide input and data on procurement matters to sponsors and policy branches as required and signpost staff to appropriate

written or professional guidance. There is a long list of exceptions where procurement regulations do not apply - e.g. employment contracts and most public sector to public sector relationships - but as a general rule of thumb, formal professional advice on conducting procurements or entering contracts without competition must be sought from a Centre of Procurement Expertise (CoPE) where the expenditure is over £5k in total.

8.5 Finance (and not sponsors) will process all direct award contract requests from ALBs above their delegated limit for direct awards to the point of consideration by the Accounting Officer, with input from policy and sponsor colleagues as appropriate. Sponsors will be copied into above delegated limit direct award requests by private office when they are received, as they may evidence wider problems in the organisation.

Lease Business Cases

8.6 Lease business cases are submitted by the ALB to Investment Directorate in the Department. As part of the business case approval process, sponsor branches will be asked by Investment Directorate to support the business case, using their knowledge of the organisation.

9.0 Corporate and Annual Business Plans

9.1 All of the Department's ALBs should have in place a Corporate Plan that is aligned with the NI Executive's Programme for Government (PfG) and an annual Business Plan. Corporate and business plans will be formally approved by the Department.

9.2 Planning arrangements in Trusts are unique. Trusts currently prepare annual Trust Delivery Plans which are approved by the Health and Social Care Board. Future planning arrangements in Trusts will be an important consideration in the ongoing work on HSC restructuring.

Corporate Plan

9.3 The requirements of a Corporate Plan are typically reflected in ALB Management Statements and can be supplemented by specific departmental and ALB requirements.

9.4 The Corporate Plan will reflect the ALB's statutory duties and functions, and within those duties and functions, the priorities set by the Minister. In particular, the plan will demonstrate how the ALB contributes to the achievement of the Department's strategic aims and objectives and the Executive's PfG in the context of the current and forecast financial environment.

Annual Business Plan

9.5 The business planning process sets out in detail the framework through which the ALB contributes to the Department's strategic aims, objectives and targets arising from the Executive's PfG. The annual Business Plan will include key objectives, targets, actions and milestones, as appropriate.

9.6 Governance Unit will provide annual advice and guidance on the development of plans and Sponsor Branches should liaise with ALBs on the content of the plans and timeframe for submission.

9.7 On receipt of the Business Plan Sponsor Branches should:

- review the plan and circulate to departmental colleagues for comment;
- collate comments from departmental colleagues and communicate them to the ALB if change/clarification is required; and,
- make a recommendation to the EBM Sponsor on whether the Department should approve the business plan.

9.8 In reviewing the plan, Sponsor Branches, in liaison with Policy Leads as appropriate, should ensure that Plans:-

- support the delivery of Programme for Government outcomes;
- support the delivery of departmental policy and strategy;
- deliver on the functions etc. specified in the ALBs founding legislation setting out the purposes for which the ALB was created and the functions/services it is to deliver; and
- address known areas of underperformance, the findings of inquiries etc. and respond to particular events, serious adverse incidents and near misses.

9.9 As the objectives and targets set as part of the business planning process are those against which the Department will hold the ALB to account for delivering throughout the year, it is important that they are robust and measurable. Monitoring of performance will form a key strand of the Ground Clearing meetings.

10.0 Risk Management

10.1 All of the Department's ALBs should have in place a risk management process which identifies, assesses, evaluates, reviews and reports on key risks relevant to the ALB. ALBs are also required to have an assurance framework in place that maps out business objectives, the risks to their achievement, and related controls.

10.2 ALB risk registers should be submitted to Sponsor Branch at least twice a year and this should align with the mid year and end year accountability process.

10.3 Sponsor Branches should ensure that:

- the ALB risk register is a 'live' document i.e. is there evidence of:
    - text being updated, risks moving on and off register over time, rating of risks changing, action points being added and removed as addressed;
    - regular reports to the Audit/Governance Committee and ALB Board on risks; and
    - it being reviewed by ALB internal Audit.
- the register includes mitigating measures, actions and timescales to address identified risks; and
- the risk register is considered by the Audit Committee and approved by the ALB Board.

10.4 Sponsor Branches should review ALB risk registers bearing in mind other supporting information that the Department has available on the ALB's business e.g. evidence obtained from accountability meetings, mid year assurance Statements and Governance Statement and internal/external audit reports etc. The Sponsor Branch should challenge the ALB if they feel that the risk register does not adequately reflect known risks.

10.5 In considering the risk register it is reasonable that Sponsor Branches may need to seek input from the relevant Policy Lead on a specific risk. Depending on the nature of the issue or risk, it may be appropriate for the Policy Lead to engage with the ALB directly to seek clarity. Sponsor Branch must be kept informed of the outcome of this engagement and must liaise with the Policy Lead to ensure that any unresolved issues are factored in to the accountability process as appropriate (Ground Clearing, Assurance/Governance Statement, Accountability Meeting).

10.6 Where a significant ALB risk has been identified, the Sponsor Branch in conjunction with the Policy Lead should consider the need for escalation within the Department. The process for escalation is set out in the Framework for Business Planning, Risk Management and Assurance. The standing agendas of formal management meetings such as the Departmental Board and the Top Management Group provide opportunities for the EBM Sponsor or EBM Policy Lead to highlight potential issues for escalation. If appropriate, the Departmental Risk Register should be updated, subject to approval of the Departmental Board.

10.7 Governance Unit is responsible for maintaining and updating central guidance to ALBs on risk management and associated processes.

11.0 Assurance Reporting

Mid-Year Assurance Statement

11.1 All ALBs are required to submit a Mid-Year Assurance Statement to the Department. The function of this Statement is to enable ALB Accounting Officer's to attest to the continuing robustness of their organisation's system of internal governance. The Statement should provide a balanced appraisal, capable of substantiation, of the state of the organisation's internal governance.

11.2 Governance Unit commissions the Mid-Year Assurance Statements directly from ALBs in September each year. Governance Unit will receive the Mid-Year Assurance Statement from each ALB and will send to the relevant Sponsor Branch. Governance Unit will review each statement from a governance perspective and provide comments and/or briefing to Sponsor Branches if required. Ground Clearing and Accountability meetings allow for issues to be identified and escalated if necessary.

11.3 Sponsor Branches should:-

- critically review and evaluate the Mid-Year Assurance Statement to determine if the information provided is in line with the Department's knowledge of the ALB and any particular risks or issues facing the organisation;
- consider any information provided by the ALB Accounting Officer which indicates that there are issues emerging of which the Department was perhaps previously unaware, or which the Department needs to consider further;
- circulate the statement to EBMs and Policy and Professional Leads, as appropriate, for comment. If Policy or Professional leads decide that issues identified within the statement should be escalated to the Ground

Clearing/Accountability meeting they should provide appropriate briefing/input to the meeting.

- co-ordinate briefing for Ground Clearing and Accountability meetings ensuring that issues arising from the consideration of the Mid-Year Assurance Statement are included as appropriate.

Governance Statement

11.4 All ALBs are required to produce an annual Governance Statement signed off by their Accounting Officer. The statements are commissioned by and submitted to the Department's Finance Directorate. Finance Directorate review the draft Governance Statements to identify issues for inclusion in the Department's own Governance Statement and forward the statements to Sponsor Branches.

11.5 Sponsor Branches should review their ALB statement/s to determine if the information provided is in line with the Department's knowledge of the ALB and any particular risks or issues facing the organisation and to ensure they have been completed in line with departmental guidance. The statements should also be reviewed by relevant policy and professional areas (as identified by the Sponsor Branch) and by Governance Unit and Finance Directorate and relevant issues should be identified for potential inclusion in the Department's Governance Statement. A departmental response is prepared by the Sponsor Branch and signed by the Sponsor EBM or Grade 5 Sponsor Lead.

11.6 Sponsor Branches should also consider whether any issues identified in the Governance Statement should be discussed further with the ALB at the Ground Clearing or AO Accountability meetings.

11.7 Further guidance on the Governance Statement is available from Governance Unit.

12.0 Audit Committees

12.1 Each ALB with responsibility for administering public funds is required to have an Audit Committee. The Audit Committee is a committee of the Board, and its purpose is to advise the Board and the ALB's Accounting Officer on the risk management, control and governance arrangements within the body. While the role of the ALB's Audit Committee is primarily to provide assurance to the ALB's Accounting Officer and Board, an effective ALB Audit Committee will also assist the Department meet its oversight and sponsorship responsibilities.

12.2 One of the main Audit Committee principles is that it should be independent of executive management. This means that the Audit Committee in an ALB will be made up of the Non-Executive Board Members with one of these Members acting as Audit Committee Chair.

12.3 The primary source of guidance on Audit Committees including a suggested work programme is contained within the Audit and Risk Assurance Committee Handbook. The Audit Committee work programme should be approved by the ALB Board. The Chair of the Audit Committee should provide a report to the Board after each meeting and produce an annual report to support the Governance Statement.

12.4 A departmental representative should attend at least one audit committee meeting, in an observer capacity, in the course of the financial year. This may be a representative from Sponsor Branch or Finance Directorate. Through such attendance the Department is able to assess how effectively the Audit Committee is discharging its challenge function and to gain a good insight into the governance arrangements within the ALB. It also helps to gain a greater understanding of the ALB's business and the key risks and issues facing the organisation. A short report should be prepared for the EBM sponsor by the departmental representative following the meeting. Any identified issues must be brought to the attention of the Sponsor Branch.

National Audit Office (NAO) Checklist

12.5 It is best practice that Audit Committees should periodically review the overall effectiveness of the Committee. Since 2009 the Department has required ALBs to complete the NAO checklist annually. The ALB provides assurance on completion of the checklist through their Mid-Year Assurance Statement and should report any exception issues to the Department.

12.6 The NAO checklist's prime purpose is to assist organisations in assessing their effectiveness by reference to five broad areas:

- membership, independence and objectivity;
- skills;
- the role and scope of the committee; and
- communication and reporting.

Role of Internal Audit

12.7 ALBs are required to have an Internal Audit function which complies with Public Sector Internal Audit Standards (PSIAS). The role of Internal Audit within an ALB is to provide the ALB Accounting Officer with an opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The internal audit function for each ALB is provided by BSO Internal Audit.

12.8 In line with PSIAS an ALB's internal audit function should prepare its audit strategy and annual audit plans on a risk based approach. The Sponsor Branch and the ALB internal auditor should engage with each other at an early stage in the audit planning process. Sponsor Branches should also make arrangements to ensure they are kept informed on the progress of the ALB's internal audit plan and to formally agree with the ALB the procedures through which they wish to receive copies of internal audit assignment reports (where satisfactory assurance is not received) and the Head of Internal Audit's (HIA's) interim and annual reports on a timely basis. The Sponsor

Branch should also act as the channel for providing departmental Internal Audit with assignment, interim and annual reports etc.

13.0 Performance Review

13.1 Ground Clearing and Accountability meetings are held at mid and end year. The purpose of Ground Clearing and Accountability meetings is both to seek assurance (focusing particularly on systems of internal control) and to hold ALBs to account for their performance against organisational and service delivery priorities which should be reflected in each ALB business plan.

13.2 Issues identified at the Ground Clearing meeting which cannot be resolved at the meeting or through other avenues should be escalated for discussion to the Accounting Officer Accountability meeting with the Chair and Chief Executive of the ALB.

Ground Clearing Meetings

13.3 The Executive Board Member (EBM) sponsor of the ALB should chair the Ground Clearing meetings. In specific circumstances this may be delegated to the Grade 5 Sponsor Lead. Depending on the circumstances of the ALB, a representative from Finance Directorate may also be required to attend. When commissioning briefing from Finance Directorate for the Ground Clearing meeting, Sponsor Branch should therefore seek Finance Directorate's advice as to whether a finance representative is required to attend the meeting. Beyond this the attendance of other senior officials is at their own discretion and will depend on the agenda items.

13.4 The Ground Clearing meeting should be attended by relevant parties from the ALBs. It is at the discretion of each ALB to decide which Directors should attend these meetings.

13.5 All end-year and mid-year Ground Clearing meetings should follow a broadly standard agenda to ensure a consistent approach across the Department. The agenda will address performance of the ALB under the Assurance and Accountability domains:

- Corporate Governance – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;
- Quality – the arrangements for monitoring and improving the quality of programmes/services provided by and for the ALB. Ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;
- Resources – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources (incl HR and Estates) are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;
- Service delivery/improvement – the arrangements for ensuring the delivery of PfG outcomes, ministerial targets, other targets/priorities and required service improvements; and
- Other significant operational issues and risks.

13.6 Briefing for Ground Clearing meetings is co-ordinated by Sponsor Branches with timely input from policy/professional leads.

Accountability Meetings

13.7 For all 17 ALBs, the Accounting Officer Accountability meetings will normally be led by the Permanent Secretary, supported by the EBM sponsor and a note-taker. These meetings are attended by only the Chair and Chief Executive of the ALB.

13.8 Following the Ground Clearing meeting the EBM Sponsor will be required to provide the Permanent Secretary with a note outlining the issues which they feel need to be escalated to the accountability meeting and enclosing a proposed agenda. The sponsor EBM also documents a provisional assessment on whether any adjustment is required to the baseline level of sponsorship and control and provides a rationale for such an assessment.

13.9 Briefing for accountability meetings is co-ordinated by Sponsor Branches with timely input from policy/professional leads.

13.10 If there are no issues arising from Ground Clearing meeting, the EBM sponsor should provide assurance to the Permanent Secretary that there are no issues for escalation. In such instances, the Permanent Secretary may decide to meet with the ALB Chair and Chief Executive on a more informal basis.

Minutes and Action Points

13.11 Minutes for both meetings should be drafted and circulated as promptly as possible after the meeting, ideally within 2 weeks. Minutes should be agreed by all parties and finalised as soon as possible, ideally within 4 weeks of the meeting.

13.12 Detailed guidance on the accountability process is available from Governance Unit.

13.13 Assurance and accountability is ongoing and not confined to formal process. Outside the formal accountability meetings, Sponsor Branches should engage (meetings, emails etc) regularly with the ALB through-out the year. This engagement should be timely, pitched at the correct level and appropriate to the circumstances.

Reports to Top Management Group (TMG), Departmental Board etc

13.14 As part of the routine business of the Department, EBM sponsors and policy/professional leads are responsible for providing updates to TMG and the Departmental Board, as required, on specific aspects of ALB performance.

13.15 Governance Unit will provide biannual update reports on ALB Governance to the Departmental Board and the Departmental Audit and Risk Assurance

Committee (DARAC). These reports will include an overview of the mid and end year accountability process including completion of the sponsor branch checklists and any significant issues or common emerging themes. Sponsor Branches and policy/professional leads will provide input to these reports.

13.16 The Department's Internal Audit will carry out a rolling programme of sponsorship audits and will report to DARAC on its findings.

14.0 Policies

Fraud and Whistleblowing

14.1 It is important that each of the Department's ALBs has in place adequate and effective anti-fraud arrangements in order to ensure that public funds are adequately safeguarded and protected.

14.2 Sponsor Branches should ensure that each ALB has made satisfactory arrangements in terms of having robust anti-fraud measures in place in line with Appendix A.4.7 of MPMNI and has a bespoke whistleblowing policy in place. These should be considered by the ALB Audit Committee and approved by the ALB Board.

Acceptance and Provision of Gifts and Hospitality

14.3 Acceptance and Provision of Gifts and Hospitality Policy should set out the principles and requirements under which gifts and hospitality can be received and in turn when such offers can be made in line with Department of Finance guidance.

15.0 Information

Information flows

15.1 In discharging its sponsorship role the Department must ensure appropriate record keeping. Clear and sufficient audit trails are important for supporting the evidence based assurance and accountability process.

15.2 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.

15.3 The Department has access to and can request from each ALB or from independent sources information necessary and appropriate to discharge its sponsorship role e.g.

- 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.

Information Streams External to ALBs

15.4 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 Medicines and Healthcare products Regulatory Agency (MHRA);
- reports from Committees of the Assembly; and
- reports from Inquiries and Coroners Inquests.

Information on Staff Travel

15.5 Sponsor branches are responsible for co-ordinating requests for overseas travel by Chief Executives and overseas travel proposed by a member of staff that will exceed more than 5 times in a calendar year. The requests are submitted to sponsor branches by the ALB and the sponsor branch prepares a submission for approval by the Permanent Secretary/Minister as appropriate. At the request of Governance Unit, Sponsor branches also collate detailed information on staff travel at regular intervals for consideration by Permanent Secretary.

16.0 Sponsor Branch Staff

Training

16.1 Sponsorship training should be provided to staff who are involved in the sponsorship of the Department's ALBs. Attendance at relevant Centre for Applied Learning courses on Arm's Length Body sponsorship may be useful in, at least partly, addressing this need. Other training needs for sponsor staff, such as that on finance, governance, policy development, etc. should also be considered.

16.2 Governance Unit will arrange an induction session with staff who are new to sponsorship to discuss the assurance and accountability arrangement set out in this handbook.

Sponsor Branch Forum

16.3 A Sponsor Branch Forum, chaired by Governance Unit, has been established to discuss generic sponsorship issues and to identify and disseminate best practice in sponsorship arrangements across Sponsor Branch staff. The Forum, which meets every few months, allows Sponsor staff within the Department to contribute to the agenda; provide supporting papers where appropriate; share experiences and lessons learned; and contribute to discussions and work undertaken to improve the Department's sponsorship practices.

16.4 Governance Unit can be contacted for further advice as necessary on any aspect of this handbook which will be reviewed annually to ensure that it remains valid and up-to-date.

MAHI - STM - 089 - 6506

CIRCULAR: HSS (STATUTORY FUNCTIONS) 1/2006

DHSSPS CIRCULAR

RESPONSIBILITIES, ACCOUNTABILITY AND AUTHORITY OF THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY, HEALTH AND SOCIAL SERVICES BOARDS AND HEALTH AND SOCIAL SERVICES TRUSTS IN THE DISCHARGE OF RELEVANT[1] PERSONAL SOCIAL SERVICES FUNCTIONS TO SAFEGUARD AND PROMOTE THE WELFARE OF CHILDREN

1 INTRODUCTION

1.1 Family and Child Care services occupy a unique position in the social services by virtue of the range of statutory powers and duties which direct and inform the provision of services.

1.2 The purpose of this guidance is to reclarify the respective roles, responsibilities, accountability and authority of the Department of Health, Social Services and Public Safety (the Department) and Health and Social Services Boards (Boards) and Health and Social Services Trusts (Trusts) with particular reference to the discharge of their statutory functions to safeguard and promote the welfare of children.

1.3 Since the commencement in November 1996 of the Children (Northern Ireland) Order 1995[2] (The Children Order), the need for greater clarity has been demonstrated by cases arising in the courts from time to time. In responding to a directive from the Judiciary to explain why a Trust had not discharged its duty to provide appropriate care for a child, some Trusts have sought, on legal advice, to involve both the Board and Department. Trusts have also sought to justify breaches in the discharge of their statutory functions by claiming that they had not been allocated sufficient resources to enable them to discharge these. None of these cases proceeded to final hearing. There has consequently not therefore been a judicial interpretation of the respective roles and responsibilities of the Department, Boards and Trusts in relation to relevant statutory functions.

1.4 The Review of Health and Social Services in the case of David and Samuel Briggs (DHSSPS, 2003) highlighted particular differences in the perception and understanding of the respective roles and responsibilities

[1] Commonly referred to as "statutory functions."
[2] S.I. 1995/955 (N.I.2)

of the Department, Boards and Trusts. The Review contained a recommendation that the Department should 'reclarify the roles of the Board and the Trust in terms of commissioning, managing and delivering the service'.

1.5 This circular seeks to explain and address these matters within both the legislative framework and the arrangements governing the structures for the delivery of services.

2 LEGISLATIVE AND STRUCTURAL BACKGROUND

The Department

2.1 The Department's powers derive from the Health and Personal Social Services (Northern Ireland) Order 1972[1] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department (then, the Ministry of Health and Social Services) the duty to:-

- provide or secure the provision of integrated health services in NI designed to promote the physical and mental health of the people of NI through the prevention, diagnosis and treatment of illness;
- provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland; and
- to discharge its duty as to secure the efficient coordination of health and personal social services.

2.2 On 1 January 1974, the Ministry of Health and Social Services became known as the Department of Health and Social Services. On 1 December 1999, the public safety functions of the Department of the Environment were transferred to the renamed Department of Health, Social Services and Public Safety (DHSSPS)[2].

Health and Social Services Boards

2.3 On 1 September 1972, Boards were established under Article 16 of the 1972 HPSS Order. The Health and Personal Social Services (Establishment and Determination of Areas of Heath and Social Services

[1] S.I.1972/1265 (N.I.14)
[2] See S.R. 1999 No. 481 and I.1999/283 (N.I.1)

Boards) Order (Northern Ireland) 1972[1] determined the geographical area of each Board and specified its administrative Districts.

2.4 Article 17 of the 1972 HPSS Order specified the key functions of the Boards in respect of health and personal social services. These included, inter alia:

- the exercise on behalf of the then Ministry of Health and Social Services, such functions (including functions imposed under an order of any court) with respect to the administration of such health and personal social services as the Ministry may direct; and

- the exercise on behalf of the then Ministry of Home Affairs such functions (including functions imposed under an order of any court) with respect to the administration of such personal social services under the Children and Young Persons Act (Northern Ireland) 1968 (the Children and Young Persons Act) and the Adoption Act (Northern Ireland) 1967 (the Adoption Act) as the Ministry may direct;

in accordance with regulations and directions. Article 17 (2) of the 1972 HPSS Order also provides that where a function is conferred on a Board by any other legislation, that function shall be deemed to be a function which the Department has directed a Board to exercise on its behalf under Article 17 (1).

2.5 The Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1973 (The No. 1 Direction) specified the functions under the 1972 HPSS Order to be exercised by Boards on behalf of the then Ministry of Health and Social Services subject to the conditions contained in the Direction.

2.6 The Functions of Health and Social Services Boards (No. 2) Direction (Northern Ireland) 1973 (the No 2 Direction) specified functions of the then Ministry of Home Affairs under Articles 72 and 73 of the1972 HPSS Order relating to personal social services under the Children and Young Person's Act and the Adoption Act which were to be exercised by Boards on behalf of the Ministry of Home Affairs subject to the conditions contained in the Direction.

2.7 A number of functions under the Children and Young Person's Act, including those relating to training schools, attendance centres and remand homes were reserved to the Secretary of State in accordance with the provisions of the Northern Ireland (Modification of Enactments – No 1) Order 1973 (the 1973 Order) made under the Northern Ireland

[1] S.O. 1972 No. 217

Constitution Act 1973. These remained the responsibility of the Northern Ireland Office.

2.8 Additional functions under the Children and Young Person's Act, including Fit Person's Orders, in so far as they related to the treatment of children and young persons found guilty of offences were also reserved in the 1973 Order to the Secretary of State. Operational difficulties that this presented to Boards were overcome by a subsequent agency arrangement made under section 11 of the Northern Ireland Constitution Act 1973, whereby the Department undertook these functions on behalf of the Secretary of State. The Functions of Health and Social Services Boards (No 1) Direction (Northern Ireland) 1974 provided for the local discharge of these functions by Boards.

2.9 By virtue of the Departments (Transfer of Functions) Order (Northern Ireland) 1973[1], all functions under the Adoption Act and all remaining functions under the Children and Young Persons Act transferred on 1 January 1974 to the Department from the Ministry of Home Affairs[2] subject to the provisions of the 1973 Order as referred to in paragraph 2.7. The No. 2 Direction (see paragraph 2.6) remained the applicable instrument of delegation for these functions.

2.10 With the introduction of the Adoption (Northern Ireland Order) 1987 (the Adoption Order) certain functions were conferred directly on Boards. Article 17 (1) of the 1972 HPSS Order was amended by that Order so that those functions under the Adoption Order are functions which the Board must exercise in accordance with regulations made by, and directions given by the Department.

The community care reforms

2.11 During the early 1990s, the changes introduced by the White Papers "Caring for People" and 'Working for Patients', (DoH, 1989) respectively set out proposals for improving community care services and health services in England and Wales. The equivalent Northern Ireland policy document, "People First" (DHSS,1990) introduced for the first time a division between the purchasing and provider roles within health and personal social services in Northern Ireland.

2.12 The role of Boards as coordinators, purchasers and quality controllers was strengthened relative to their primary role, at that time, as service providers. Management at local level was also strengthened through the

[1] SR & O 1973 No 504
[2] See S.I. 1973/2162 (C.64)

appointment of Unit General Managers. In the early 1990s this internal reorganisation changed the administrative structure from districts to General Units of Management, and reconfigured the geographical areas of the former administrative districts.

2.13 Under the People First policy reforms, Boards as commissioners and purchasers of services, were responsible for:

- assessing the health and social care needs of their resident population;
- strategic planning to meet need; and
- the development of purchasing plans.

2.14 People First required Boards to promote a mixed economy of care and a range of providers to maximise user choice and ensure the economic, effective and efficient delivery of services.

2.15 The Health and Personal Social Services (Northern Ireland) Order 1991 (the 1991 HPSS Order) gave effect to these changes and enabled health services bodies to enter into arrangements (HSS contracts) for the provision of goods or services to or by them.

Health and Social Services Trusts

2.16 Central to the reforms in England and Wales was the concept that hospitals and community health providers were to be given the option to become self-governing Trusts.

2.17 As health and personal social services in Northern Ireland, however, are integrated under the 1972 HPSS Order, account had to be taken of the Boards' responsibilities for the discharge of certain functions in relation to the personal social services. Under the 1972 HPSS Order, these included services delivered under the Children and Young Person's Act and the Adoption Order. The 1991 HPSS Order empowered the Department to establish bodies, to be known as Health and Social Services Trusts. The first of these were established in shadow form in 1993 as corporate bodies, managerially and administratively independent of Boards. Further primary legislation was required to enable newly established Trusts to discharge the personal social services functions on behalf of their respective Boards.

2.18 The Health and Personal Social Services (Northern Ireland) Order 1994 (the 1994 HPSS Order) provides for certain functions of Boards to be exercisable on behalf of Boards by Health and Social Services Trusts. These functions were prescribed for the purposes of the 1994 HPSS Order in The Health and Social Services Trusts (Exercise of Functions) Regulations (Northern Ireland) 1994 (The Exercise of Functions Regulations) and are known as "relevant functions." The schedule to the regulations, which defined the relevant functions, is set out in full at Annex A. It includes functions under the Adoption Order and the Children and Young Person's Act and was subsequently amended in 1996 to include functions under the Children Order.

3 THE LEGAL RELATIONSHIP BETWEEN BOARDS AND TRUSTS IN RELATION TO CHILDREN'S SOCIAL SERVICES AND THE DISCHARGE OF RELEVANT FUNCTIONS

3.1 Under the 1994 HPSS Order, Boards may, by instrument in writing under seal ("an authorisation") provide for such relevant functions of the Board as are specified to be exercised by a Trust on behalf of the Board. Authorisations require the approval of the Department. The 1994 HPSS Order requires each Trust to submit to the Board or approval a scheme for the exercise by the Trust of specified relevant functions. The Board must then submit the scheme for the approval of the Department.

3.2 Schemes, known as "Schemes for the Delegation of Statutory Functions" were developed by Trusts in co-operation with the relevant Board, which subsequently approved each scheme and submitted it to the Department for approval. As part of the approval process, the Department's role was to ensure that proper provision had been made for the exercise of the relevant functions to be delegated to Trusts and that Boards had appropriate arrangements in place to assure themselves that Trusts were exercising relevant functions effectively.

The Children (Northern Ireland) Order 1995

3.3 Prior to the commencement of the Children Order in November 1996, the Department amended the Exercise of Functions Regulations[1] to prescribe as relevant functions all functions under the Children Order. The Department subsequently approved all schemes to enable the Trusts to discharge specified relevant functions under the Children Order and the Adoption Order.

[1] SR 1996 No. 439

3.4 Boards continued to exercise functions under Articles 80 – 87 and 96 – 103 of the Children Order, which deal with the registration and inspection of children's homes and under Article 176 of the Order which provides for the inspection of schools accommodating children. The arrangements and standards for the discharge of these functions had to be equivalent to those of the Trusts and were quality assured by the Department. The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, has now transferred the above registration and inspection functions from Boards to the Northern Ireland Heath and Personal Social Services Regulation and Improvement Authority, now known as the Regulation and Quality Improvement Authority (RQIA).

3.5 In 1998, the Department amended the Children Order to add to the duties of Boards in the Children (1995 Order) (Amendment) (Children's Services Planning) Order (Northern Ireland) 1998[1]. This requires each Board to review the services provided in its area under Part IV of the Children Order and prepare and review plans in light of the review of services.

4 ACCOUNTABILITY

Legal accountability

4.1 The State is ultimately the parent of all children, in accordance with the common law principle of 'parens patriae'. Generally, the State exercises its powers to safeguard and promote the welfare of children through statutory agencies, named as the responsible authorities in primary legislation. Legislation specifies, in broad terms, what the State considers is required to safeguard and promote the welfare of children and provides the legal authority for responsible authorities to discharge statutory functions on behalf of the State. There are circumstances in which the State names the appropriate Government Department in legislation as the responsible authority. In these situations the Department is responsible in law for the exercise of the statutory functions unless it has delegated the functions to another statutory body.

4.2 In primary legislation, where Boards are named as the responsible authorities for the exercise of the functions, these functions are deemed to be a function which the Department has directed the Board to exercise under Article 17 (1) of the 1972 HPSS Order. Where a Board delegates relevant functions to a Trust in accordance with the provisions of the 1994 HPSS Order, under Article 3(7) of that Order the Trust:

[1] SR 1998 No. 261

> "…shall be liable in respect of any liabilities (including any liability in tort) in the exercise of these functions in all respects as if it were acting as a principal and all proceedings for the enforcement of such rights or liabilities shall be brought by or against the HSS Trust in its own name".

4.3 The Children Order, Article 2(3), confirms that "where a function is exercisable by a Health and Social Services Trust by virtue of an authorisation for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994, references to an authority are, to the extent that that function is exercisable by that Trust, references to that Trust". Trusts, therefore, are responsible in law for the discharge of all relevant functions delegated to them by Boards.

Accountability for Implementing the Schemes

4.4 Whilst Trusts are responsible in law for the discharge of statutory functions, they are also accountable to Boards and to the Department for the implementation of the schemes and the proper discharge of those relevant functions delegated to them. There is therefore a clear line of accountability from provider Trusts, through commissioning Boards to the Department. A delegating Board is able to hold a Trust to account for how it is discharging relevant functions on its behalf. A Board may, with the approval of the Department, revoke an authorisation to a Trust to exercise relevant functions, should circumstances warrant such action.

5 ROLES AND RESPONSIBILITIES

The Department

5.1 The Department has a responsibility to safeguard and promote the welfare of children. Its main role is to provide the legislative and strategic policy direction to enable its agents and significant others, such as the independent sector to achieve its objectives for children. In discharging its responsibilities the Department undertakes a wide range of functions. These include establishing regional priorities, setting targets and providing resources to meet those priorities in the form of a Public Service Agreement. The Department also monitors delivery against these targets and ensures value for money for the citizen. The Department also has a duty to ensure the quality and good governance

of the social services and to liaise with other Government Departments and relevant non HPSS bodies, for example education services and the family and criminal justice systems to assist the achievement of its objectives.

5.2 The State is the parent of all children. Under the 1994 HPSS Order, the Department has power to direct Boards to execute authorisations in such terms as it may direct. The Department is also responsible for approving the schemes for the delegation of relevant functions and any subsequent proposed changes to them. Under the 1991 HPSS Order a Trust must comply with any directions given to it by the Department about the exercise of the Trust's functions. The Department is also responsible for ensuring that there are satisfactory arrangements in place for the exercise of statutory functions by Boards and Trusts and that Boards have established mechanisms to assure and determine that these functions are being properly exercised and to agreed standards. Under Article 152 of the Children Order, the Department may cause local or other inquiries to be held in any cases where it appears to the Department to be advisable to do so in connection with the functions of an authority in so far as those functions relate to children

5.3 Since the enactment of the Adoption (Intercountry Aspects) Act (Northern Ireland) 2001[1], (the Adoption Intercountry Aspects Act) intercountry adoption is the only area of children's services for which the Department is legally responsible and accountable for the discharge of specified statutory functions. The Adoption Intercountry Aspects Act gave effect to the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption concluded at the Hague on 29 May 1993. Under this Act, the Department must exercise all the statutory functions of a Central Authority under the Convention. The Department must also ensure that in each adoption there is compliance with the Intercountry Adoption (Hague Convention) Regulations (Northern Ireland) 2003[2] in the case of Convention adoptions and the Adoption of Children from Overseas Regulations (Northern Ireland) 2002[3] in the case of non Convention adoptions.

Health & Social Services Boards

5.4 Boards are responsible for commissioning services to meet the needs of their populations. Boards receive allocations from the Department at the start of each financial year on a capitation basis. They are required to

[1] 2001c.11 (N.I.)
[2] SR 2003 No.16
[3] SR 2002 No 144

spend these monies to secure the delivery of health and personal social services in line with the schemes for the delegation of statutory functions, Departmental priorities and agreed plans as set out in the Priorities for Action and Health and Wellbeing Investment Plans. They have a strategic planning and coordinating role, including that of Children's Services Planning as set out in paragraphs 2.12 and 3.5.

5.5 Boards are also responsible for agreeing the schemes for the delegation of relevant functions with Trusts and following approval by the Department these functions are then delegated to Trusts by way of a written authorisation sealed by the Boards. Under the terms of the schemes the Boards, as commissioners and purchasers of services:

- prescribe professional and other quality standards to provide a baseline for the provision of services in accordance with statutory requirements;

- approve policies and procedures in respect of relevant functions;

- monitor, evaluate and inspect services to ensure that they are provided in accordance with prescribed policies and standards and within agreed and approved procedures; and

- must satisfy themselves as to the arrangements that Trusts have in place to quality assure the services and satisfy accountability requirements.

5.6 Following the delegation of relevant functions, Boards are responsible for ensuring that the schemes are properly implemented and that they are reviewed at least bi-annually. The Boards also have a role in quality assuring the discharge of those relevant functions which they have delegated to Trusts.

5.7 Under the schemes, Boards are required to agree the Trusts' monitoring arrangements, as well as the information that will be provided and at what intervals. They have the authority to monitor, evaluate and inspect services directly and to require Trusts to provide them with information on any matter related to the discharge of relevant functions. The Board must specify areas of service in which it intends to have a direct monitoring role, taking account of the information already provided by the Trusts in order to avoid unnecessary duplication.

5.8 Boards are also required under the schemes to receive from Trusts reports of untoward incidents, including serious complaints. Boards have

a responsibility to keep the Department informed of the outcome of their quality assurance arrangements in respect of Trusts' discharge of relevant functions, or if there is an unresolved dispute, to bring it to the attention of the Department.

Health & Social Services Trusts

5.9 Trusts are accountable to Boards for the quantity, quality and efficiency of the service they provide. Boards agree contracts with Trusts at the start of each financial year. In their delivery plans, Trusts are required to describe how they will deliver services in an efficient manner. Their performance and expenditure are monitored by Boards and the Department. Trusts are responsible for the exercise of all of the relevant functions delegated to them by the Boards. They have the legal authority and are responsible in law for the discharge of these functions in accordance with the approved schemes and for ensuring that the standards required under the authority of the schemes are met.

5.10 Trusts are also responsible for evidencing compliance with the schemes through their monitoring and reporting arrangements, in accordance with the format and frequency agreed with the Boards.

5.11 As separate legal entities accountable for the discharge of these functions, Trust must create sound organisational arrangements to ensure that professional practice in the discharge of relevant functions is of a high standard and that staff are appropriately qualified, supported and trained to ensure competency in the discharge of the functions. Trusts must also ensure that there is clear and appropriate managerial and professional accountability.

5.12 Trusts also have a responsibility to assist the Boards and Department, as appropriate, in the discharge of functions which have not been delegated to them, and for which they are not responsible in law. For example, Trusts have a responsibility to contribute to the strategic partnerships which Boards operate within the wider HPSS and other non HPSS bodies, which impact on the discharge of relevant functions by Trusts.

6 WORKING RELATIONSHIPS

6.1 This circular sets out the roles, responsibilities and accountability of the Department, Boards and Trusts in relation to the discharge of relevant functions relating to children's services. Partnership is a fundamental

principle, however, in safeguarding and promoting the welfare of children. Other agencies are required to assist Boards and Trusts with the discharge of certain functions, in so far as this is compatible with their bodies' own statutory duties and obligations (Article 46 of the Children Order) and in the investigation of matters under Article 66 of the Children Order, unless to do so would be unreasonable in all of the circumstances of the case. Boards and Trusts must therefore give priority to developing and maintaining good working relationships with all agencies involved with children in a 'working together' approach, which is in the best interests of children and their families.

ANNEX A

The Schedule to the Health and Social Services Trusts (Exercise of Functions) Regulations (Northern Ireland) 1994.

Relevant functions of Health and Social Services Boards

Statutory Provision	Relevant functions of a Health and Social Services Board
Children and Young Persons Act (Northern Ireland) 1968	All functions.
Health and Personal Social Services (Northern Ireland) Order 1972	Functions under Articles 14A, 15, 36, 37, 38, 29, 71(2), 99, 101, 101A and Schedule 6.
Chronically Sick and Disabled Persons (Northern Ireland) Act 1978	Functions under sections 1(2), 2 and 12(1).
Mental Health (Northern Ireland) Order 1986	All functions except that of designating a hospital under Article 46(1) for the purposes of Article 46(2)(a), and those under Articles 28(3), 42(9)(a), 46(3)(a), 86(2), 90(2), 108(2), 112, 113, 114, 116, 118, 121(1), 123(1)(a), 129(7) and 133(4).
Adoption (Northern Ireland) Order 1987	All functions.
Disabled Persons (Northern Ireland) Act 1989	All functions.
Children (Northern Ireland) Order 1995	All functions.
Carers and Direct Payments Act (Northern Ireland) 2002	All functions.

CIRCULAR (OSS) 4/2015:

STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT

DHSSPS CIRCULAR

ROLES AND RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY, THE HEALTH AND SOCIAL CARE BOARD AND THE HEALTH AND SOCIAL CARE TRUSTS FOR THE PROFESSIONAL OVERSIGHT OF THE DISCHARGE OF DELEGATED STATUTORY FUNCTIONS

1 INTRODUCTION

1.1 The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994 following concerns raised by the judiciary with the introduction of legislation[1] which enabled the delegation of relevant statutory functions from the legacy Health and Social Services Boards to Trusts. Arrangements for professional oversight are designed to ensure that DSFs are discharged in accordance with the law and to relevant professional standards within a system of delegation.

1.2 The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs.

1.3 Professional oversight arrangements are an integral part of the overall system of checks and balances that hold the HSCB and Trusts to account for their performance. Professional oversight involves:

- ❖ Approval of Schemes for the Delegation of Statutory Functions
- ❖ Discharge of DSF
- ❖ Performance management
- ❖ Strategic oversight
- ❖ Continuous improvement
- ❖ Reporting

[1] Health and Personal Social Services (Northern Ireland) Order, 1994

1.4 This circular outlines the roles and responsibilities of the CSWO, the HSCB Director and Trust EDSWs for the professional oversight of DSFs in line with the role, function and responsibility of each organisation.

1.5 This circular should be read in conjunction with Circular (OSS) 3/2015 which sets out the legislative and structural arrangements in respect of the authority of the Department, the HSCB and Trusts in the discharge of DSFs.

2. STATEMENT OF PRINCIPLES

2.1 Arrangements for the professional oversight of DSFs within and between each organisation should be based on a commitment to:

(i) co-operation in the interests of improving and safeguarding the social wellbeing of children, families and adults;

(ii) evidence-informed decision-making;

(iii) securing improved outcomes for service users;

(iv) regional consistency and fairness in availability, quality and effectiveness of services;

(v) continuous improvement based on learning from the professional oversight processes;

(vi) timely reporting, prompt responses and early resolution of issues;

(vii) efficiency, proportionality and effectiveness.

3. ACCOUNTABILITY

3.1 Accountability is a key element in the discharge of DSF. The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.

3.2 Responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs.

3.3 Professional oversight arrangements ensure the Accounting Officer and the board of directors of each Trust and of the HSCB receive authoritative professional advice and analysis regarding their organisation's discharge of DSF which, in turn, enables each Accounting Officer to account to the HSCB and/or Department as appropriate. The Department's Accounting Officer is advised by the CSWO on all relevant professional matters, including DSFs.

3.4 As such, arrangements for the professional oversight of DSFs are an integral part of each organisation's internal corporate governance and accountability arrangements and should not duplicate reporting processes in place for these purposes.

3.5 Due regard will be given by the Department, the HSCB and Trusts as to the views of individuals and/or agencies in terms of the performance of the HSC system in improving and safeguarding the social wellbeing of people in Northern Ireland.

4. PROFESSIONAL LEADERSHIP

4.1 The CSWO, the HSCB Director and the EDSW of each Trust are individually and collectively responsible for:

- providing professional leadership on all social work and social care matters, including DSFs within their respective organisations, and, where relevant, to other organisations;
- ensuring appropriate internal organisational, managerial and professional arrangements are in place for the professional oversight of DSFs in line with the requirements set out in this circular and other relevant guidance;
- providing authoritative professional advice and analysis in respect to DSFs to their Accounting Officer and board of directors;
- maintaining open and constructive working relationships and sharing information with each other as appropriate; and
- adopting a collaborative and supportive approach to clarifying and resolving issues as they arise thereby minimizing the need for escalation and/or formal intervention.

4.2 The CSWO, HSCB Director and EDSWs are required to be professionally qualified social workers in accordance with Article 8 (1) of the Health and Personal Social Services Act (Northern Ireland), 2001 (the 2001 Act) and registered with the Northern Ireland Social Care Council to ensure the availability of high quality professional advice within their respective organisations on the complex issues involved in the exercise of duties, powers and responsibilities particularly, but not exclusively, with regard to protecting individuals from risk of harm of neglect, abuse or exploitation.

4.3 Chief Social Work Officer – role and responsibilities

4.3.1 Chief Professional Officers, including a CSWO, are employed by the Department at a senior level to provide the Minister, Permanent Secretary and Department board with authoritative professional advice and insights in respect of the provision of the full range of health and social care.

4.3.2 The CSWO (who is also Deputy Secretary for Children's, Families and Adult Social Care policy) is the lead professional officer for social work and social care in Northern Ireland and sets the strategic direction for relevant service areas. S/he provides strategic professional advice and expertise to policy colleagues, government Departments, HSC agencies and other organizations as required. The CSWO/Deputy Secretary sits as an executive member on the Departmental board.

4.3.3 The CSWO has a wide range of professional responsibilities including responsibility for the professional oversight of DSFs within an integrated HSC system. This oversight is part of the overall system within the Department for monitoring the delivery of the Department's policies by its ALBs and holding them to account.

4.3.4 The CSWO is responsible for issuing and keeping under review all relevant Circulars, professional standards, guidance or directions in respect of arrangements for the discharge of relevant functions.

4.3.5 Annex A sets out the full range of professional responsibilities of the CSWO

4.4 The Director of Social Care and Children – role and responsibilities

4.4.1 The HSCB Director (who is also the Executive Director for Social Work within the HSCB) is a prescribed member[2] of the HSCB board and is responsible for providing strong professional leadership and strategic direction for social work and social care within an integrated HSC system and ensuring coherent regional arrangements for the delivery of relevant services. S/he is responsible for the delivery of the HSCB's responsibilities as the 'named authority' in legislation for the discharge of DSFs by Trusts and for providing strategic advice at board level on future developments and direction.

4.4.2 Annex B sets out the full range of professional responsibilities of the HSCB Director/EDSW.

[2] Section 2(2)(a) The Regional Health and Social Care Board (Membership) Regulations (Northern Ireland) 2009

4.5 The Trust Executive Director of Social Work – role and responsibilities

4.5.1 Trust EDSWs (who are also Directors of Children's Services) are prescribed members[3] on Trust boards. The role of a Trust EDSW is to provide strong professional leadership for social work and social care within his/her Trust and assurance of satisfactory arrangements for the discharge of Delegated Statutory Functions. This includes professional responsibility for ensuring the discharge of DSFs in accordance with the law, approved Schemes of Delegation and agreed professional standards and for providing strategic advice at board level on future developments and direction. The EDSW should seek assurances from any other Operational Directors who have responsibility and accountability for the relevant service area that all social care functions are being fulfilled to the required standard.

4.5.2 Annex C sets out the full range of professional responsibilities of the Trust EDSWs/Directors of Children's Services.

5. APPROVAL OF SCHEMES FOR THE DELEGATION OF STATUTORY FUNCTIONS

5.1 The Schemes set out the arrangements for the discharge of relevant statutory functions by the Trusts on behalf of the HSCB. The Schemes specify the powers and duties which the HSCB has delegated under all relevant legislation and describe the principles and values that underpin the discharge of DSFs and delivery of associated services. They also outline the quality control framework whereby monitoring and reporting of DSFs is an integral part of the corporate accountability and professional governance arrangements in each Trust and in the HSCB as well as between the two organisations.

5.2 Trust Responsibilities

5.2.1 Trusts have a legal responsibility to submit to the HSCB Schemes for the Delegation of Statutory Functions[4] and to comply with any request by the HSCB to submit a new or amended scheme.

5.2.2 Trusts are responsible for keeping the Schemes under regular review and amending/updating as required. New, amended or updated Schemes require the approval of the HSCB and the Department.

[3] Section 4(1)(d) The Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994
[4] Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1994

5.2.3 The Trust board should agree a Trust Scheme prior to submission to the HSCB for agreement.

5.2.4 Trusts should retain a copy of the Scheme agreed by the HSCB and approved by the Department.

5.3 HSCB Responsibilities

5.3.1 The HSCB is responsible for approving Schemes submitted to it by Trusts and, in turn, submitting the Schemes to the Department for approval.

5.3.2 Under the Schemes, the HSCB will agree the Trusts' internal monitoring arrangements, as well as the information each Trust will provide[5] to the HSCB and at what intervals.

5.3.3 The recommendation to approve Trust Schemes should be agreed by the Accounting Officer and endorsed by the HSCB board prior to submission to the Department for approval.

5.3.4 Following approval by the Department, the HSCB is responsible for delegating functions to the Trusts by way of a written sealed authorisation.

5.3.5 The HSCB will keep the Schemes under regular review to ensure their adequacy and fitness-for-purpose but should formally review Schemes along with Trusts at a minimum of three yearly intervals.

5.3.6 The HSCB may, with the approval of the Department, revoke an authorisation to a Trust to exercise relevant functions, should circumstances warrant such action.

5.3.7 Decisions for revocation of an authorisation will be made by the HSCB Accounting Officer based on recommendation and advice from the HSCB Director. The HSCB board will be informed of any such decision and reasons for same in a timely way.

5.3.8 The HSCB should retain a copy of the Schemes approved by the Department.

5.4 The Department's Responsibilities

5.4.1 The Department may approve a scheme submitted to it by HSCB either with or without modifications or with such modifications as may be agreed with the HSCB and the Trust concerned.

5.4.2 The recommendation of the CSWO to approve Schemes should be agreed by the Permanent Secretary.

[5] Paragraphs 6A (1), (2) and (3) of Part II of Schedule 3 of The Health and Personal Social Services (Northern Ireland) Order 1994

5.4.3 The Department may direct or agree to a request from the HSCB for an authorisation to a Trust to exercise relevant functions to be revoked, should circumstances warrant this. Such circumstances will be determined by the Department, but are likely to represent a significant systemic failure within an organisation with regard to the delivery of DSFs.

5.4.4 Decisions for revocation of an authorisation will be made by the Permanent Secretary based on recommendation and advice from the CSWO. The Departmental board will be informed of any such decision and reasons for same in a timely way by the Permanent Secretary.

5.4.5 The Department will inform the HSCB and Trusts of all relevant changes in legislation which will require an amendment or update to the Schemes in a timely way.

6. DISCHARGE OF DELEGATED STATUTORY FUNCTIONS

6.1 Trusts, as separate legal entities, are responsible in law for the discharge of relevant statutory functions delegated to them by the HSCB.

6.2 Trust EDSWs are responsible for ensuring approved Schemes are properly implemented and managed within all programmes of care. This includes ensuring:

- legal and professional responsibilities are assigned and necessary systems and procedures are in place;
- compliance with all statutory, regulatory or professional requirements;
- all staff responsible for the discharge of DSFs have access to relevant training, professional support and supervision;
- the maintenance and operation of an efficient data collection system and provision of data and reports to HSCB and Department as required;
- implementation of actions, including improvement plans agreed with the HSCB, to improve the safety, quality and effectiveness of services;
- the Accounting Officer, Trust board and the HSCB are informed, at agreed intervals, on the Trust's performance in respect of DSFs, including early notification of risks, resource pressures and legal challenges and proposed actions to address;
- timely action to address and/or prevent the escalation of any identified issues;
- the HSCB and, where appropriate, the Department are notified in a timely way of any relevant issues through established mechanisms[6] and proposed actions to address.

[6] Established mechanisms include the Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

6.3 Trust EDSWs will be supported in their responsibilities by a Social Care Governance Officer (Trust Governance lead) who will report directly to the EDSW in relation to the Trust's compliance with DSFs and related governance issues. The Trust Governance lead will be supported by an identified social work lead in each programme of care who is responsible for reporting to and informing the Trust Governance lead in relation to their respective area's compliance with DSFs and related governance issues. Trust Governance leads and identified social work leads should be suitably qualified in accordance with Article 8(1) of the Health and Personal Social Services **Act** (Northern Ireland) **2001 (the** 2001 Act).

7. PERFORMANCE MANAGEMENT

7.1 The HSCB Director/EDSW is responsible for ensuring the approved Schemes are implemented by the Trusts through agreed performance management and quality assurance mechanisms.

7.2 The HSCB Director/EDSW is responsible for ensuring approved Schemes are properly implemented by the Trusts to agreed standards. This includes:

- ensuring effective arrangements within the HSCB for monitoring and quality assurance of each Trust's management and discharge of DSFs in compliance with approved schemes and all statutory, regulatory and professional requirements;
- maintaining oversight of individual Trust compliance with DSFs through regular liaison with Trusts and receipt and analysis of relevant information, data and reports;
- maintaining regional oversight of consistency of Trusts' compliance with DSFs and related governance issues and ensuring the best use of resources;
- taking prompt action to address and/or prevent escalation of any issues, including under performance or non-compliance;
- overseeing the implementation of agreed Trust improvement/action plans;
- advising the Chief Executive and the HSCB board, at agreed intervals, on the Trusts' performance in respect of DSFs, including timely notification of risks, resource pressures and legal challenges and proposed actions to address;
- alerting the Department in a timely way of any unresolved disputes, substantive issues or concerns regarding a Trust's discharge of DSFs and HSCB's proposed actions to address.

7.3 The HSCB Director/EDSW will be supported in his/her responsibilities by a Social Care Governance Officer (HSCB Governance lead) who will report directly to the Director in relation to the Trusts compliance with DSFs and related governance issues. The HSCB Governance lead will be supported by the professional social care commissioning leads for each programme of care

in the HSCB and the Trust Governance leads who will inform and/or report to the HSCB Governance lead on DSFs and related governance issues ensuring a comprehensive overview of performance at programme of care level, individual Trust level and regionally. The HSCB Governance lead and professional social care commissioning leads should be suitably qualified in accordance with Article 8(1) of the 2001 Act.

8. STRATEGIC OVERSIGHT

8.1 The Department is responsible for maintaining a strategic professional oversight of the effectiveness of the HSCB's arrangements for the professional oversight of each Trust's exercise of DSFs and that proper provision has been made by the HSCB to Trusts for the discharge of DSFs.

8.2 The CSWO is responsible for ensuring the HSCB discharges its responsibility as the named 'authority' for the discharge of relevant statutory functions in accordance with the law, approved Schemes and relevant policies, guidance, standards and directions. This includes:

- ensuring effective arrangements within the Department to maintain ongoing oversight of all relevant information including the receipt and analysis of data and reports in respect of DSFs submitted by HSCB and/or Trusts;
- ongoing engagement with the HSCB Director and Trust EDSWs through established mechanisms and as and when required;
- providing authoritative professional advice and/or direction to the HSCB and/or Trusts to address identified issues of concern, non-compliance or under-performance;
- advising the Permanent Secretary and Departmental board at agreed intervals on DSFs, including timely notification of risks, resources pressures or legal challenges and proposed actions to address.

8.3 In the event of significant concerns arising from any Trust's performance in relation to the discharge of DSFs, the Department may use its powers under Articles 3 and 6 of the Health and Social Care (Reform) Act, 2009 to direct the HSCB to take specific actions that the Department deems necessary to improve a Trust's performance.

8.4 The CSWO will be supported in his/her responsibilities by the Deputy CSWO who will report directly to the CSWO on the HSCB's and, where relevant, the Trusts' discharge of DSFs. The Deputy CSWO will be supported by professional and policy officers with responsibility for professional and/or policy lead for children's and adult social care services. The input of all relevant staff will be co-ordinated by the Office of Social Services Head of

Governance and Planning. The Deputy CSWO and professional officers should be suitably qualified in accordance with Article 8(1) of the 2001 Act.

9. CONTINUOUS IMPROVEMENT

9.1 Arrangements for the professional oversight of DSF should support a systems-wide culture of learning and continuous improvement and contribute to HSCB and Trust compliance with the statutory duty to monitor and improve the quality of services[7].

9.2 Continuous improvement will be supported by:

- evidence-informed improvement initiatives;
- programmes of audit; and
- identification and promulgation of good practice.

9.3 Evidence informed improvement initiatives

9.3.1 Proposals for improvement initiatives should be: designed and planned to improve outcomes for service users; informed by research, evidence and people's experiences of services; and measured for impact and outcomes.

9.4 Programmes of audit

9.4.1 Each Trust will plan and undertake an annual programme of audit as part of the internal monitoring and quality assurance of the discharge of DSFs. The learning and outcomes of audit activity will inform improvements in each Trust's arrangements for the discharge of DSFs.

9.4.2 Each Trust will report on its audit and improvement activity in its end year report to the HSCB.

9.4.3 The HSCB will carry out and/or commission a regional programme of audit to be undertaken each year as part of its performance management and monitoring arrangements. The learning and outcomes of audit activity will inform improvements in individual Trust and/or regional arrangements for DSFs.

9.4.4 The HSCB will report on its own and each Trust's audit and improvement activity in its end of year overview report to the Department.

9.4.5 The Department will ensure an audit of the HSCB's arrangements for the professional oversight of Trusts' discharge of DSFs is carried out at agreed intervals, but no longer than 5 yearly intervals. The learning and outcomes of

[7] Article 34, HPSS Quality, Improvement and Regulation (Northern Ireland) Order, 2003

this audit activity will inform improvements in the HSCB's professional oversight arrangements.

9.4.6 The Department and the HSCB audit activity should not duplicate other audit processes. The outcomes of other relevant audit activity may be used by the Department, the HSCB and Trusts as part of their compliance with the requirements of this circular.

9.4.7 All audits of DSFs arrangements should be led by suitably qualified staff in accordance with Article 8 (1) of the 2001 Act and with relevant experience and/or expertise in audit and/or social care governance.

9.5 Identifying and promulgating good practice

9.5.1 A regional DSFs learning event will be organised by the HSCB at least once every two years to share good practice and learning from the professional oversight of DSFs, including regional trends and themes, outcomes from audit and improvement initiatives and proposals for improvement.

10. REPORTING ARRANGEMENTS

10.1 In-year reporting

10.1.1 Professional oversight is a dynamic process and involves ongoing monitoring and reporting throughout each reporting year. This is done through established mechanisms.

10.1.2 Timely reporting in respect of the discharge of DSFs is important and early reporting of emerging concerns or significant issues is crucial in order to facilitate appropriate decision making and, where necessary, timely responses.

10.1.3 Any substantive issues regarding the discharge of DSFs should be reported promptly to HSCB and, where appropriate to the Department, to facilitate timely action.

10.2 End year reporting

10.2.1 End year reports provide an opportunity for individual organisations and the system as a whole to take stock of performance throughout the year and plan for the future. End year reports should facilitate strategic decision making about actions required to further improve services and outcomes for service users.

10.2.2 Each Trust is required to submit an annual end year report, approved by its Trust board, on how it has discharged its functions to the HSCB no later than end of May each year.

10.2.3 The Trust end year report should include an analysis of data and performance to assist the Trust board and the HSCB in their respective governance, accountability and strategic planning roles to identify the Trust's:

- compliance with the law and agreed standards and targets;
- performance gaps and/or areas of concerns, including non-compliance;
- effectiveness of Trust's monitoring and reporting arrangements;
- outcomes of in-year audit and improvement activity;
- outcomes for service users;
- new or emerging trends or pressures:

10.2.4 The HSCB will submit an annual end year overview report to the Department, approved by its board, by the end of June each year based on its analysis of Trust end year reports and any other relevant data and information gathered as part of its professional oversight throughout the year.

10.2.5 The end year overview report should reflect both operational performance and strategic issues and assist the HSCB Board and Department in their respective governance, accountability and strategic planning roles including:

- overview and analysis of Trusts' performance in respect of DSFs, including good practice and performance gaps;
- level of compliance with the law, professional standards and targets;
- outcomes of in-year audit and improvement activity;
- emerging pressures and/or concerns;
- regional comparison and trends.

10.2.6 The HSCB will agree an action/improvement plan with agreed timelines for implementation with each Trust by end of June each year.

10.2.7 The HSCB will also submit within the same timeframe, either separately or as an integral part of its end year overview report: data on the configuration of the Social Work workforce in all Programmes of Care across Trusts; an update on the qualification profile of the social work workforce in Trusts including numbers of relevant qualifications achieved in-year against Departmental targets; the volume and range of learning and development activity including spend against Departmental commissioning priorities.

10.2.8 The CSWO will advise the Permanent Secretary and Departmental board of the key findings of the approved end year overview report from the HSCB within 6 weeks' of receipt and/or confirmation of approval.

10.2.9 Where a significant issue is identified in the process of compiling end year reports which has not been previously reported during the year, the HSCB and/or Department should be alerted immediately in advance of submission of the end year report.

10.2.10 In the event, of the process and timeline of board approval of end year reports significantly delaying submission within agreed timescales, a Trust and/or the HSCB should submit its draft report pending board approval. This is based on the principle that it is better to receive information (within acceptable tolerances of precision) in good time accepting there may be some modifications rather than awaiting completely accurate information which will be too late.

10.2.11 In these circumstances, the HSCB and/or Trust must confirm board approval for the end year report in writing within two weeks of such approval being given. Should there be any changes to the draft report submitted pre-approval, the HSCB and/or Trust should resubmit the approved revised report clearly indicating where changes have been made within the same timescale.

ANNEX A

PROFESSIONAL RESPONSIBILITIES OF CHIEF SOCIAL WORK OFFICER FOR SOCIAL WORK AND SOCIAL CARE MATTERS

Introduction

The Chief Social Work Officer (CSWO) provides professional leadership for social work and social care across the full range of social care services for children and adults in the statutory, voluntary and private sectors as well as coordinating social care policy and legislation and supporting the decision making and accountability processes associated with the effective operation of the Department.

Accountability

The CSWO is directly accountable to the Permanent Secretary (PS) and to the Minister for the provision of authoritative professional advice and insights in respect of all social work and social care matters and for reporting on relevant statutory functions across a range of children's and adult services.

Professional Responsibilities

A summary of the professional responsibilities of the CSWO are provided below:

Professional Leadership

- Providing professional leadership for the social work and the social care workforces in Northern Ireland;
- Setting the strategic direction for social work and social care within an integrated HSC system;
- Promoting a strong voice for all adults, families, children and carers using social care services and for frontline workers delivering services in the development of policies, strategies and standards;
- Working collaboratively with others, including other Government Departments, the Executive Directors of Social Work (EDsSW) within the HSC system and other key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining East/West, North/South and international professional relationships and networks to share best practice and learning;

- Communicating the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

- Providing authoritative professional advice and insights to the Minister of Health, Social Services and Public Safety and other Executive Minister in respect of social work and social care matters;
- Proving authoritative professional advice and insights to the PS, senior policy colleagues, other Departments, the NI Assembly and its Committees, HSC agencies, the independent sector, the Further and Higher Education Sector and the media.
- Working in collaboration with the HSCB Director of Social Care and Children's Services and Trust EDsSW with regard to seeking and giving professional advice on social work and social care matters.
- Ensuring appropriate professional advice in the development and implementation of policies, strategies and standards and in Departmental responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

- Making authoritative and final decisions on complex/controversial professional practice matters, including intervention action through the HSCB;
- Making decisions/recommendations on the most complex cases, where individual cases may be the subject of public and/or media interests and in which the Minister may be asked/be required to become personally engaged;
- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;
- Professional endorsement of Trust applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children (NI) Order 1995 Regulations and Guidance;
- Discharging the responsibility of the Department's Child Protection Officer;
- Authorisation of transfer of mental health patients to other jurisdictions in line with the Mental Health (NI) Order Guide (1986).

Professional Governance

- Ensuring effective arrangements within the Department for the approval of schemes for the delegation of statutory functions (DSFs) and professional oversight of the discharge of DSFs, including fulfilment of Corporate Parent duties, within an integrated HSC system in line with Circulars (OSS) 3/2015 and (OSS) 4/2015;

- Ensuring effective arrangements within the Department for professional advice and responses to professional issues raised by MLAs, members of the public or through established reporting mechanisms[8];
- Contributing as a senior professional lead to the Department's formal assurance and accountability arrangements with its Arms Length Bodies(ALBs);
- Accounting directly to the PS and the Departmental Board on the discharge of the Department's relevant statutory functions;
- Promoting (alongside those responsible in the Department for advice on the commissioning system) a robust framework for commissioning and delivery in social care services, including the development of standards for social care services in place to deliver services.
- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social care provision, to the Permanent Secretary and relevant policy leads;
- Sponsorship of the Northern Ireland Social Care Council (NISCC), the Northern Ireland Guardian ad Litem Agency (NIGALA) and the Safeguarding Board for Northern Ireland (SBNI).

Professional Capacity and Capability

- Promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including the discharge of delegated statutory functions, and compliance with all relevant standards;
- Commissioning sufficient social work student places to ensure an adequate supply of qualified social workers to meet service needs;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- Setting the strategic direction and annual commissioning priorities and targets for the education and training of social workers and social care workers;
- Promoting a robust infrastructure for the professional development, supervision and support of social workers;
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non- compliance;
- make recommendations, as necessary, to the Department in relation to professional and disciplinary matters affecting social services staff;

[8] Established mechanisms include Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

ANNEX B

PROFESSIONAL RESPONSIBILITIES OF HSCB DIRECTOR OF SOCIAL CARE AND CHILDREN/EXECUTIVE DIRECTOR OF SOCIAL WORK FOR SOCIAL WORK AND SOCIAL CARE MATTERS

Introduction

The HSCB Director of Social Care and Children/Executive Director of Social Work (the EDSW) provides professional leadership for social work and social care across the full range of social care services for children and adults in the statutory, voluntary and private sectors as well as coordinating and commissioning of social care services. She/he is responsible for ensuring that all legislative requirements, including the discharge of delegated statutory functions (DSF) are fulfilled to a high quality standard, including all relevant professional standards.

Accountability

The EDSW is responsible for the professional oversight of the discharge of DSF by the Trusts and is directly accountable to the HSCB Chief Executive Officer (CEO) who reports to the Permanent Secretary and to the Minister in respect of HSCB's performance in respect of DSFs.

Professional Responsibilities

A summary of the professional responsibilities of the HSCB EDSW are provided below:

Professional Leadership

- Providing professional leadership for the social work and the social care workforces in Northern Ireland;
- Contributing to the strategic direction for social work and social care within an integrated HSC system;
- Promoting a strong voice for all adults, families, children and carers using social care services
- Working collaboratively with the Trust EDSW and other professional leads, agencies and key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining professional, inter-professional and regional relationships and networks to share best practice and learning;
- Communicating the positive contribution of social work and social care services to improving and the social wellbeing of adults, families, children and carers;

- Providing strong leadership across different staff groups and professions, within the HSCB and beyond, to plan, commission, secure and sustain social care services based on assessed need, including child protection services, to improve and safeguard social wellbeing of people in Northern Ireland;
- Building and sustaining effective partnerships with and between all relevant bodies in the statutory, voluntary, community and private sectors, to improve the health and social wellbeing of adults, children and young people and their families.

Professional Advice

- Contributing to the formulation of operational policies and strategies which will promote the health and social wellbeing of people across the region;
- Providing authoritative professional advice and insights to the CEO of HSCB, to the Board of HSCB and to the CSWO in respect of social work and social care matters and the HSCB's social services functions;
- Proving authoritative professional advice and insights to Trusts, the PHA and other HSC agencies, the independent, voluntary, community and private sectors and the media.
- Working in collaboration with the CSWO and Trust EDSWs with regard to seeking and giving professional advice on social work and social care matters.
- Ensuring appropriate professional advice in the development and implementation of policies, strategies standards and guidance and in HSCB's responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions;

Senior Professional Practice Lead

- Ensuring the responsibilities of the HSCB's Child Protection Office are discharged effectively;
- Responsibility for ensuring that the HSCB discharges its duties in relation to children's services planning under the Children (Northern Ireland) Order 1995 as amended by the Children (1995 Order) (Amendment) (Children Services Planning Order) (Northern Ireland) 1998 and fulfils its obligations as set out in departmental circulars and guidance; Providing authoritative professional advice and guidance and recommendations to HSCB Board in relation to the numbers of children in need[9] within the HSCB's area, the nature and extent of those needs and the services requires to meet those needs
- Providing authoritative professional advice and guidance and recommendations to HSCB Board on the most complex cases, where individual cases may be the subject of public and/or media interests;
- Taking the lead role for the development of HSCB's strategic and operational policies for meeting the social care needs of adults children and young people, families and carers;

[9] A definition of 'child in need' is provided in Article 17 of the Children (Northern Ireland) Order 1995

- Involving and listening to children and their families to ensure their views inform the HSCB's planning and commissioning of services for them;
- Ensuring compliance with professional and other quality standards through appropriately informed commissioning of social services at both regional level and through audit and review of services;

Professional Governance

- establishing and operating an efficient system to ensure effective social care governance arrangements within the HSCB and overseeing social care governance arrangements within HSCB;
- Ensuring effective arrangements within the HSCB for the professional oversight of the discharge of DSFs , including fulfillment of Corporate Parent duties, within an integrated HSC system in line with Circulars (OSS) 3/2015 and (OSS) 4/2015;
- Advising the HSCB Board of Directors in relation to the approval and review of schemes for DSFs to Trusts and establishing appropriate monitoring arrangements to assure the HSCB Board of Directors that Trusts are discharging relevant functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, take remedial action;
- Professional responsibility and accountability for the effectiveness, availability, quality and value for money for children's services commissioned by, and delivered on behalf of, the HSCB;
- Providing professional leadership and ensuring regional consistency of high standards of social work and social care services provided adults, families, children and carers by HSCTs;
- ensuring the appropriate collection, maintenance and analysis of data to monitor the discharge of DSF and sharing such information with the Department;
- ensuring that resources allocated to and by the Trusts are efficiently and effectively used to ensure the safe and effective discharge of DSF;
- Providing feedback to Trusts regarding their performance in respect of DSF and agreement of action plans to address non-compliance and/or areas of concern, ensuring the resolution of any performance issues in respect of a Trust's discharge of DSF;
- the production of an Annual Action Plan for each Trust identifying improvements required in relation to a Trust's performance in respect of DSF and Corporate Parenting responsibilities, a prescribed timescale and arrangements for review and assurance that improvements have been achieved and maintained;
- ensuring that the HSCB Board and the CSWO are appropriately briefed in relation to Trusts' discharge of DSF, the Action Plans agreed with each Trust in respect of DSF and Corporate Parenting responsibilities, and any instances of non-compliance
- the production and submission to the Department of an annual regional Overview Report in respect of the Trusts' discharge of DSF, including the HSCB's critical analysis of the Trusts' performance;
- escalating
    - issues that the HSCB has been unable to resolve with a HSCT
    - issues of concern and/or risks, including resource issues and/or service pressures,

to the HSCB Board and to the CSWO as appropriate.

Professional Capacity and Capability

- Working collaboratively with DHSSPS and Trusts to ensure strategic priorities in respect of building the capacity and capability of the social work and social care workforces are met;
- Promoting and monitoring compliance with professional and regulatory standards/requirements for the workforce and commissioning relevant education and training to ensure safe and effective practice and service provision, including discharge of DSF;
- Specifying, through the commissioning process, the workforce skills and qualifications required for high quality, safe and effective service provision;
- Advising the HSCB Board and CEO on staffing levels which are sufficient to ensure the safe discharge of DSF and delivery of commissioned social work and social care services by Trusts for which the HSCB is responsible;
- Promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including the discharge of DSFs, and compliance with all relevant standards;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- ensuring that each Trust has adequate numbers of professionally qualified social work staff and social care staff to ensure effective management and delivery of social care services;
- ensuring adequate, high quality education and training for social work students and social workers and social care workers employed in Trusts to ensure the safe and effective discharge of DSF;
- Promoting a robust infrastructure for ensuring that all social workers receive professional supervision in compliance with professional standards and regional guidance and social care workers receive appropriate and adequate supervision and support;
- ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non- compliance;
- make recommendations, as necessary, to the HSCB in relation to professional and disciplinary matters affecting social services staff;

ANNEX C

PROFESSIONAL RESPONSIBILITIES OF TRUST'S EXECUTIVE DIRECTORS OF SOCIAL WORK FOR SOCIAL WORK AND SOCIAL CARE MATTERS

Introduction

Trusts Executive Directors of Social Work (EDsSW) are required to;-

1. Participate in and share corporate responsibility for the work of the Trust;
2. Fulfil a functional role as a second line manager responsible directly to the CEO of the Trust; and
3. Provide professional social work and social care leadership throughout the Trust

EDsSW provide professional leadership for social work and social care workers across the full range of social care services provided by or commissioned by the Trusts for children and adults in the statutory, voluntary and private sectors.

The EDsSW have key responsibilities within the Trust to provide professional advice and support to the CEO and Trust Board to ensure that all legislative requirements and DSFs are fulfilled in compliance with regulations, guidance and procedures and to a high quality standard, including high professional standards.

Accountability

The EDsSW are responsible for the professional oversight of the discharge of DSFs by the Trusts and are directly accountable to their Trust's HSCB CEO who reports to the Trust Board in relation to the Trust's performance in respect of DSFs.

EDsSW are directly accountable to the Trust CEO and Trust Board for the provision of authoritative professional advice and insights in respect of all social work and social care matters and for reporting on relevant statutory functions across a range of children's and adult services.

Professional Responsibilities

A summary of the professional responsibilities of the EDsSW are provided below:

Professional Leadership

- Providing strong professional leadership for the social work and the social care workforces in the Trust , ensuring high standards of social work and social care provision and full compliance with legislative, policy and procedural requirements and compliance with standards established by the Department and/or HSCB;
- Providing professional advice and support to the CEO and Trust Board to assist setting the strategic direction for social work and social care within the Trust;
- Promoting a strong voice for all adults, families, children and carers who use or need social work and social care services;
- Supporting Trust managers, frontline social workers and social care workers delivering services on behalf of the Trust;
- Working collaboratively with other EDsSW, the HSCB EDSW the CSWO to improve and safeguard the social wellbeing of people in Northern Ireland;
- Working collaboratively within the HSC system and with other key stakeholders in the public, voluntary, community and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at managerial and operational practice levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Communicating, at local and regional levels, the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

- Responsibility for giving advice and assistance to the Trust in determining its policies and strategies for personal social services and for executing those policies and strategies;
- advising the Trust on professional social services issues and ensure robust professional governance arrangements for the discharge of DSF within Children's and Adult Social Care Services;
- giving advice and assistance to the Trust Board and CEO in determining its policies and strategies for social care services and for executing those policies and strategies ;
- advising and assisting the Trust Board and CEO in determining its expenditure on personal social services and securing the resources required to deliver social care services, including DSF, and in tracking expenditure on service delivery;
- Providing authoritative professional advice and insights to the CEO and Trust Board in respect of social work and social care matters;
- Proving authoritative professional advice and insights to other professional leads, partner and key stakeholder organisations, the independent sector and the media.

- Working in collaboration with the HSCB EDSW and the CSWO with regard to seeking and giving professional advice on social work and social care matters.
- Ensuring appropriate professional advice in the development and implementation of Trusts policies, strategies and standards and in responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

- Providing authoritative professional advice to the CEO and, when necessary, making authoritative and final decisions on complex/controversial professional social work and social care practice matters on behalf of the Trust;
- Providing authoritative professional advice and, as necessary, making decisions/recommendations on the most complex social work and social care cases, where individual cases may be the subject of public and/or media interests;
- encouraging the development and maintenance of relationships with the voluntary and private sectors to foster constructive and collaborative working relationships

Professional Governance

- ensuring compliance with the general guidance issued by the Department of Health and Social Services and within the terms of contracts with purchasers;
- Ensuring effective arrangements within the Trusts for the professional oversight of the discharge of DSF, including fulfilment of Corporate Parent duties, within an integrated HSC system in line with Circulars (OSS) 3/2015 and (OSS) 4/2015;
- Ensuring effective arrangements within the Trust for professional advice and responses to social work and social care issues raised through established reporting mechanisms;
- Accounting directly to the Trust's CEO and Trust Board on the discharge of the Trust's DSFs and ensuring they are briefed about the Trust's performance in respect of DSF and Corporate Parenting responsibilities and any instances of non-compliance
- implementing any actions or directions agreed within the Trust and/or with the HSCB and/or Department to address any issues of under-performance and/or non-compliance;
- Promoting a robust framework for commissioning and delivery in social care services, including the development of standards for social care services in place to deliver services.
- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social work/social care provision, to the Trust's CEO and Trust Board;
- submitting to the HSCB for approval the Schemes for the DSFs (children and adults) to HSC Trusts;
- Ensuring that the Trust's legal responsibilities in relation to social services functions are assigned and the necessary systems and procedures developed within the context of the scheme devised by the Trust and agreed by HSCB and the Department;

- Monitoring the operation of those systems and procedures and reporting to the Trust Board;
- ensuring that an appropriate system of professional audit exists for assessing and reviewing the quality of social work and social care practice and services;
- monitoring, evaluating and quality assuring the provision of social care services commissioned by the HSCB and in particular the discharge of DSFs through audit and review;
- establishing appropriate monitoring arrangements to assure the HSCB that the Trust is discharging relevant functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, taking immediate remedial action;
- ensuring the appropriate collection, maintenance and analysis of data to monitor service provision, including the discharge of DSF, and sharing such information with the HSCB;
- establishing and operating an efficient system to ensure effective social care governance arrangements within the Trust and to oversee social care governance arrangements within the Trust;
- submitting an annual report, including a self-assessment and critical analysis of performance, to the HSCB on the discharge of DSF;
- escalating any issues of concern and/or risks, including resource issues and/or service pressures, to the Trust Board and, where appropriate, to the HSCB.

Professional Capacity and Capability

- Contributing to workforce planning within the Trust to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- advising the Trust Board and CEO on staffing levels which are sufficient to ensure the safe discharge and delivery of DSF and social work and social care services for which the Trust is responsible;
- ensuring all social work staff have a working knowledge of and comply with all relevant legislation, regulations, Departmental Circulars, policies, procedures, protocols and guidance in their practice, discharge of DSF and delivery of social care services;
- Promoting high standards of professional practice by identifying training needs and ensuring social workers and social care staff receive appropriate learning, training and development opportunities and professional supervision to support effective practice and the safe discharge of DSF;
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non- compliance;
- make recommendations, as necessary, to the Trust in relation to professional and disciplinary matters affecting social services staff.

Health and Social Care Board

Directorate of Social Care and Children

Delegated Statutory Functions

Composite Corporate Parenting Report

1st April 2016 – 31st March 2017

Introduction

This is an overview report, prepared by the Directorate of Social Care and Children detailing the requirements, processes and issues arising within Health and Social Care Trusts as reported under the Scheme for the Delegation of Statutory Functions.

The Health and Social Care Board (HSCB) and Trusts apply a set of principles to govern the Discharge of Statutory Functions. These state that the Discharge of the Delegated Functions should:-

- ensure clarity as to who is actually responsible on the ground in any particular case;
- be consistent with the strategic commissioning role of the HSCB;
- preserve the operational freedoms of the Trusts.

The individual reports submitted by each Trust are available, but they represent only the beginning of a process of dialogue with the Trusts that continues throughout the year. Action notes are produced and agreed with each Trust and updated throughout the year. This report provides the HSCB with an overview of the current issues and is supplemented by a statistical report which is appended.

Background

The Scheme for the Delegation of Statutory Functions sets out the arrangements between the Health and Social Care Board (hereafter referred to as 'the Board') for the discharge, under The Health and Personal Social Services (Northern Ireland) Order 1994 of relevant Personal Social Services (PSS) functions by Health and Social Care Trusts on behalf of the Health and Social Services Boards. These functions were transferred to the Health and Social Care Board under Section 24 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The Scheme describes the fundamental principles, values and accountability relationships which will underpin the delivery of services. It specifies within

the Personal Social Care Services programmes of care, including general services to people in need, the powers and duties which the HSCB has delegated to the Trusts.

To assist the implementation of the 1994 Order, the, then Department of Health, Social Services and Public Safety (DHSSPS) provided guidance on the accountability framework and on the arrangements which should exist between the Department, Boards and Trusts.

This has been supplemented by the guidance set out in Departmental Circulars, Circular (OSS) 3/2015 HSC Statutory Functions and Circular (OSS) 4/2015 Professional Oversight of the Discharge of Delegated Statutory Functions (these Circulars replaced previous guidance contained within Circular HSS Statutory Functions 1/2006 as of the 10th December 2015).

Accountability is a key element in the Discharge of Statutory Functions and is part of the main provisions within the Scheme.
Trusts, as corporate entities, are responsible in law for the discharge of statutory functions delegated to them. The HSCB is responsible for commissioning services to meet the needs of their populations and spending monies allocated to them to secure the delivery of Health and Personal Social Services in line with the Scheme for the Delegation of Statutory Functions. The 1994 Order requires the Trust to specify how it will discharge statutory functions in line with Departmental and HSCB guidance and current good practice.

The Trust is accountable to the HSCB for the effective discharge of statutory functions delegated to them as well as the quantity, quality and efficiency of the service it provides.

The HSCB also has a role in quality assuring the discharge of those relevant functions which they have delegated to Trusts.

The HSCB and the Trusts have adopted a partnership approach to promote the welfare and safeguarding of children and vulnerable adults and maintains its

responsibility to keep the Department informed of the outcome of the quality assurance arrangements in respect of Trusts' discharge of relevant functions.

Reporting

The HSCB has agreed the monitoring arrangements with the Trusts together with the information that will be provided and at what intervals. The HSCB requires that the Trusts will produce an annual report in the specified format on how the Trust has discharged their functions no later than the end of May each year.

The HSCB has also agreed arrangements to ensure that at the midpoint of the year the Director of Social Care and Children receives a report from the Trust Social Care Governance Officer on behalf of the Executive Director of Social Work.

This annual report (1st April 2016 – 31st March 2017) highlights issues and trends and in particular drawing to the Director's attention any emerging breaches of statutory functions which require immediate action, updates on the Trust Risk Registers and the reporting requirements under Corporate Parenting duties as specified in Departmental Circular CC3/02 – Roles and Responsibilities of Directors for the Care and Protection of Children.

CHILDREN'S SERVICES

In compiling this section the Health and Social Care Trusts have provided data and information reflecting the duties outlined in Department of Health Circular CC3/02 'Roles and Responsibilities of Directors for the Care and Protection of Children'.

Commentary and analysis will therefore focus on the following service areas:-

- Children in Need, including children with disability, child and adolescent mental health services (CAMHS) and unallocated cases;
- Child Protection;
- Looked After Children; this will comment on children in residential child care, foster care and children placed at home with parents;
- 16+, Young Homeless and Separated / Trafficked / Unaccompanied Children
- Fostering Services
- Adoption Services, including Inter-country Adoption;
- Early Years Services
- Representations and Complaints

1 CHILDREN IN NEED

1.1 Child Care Population by Trust

The table below sets out the number of children, from birth to 17 years old resident within each Trust. While Trusts have a statutory duty for children i.e. 0-17 years and as relevant young people who had been looked after and to whom The Children (Leaving Care) Act (Northern Ireland) 2002 applies, the population breakdown helps to demonstrate variations in population across Trusts, explain funding arrangements and provides one measure to aid performance management and benchmarking.

Across all age groups, the Northern Trust has the largest population i.e. 25% of those resident in Northern Ireland, while the Western Trust has the smallest population with 16.8% of the resident population.

Twenty three per cent of the total population in N Ireland is aged 0-17 years. Under the Leaving Care Act the Trusts have responsibilities extending through to young people aged 21 years or 24 years where they are completing a course of education.

Table 1: Population by Trust 0-17 years

The Northern Ireland Statistics and Research Agency 2016 Mid-Year Estimates

Age	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	NI *Total Population 1,862,137*
0-17years	76,161	108,744	81,026	96,257	73,379	435,567
% Share of 0-17 year olds	17.5%	25.0%	18.6%	22.1%	16.8%	100%

1.2 Children in Need - Referrals

The table below shows the numbers of children referred from April 2014. While referral figures continue to fluctuate, activity remains high across each of the Health and Social Care Trusts (Trusts). The South Eastern Trust continues to have the lowest regional referral rate while the Belfast Trust has the highest overall rate.

Table 2: Children Referred for an Assessment of Need

	Oct. 16-Mar. 17	Apr 16 – Sept 16	Oct.15 - Mar 16	Apr 15 – Sept 15	Oct. 14 – Mar 15	Apr 14 – Sept 14
BHSCT	4830	4812	3944	3424	5041	4372
NHSCT	4614	5103	4365	4259	5332	4286
SEHSCT	2841	2659	2585	2951	2771	2797
SHSCT	3066	2986	2971	3247	3210	3180
WHSCT	3436	3271	3373	3005	3150	4279
TOTAL	**18787**	**18831**	**17238**	**16886**	**19504**	**18914**

1.3 Total Number of Children in Need by Trust

Table 3 sets out the number of Children in Need known to each Trust. The data reflects a similar trend as that for children who are referred for assessment (Table 2).

Table 3: Children in Need by Trust

	Mar 17	Sept 16	Mar 16	Sept 15	Mar 15	Sept 14
BHSCT	4262	4778	5153	4939	5739	6416
NHSCT	5326	5056	4986	5181	5067	4983
SEHSCT	3837	3721	4146	3657	3731	3809
SHSCT	4875	4818	5264	5368	4569	4325
WHSCT	4437	3632	5149	4896	4728	4837
TOTAL	**22737**	**22005**	**24698**	**24041**	**23834**	**24370**

In relation to ethnicity 78% of children are reported to be from a 'white' ethnic background, compared to last year when the figure was reported as 73%. This data will be monitored given the increasing diversity of the population to ensure accessibility of services to all.

1.4 Children with Disabilities

Four thousand six hundred and forty six children with disabilities were in receipt of services from social care professionals at the 31st March 2017; this is an increase of 284 on the September 2016 figure. The majority of children are diagnosed with a learning disability. This data excludes children supported by other Trust services e.g. paediatrics, Allied Health Professionals etc.

In relation to children with Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Trusts report an increasing number of children being referred, for example the referral rate at the 31st March 2013 was 616 compared to 1,717 at the 31st March 2017. This increase may be attributed to a number of factors including improved referral, recording and diagnosis. Work is also well advanced on a new integrated model which brings together

CAMHS, ASD, ADHD and behavioural services. Additional funding has enabled Trusts to recruit staff, which should significantly help to reduce the numbers of children and young people waiting greater than 13 weeks for a diagnosis.

The challenge of supporting children with complex health care needs has been raised by all Trusts as an increasing service pressure. To this end additional funding has been provided to enable each Trust to recruit 6 specialist foster carers. Recruitment is progressing.

A key theme from all Trusts is the area of transition between children's and adult's services and varying criteria between services and across the adult Programme of Care (POC) . This, given the legislative changes from the new Special Educational Needs (SEN) act, will bring challenges and a need for co-ordinated planning between Trusts and Education colleagues for children in the process of transition. The data returns in respect of children with a disability and transition planning remains inconsistent with some Trusts failing to provide the data required.

1.5 Unallocated Cases

The number of unallocated cases within Trusts is constantly monitored. Table 4 shows the variability in numbers from March 2013.

At 31st March 2017 there were 281 unallocated cases, the lowest number from March 2013. The South Eastern Trust has had the highest number of unallocated cases over the last 3 reporting periods. The HSCB continues to work with Trusts to address this issue.

Table 4: Unallocated Cases

	At March 2017	At March 2016	At March 2015	At March 2014	At March 2013
Belfast	72	104	45	45	24
Northern	19	37	82	82	91
South Eastern	105	179	150	71	5
Southern	44	44	27	44	50
Western	41	15	95	105	66
TOTAL	**281**	**379**	**399**	**347**	**236**

1.6 Child and Adolescent Mental Health (CAMHS)

The total number of referrals accepted across all CAMHS services for the financial year 2016/17 has shown an almost 17% increase from the previous year. Although the number of referrals to the service increased, the rate of acceptance remains consistent with rates of recent years. Trusts report increasing complexity in the referral profile which will be better understood through the information being gathered as part of the new CAMHS dataset.

The numbers of Looked After Children (LAC) waiting to be seen by CAMHS across the region at year end totalled 11. Trusts have protocol arrangements in place to support access to CAMHS by LAC while ensuring access overall is based on clinical need and not on status alone. Improving the service response to LAC in respect of their emotional and mental health needs is part of the focus of the Review of Regional Facilities which is due to report in August 2017.

The total number of breaches of the 9 week target at year end 31st March 2017, was 86. Eighty four of these were in the Belfast Trust with 2 in Southern Trust. The Western Trust who had been showing a recurring breach position reduced to zero following revision of their service model for ADHD which had accounted for the majority of their breaches. The breaches in the Belfast Trust are in the main due to staffing issues with staff on sick or maternity leave. The risk of breaches across the region remains an issue and regular monitoring is necessary, paying regard to increases in referrals, and the Trusts' reports of increasing complexity.

The combined average rates for both DNA (Did Not Attend) and CNA (Could Not Attend) (taken from the CAMHS dataset, April – November 2016) for first appointments show a notable increase across the region (25%)[1]. The CNA rate for review appointment shows a marginal reduction to 12.5% from 13% as it was at the mid-year point. Trusts are proactive in reallocating appointments to minimise loss of available clinical time. The HSCB will be working with the Trusts to specifically target this area for service improvement.

[1] Figures for 2016/17 are available for the period April – November 2016. From December – February 2017 the new data set was being piloted and figures need to be extracted from Trusts returns for this period and for March 17 returns to have consistent data for the full year.

The total number of admissions to adult wards for 2016/17 totalled two, both having occurred in the first half of the year. Both young people were 17 years old. This low number of young people admitted to adult wards reflects the impact of Crisis Resolution & Home Treatment Teams in reducing admissions. This is further reflected in the overall reduction in the numbers of young people admitted to Beechcroft.

1.6.1 Children Detained

Twenty two children (11%) were detained under The Mental Health (NI) Order 1986, all of whom resided within the Belfast and South Eastern Trusts. Equity of access to regional mental health services has been raised within the Review of Specialist Regional Facilities. This will be explored further with Trusts in order to gain an understanding of issues arising and gain a clearer understanding of this apparent anomaly.

1.6.2 CAMHS Strategic developments

1. The HSCB & PHA published the final report of the Sensemaker Audit of CAMHS & Paediatric Autism Services undertaken as part of 10,000 Voices Project which is designed to capture the lived experience of people who use services. A total of 456 responses were made and the findings and key messages have been incorporated into the design of a new service model which is pending finalisation and Ministerial approval.

2. The new Integrated Care Pathway has been finalised and work is focused on design and formatting. The new Pathway will be published in the autumn 2017.

3. The CAMHS minimum dataset was piloted across all Trusts from December 2016 – February 2017. The new dataset has been live since 1st April but further work is required within Trusts to ensure their respective information systems are capable of capturing the data as egionally agreed.

4. The establishment of a Managed Care Network for Acute CAMHS remains a work in progress. A bid has been made to the Department of Health (DoH) for investment to appoint a clinical director and an operational manager which is recognised as necessary to support the network but a final decision on the availability of funding is still pending. Nevertheless the members of the Partnership Board for the network continue to work to develop a more standardised model of service response to young people presenting in crisis, regardless of setting and putting arrangements and protocols in place that reflect the integrated approach and service model.

5. CAMHS together with children's services as a whole remains significantly underfunded. The HSCB has identified the prioritised investment necessary for CAMHS, to address the significant shortfall and to support service development based on population need, which has been submitted to the DoH.

2 CHILD PROTECTION

The HSCB requires each Trust to keep a register of every child in its area who is considered to be suffering from or likely to suffer significant harm and for whom there is a child protection plan. The register is a list of children who have unresolved child protection issues who are currently the subject of an interagency child protection plan (Source Regional Child Protection Policy and Procedures section 7.1).

The HSCB continues to collate and monitor statistical information for each of the five Trusts on a quarterly basis. Data is shared with the Safeguarding Board for Northern Ireland (SBNI) to assist with the discharge of its duties.

As at 31st March 2017 there were a total of 2,132 children on the Child Protection Register (CPR), a slight reduction on the March 2016 figure of 2,146 but a notable increase on the March 2014 figure of 1,914. Since 2014 there has been an upward trend on child protection registrations which peaked in March 2011 at 2,401 and then reduced until 2014. All of these children had an allocated Social Worker and a Child Protection Plan implemented.

(In general terms the number of children on the CPR has fallen from 2,401 in March 2011 to 2,146 in March 2016. This figure has then subsequently risen again slightly to 2,132 as at 31st March 2017).

The Northern Ireland rate per 10,000 of the child population is 49.1, England 43.1, Wales 49.0 and Scotland 30.0. It must be noted however the overall number of child protection referrals has fallen from 4,804 in 2010/11 to 4,021 during 2016/17. The main category of abuse for the CPR is physical abuse at 34%, followed by neglect at 28%. Nine per cent of children are on the CPR for emotional abuse whilst 7% of children are on the CPR for sexual abuse. Neglect and physical abuse remain the highest multiple categories at 18%.

During the reporting period there were 2,139 registrations, 397 of which were re-registrations and there was a total of 2,169 young people de-registered from the CPR.

The highest age category was 5-11 years with 800 (38%) and there were slightly more males (51%) than females on the CPR register.

The Southern and the Northern Trusts had the highest number of children on the CPR at 579 and 459 respectively, with the Southern Trust at the highest rate at 60.9 per 10,000 for 0-17 year olds. The Belfast Trust had the lowest number at 347 while the Northern Trust had the lowest rate at 42.3 per 10,000. The Southern Trust has reviewed the threshold for entry into the Child Protection system and has concluded that the cases are being appropriately responded to within the child protection process. Further work is required to more clearly understand the regional variation.

During the reporting period Belfast, Northern and South Eastern Trusts had a decrease in the number of children on the CPR whilst Southern and Western Trusts reported an increase on the number of children on the CPR. From March 2011 to March 2017 the number on the CPR had fallen from 2,401 to 2,132 which represents a fall of 269 children (11%) during the period.

During the reporting period there were 40 children on the CPR with a disability (8 physical and sensory disabilities, 32 with a learning disability). Work is underway to improve the collection of this data as part of the Understanding the Needs of Children in Northern Ireland (UNOCINI) implementation process.

Forty three per cent of children on the CPR were Roman Catholic whilst 10% were Presbyterian, 8% were from a Church of Ireland background and 23.2% were noted as other denominations. A further 10% of children on the CPR had their religious background recorded as 'unknown'. The majority of the children on the CPR were recorded as being from a white ethnic background (90%).

The majority of children (69%) are on the CPR for less than one year with 22% on the CPR between one and two years, 7% between two and three years and 2% for three or more years. All Trusts undertake a review of children and young people on the CPR for periods longer than two years to ensure that the child protection plans remain appropriate.

The HSCB co-ordinates regional meetings with the Police Service of Northern Ireland (PSNI) colleagues to look at and review child protection issues. These meetings take place on a monthly basis and each of the five Trusts have been invited to participate in this process. In addition the Protocol for Joint Investigation between Social Workers and Police Officers is currently being reviewed and it is intended that this will be issued in the Autmn of 2017.

Senior Practitioners for Child Sexual Exploitation (CSE) are also now co-located within the Public Protection Units (PPU) across all five Trusts and further consideration of placing social work Achieving Best Evidence trained staff within PSNI PPU teams is being explored.

The HSCB conducted a CSE audit as a follow up requirement to the Thematic Review undertaken by the Safeguarding Board for Northern Ireland (SBNI) in November 2016. A report was collated in January 2017and subsequently submitted to the SBNI. The SBNI is now integrating Health and Social Care and PSNI Reports into a single report which will be submitted to DoH for consideration.

During 2014 the DHSSPS initiated an inquiry into Child Sexual Exploitation (CSE). The subsequent Marshall Report was published in November 2015 and produced a series of recommendations which have subsequently been addressed. The HSC has undertaken a comprehensive review of the recommendations and all but one has been completed which is subject to ongoing review within the DoH.

Considerable data is collected as part of the Delegated Statutory Functions (DSFs) requirements. Recently the SBNI has set up a sub-group to review Child Protection Outcomes which is being co-ordinated by the HSCB and it is intended that a report will be made available outlining a process to develop an outcomes based accountability process for child protection during the next reporting period.

A recurring theme throughout discussion with Trusts has been the increasing complexity of situations and children's needs with which staff are confronted. While there is a range of variables which may account for this, a common denominator is the prevalence of and lack of resources regarding domestic violence, most notably the lack of provision of perpetrator programmes for non-court mandated offenders.

3 LOOKED AFTER CHILDREN

The number of Looked After Children (LAC) has been increasing since March 2011 when there were 2,511 children looked after by Trusts. At the 31st March 2017 this figure had risen to 2,983. In terms of rate per 10,000 children and young people, Trusts compare favouably with other GB countries at 68.7 LAC per 10,000. In England the rate is 60 per 10,000 while in Wales the rate is 90 per 10,000 and Scotland 151 per 10,000.

Table 5: Looked After Children March 2013 to March 2017

	Belfast Trust	Northern Trust	South Eastern Trust	Southern Trust	Western Trust	**Total**
March 2017	743	647	521	484	588	**2983**
March 2016	739	642	477	477	555	**2890**
March 2015	742	679	464	470	550	**2875**
March 2014	721	693	454	467	523	**2858**
March 2013	669	701	513	456	468	**2807**

During the 2016/17 financial year 859 children became Looked After, the majority were placed in foster care. Sixty seven (8%) were placed in residential care. The number of placements and the needs of those being placed has put additional stress on an already pressurised fostering services.

The highest number of children becoming looked after took place within the Southern Trust while the lowest occurred within the Western Trust.

Of the 859 children becoming looked after, 437 were planned events. However, for 234 children their admission was unplanned while 188 children experienced an emergency admission i.e. where the child and family was unknown to Social Services (146 of unplanned and emergency were admissions to kinship foster care).

Unplanned and emergency placements to kinship foster care continue to present challenges to Trusts in terms of ensuring assessments are completed and approved within the timeframe set out in regulation. The number of unregulated placements has decreased from March 2016 when 143 children under 16 were residing in an unregulated placement to 112 children at the 31st March 2017.

The HSCB continues to remind Trusts that unplanned and emergency admissions to care should be exceptional in order to minimise trauma for children and to comply with guidance and regulations. An Edge of Care Workshop is planned for October 2017, which will hopefully help understand the reasons for the volume of such admissions and provide an opportunity to further explore interventions to reduce the number of children becoming Looked After both planned and unplanned, where it is safe to do so.

The Western and South Eastern Trusts have been Piloting revised Kinship Standards, Policy and Procedures, as part of the Care Proceedings Pilot. The outcome of the Pilot will be examined and a subsequent decision will be made to determine which set of Standards and accompanying policy and procedures will be used regionally.

Sixty one per cent (61%) of children in the care system are subject of a Care Order while, 22% are voluntary accommodated. This is in contrast to the legal status of children when becoming Looked After (64%) were on a voluntary basis. Wider discussion with Trusts will take place in order to understand this and to enable the HSCB to be satisfied that children's needs and rights are being appropriately safeguarded.

3.1 Placement of Looked After Children

Table 6: Placement Type

	Belfast	Northern	South Eastern	Southern	Western	**Total**
Residential care	44	30	37	24	29	**164**
Foster Care (stranger)	222	290	195	211	203	**1121**
Kinship Foster Care	273	203	154	153	254	**1037**
Independent Sector placement	88	14	43	8	23	**176**
Placed at Home with Parents	116	84	61	63	40	**364**
Other	0	26	31	25	39	**121**
Total	**743**	**647**	**521**	**484**	**588**	**2983**

The majority of looked after children, (78%) reside in foster care (35% of foster care placements are with kinship foster carers) compared to 5.5% in residential care. This is in marked contrast to 2007/08 when 57% of children were in foster care and 13% were in residential care. This trend is expected to continue with the usage of residential care becoming more refined and specific.

As noted above the increasing foster care population is an additional and significant pressure for all Trusts.

3.2 Looked After Children – Education

Across Northern Ireland 456 LAC have a Statement of Educational Needs.

Based on information sourced from OC2 returns (2015), DoH at Key Stage 1, there has been a steady improvement in LAC achieving Level 2 or above in English, rising from 50.7% in September 2008 to 70.3% in September 2015. The figure for general school population is 90.1%.

At Key Stage 1, the number of LAC achieving Level 2 or above in Maths has also risen from 52.2% in September 2008 to 73% in September 2015.

In contrast, achievement at Key Stage 2 for LAC is notably reduced with only a 8.6% improvement over the period from September 2008 to September 2015 (i.e. 27.1% LAC attained Level 4 or above in English in September 2008 compared to 35.7% at September 2015). Similarly the gap in attainment by LAC in Key Stage 2 or above in Maths is significant with 35.7% at September 2015 compared with 78.5% of the general school population.

Children within the Western Trust achieved better than their peers in Key Stage 2 English and Maths level 4 or above (64.3% in both) compared to children looked after in the South Eastern Trust where 23.5% achieved Key Stage 2 English level 4 or above and the Sothern Trust were 14.3% achieved Key Stage 2 Maths level 4 or above.

The educational underachievement of Looked After Children is a priority area and, in particular, the notable decline in attainment between Key Stage 1 and Key Stage 2. This is being targeted through a specific initiative under the Department of Education and funding from Early Intervention Transformation Programme.

3.3 Residential Care

In line with the strategic direction set out in Transforming Your Care, reliance on residential care has steadily reduced over the past 10 years and more rapidly since 2011/12. At March 2017 5.5% (164) of children looked after resided in residential care compared to 12% in 2006/07.

Provision of residential care, as in the number of bed spaces available, varies across Trusts with some facilities showing 8 places per unit and others operating to 5 or 6 places per Home which is in line with the direction of travel set out in the Review of Residential Care. Across all Trusts, actual occupancy rates vary from 50% to 100%.

While residential care is a positive experience for many young people, all Trusts report growing challenges in terms of managing the complexity of the young people placed in residential care. Issues such as drugs and mental ill health are increasingly prevalent, with the number and nature of assaults on staff rising.

Access to secure care has been restricted in recent months due to major staffing issues (a Trust recovery plan is in place with weekly reporting to the HSCB and DoH), which has added to service pressures coupled with a reported lack of availability to specialist mental health in patient provision.

3.4 Service Reviews

The HSCB is currently leading on the regional review of:

- The four regional facilities, Beechcroft Child & Adolescent Mental Health Service Inpatient Unit, Donard - Glenmona, Lakewood Secure Care Service and Woodlands Juvenile Justice Centre, and their interface. The review will also consider whether the specific needs of young people placed in regional facilities are being met, the pathways of young people into and out of these facilities, any service gaps and whether alternative/ reconfigured provision needs to be put in place;
- Progress made in relation to the on-going review of Trust residential facilities, whether this is meeting current need, challenges presented, interface with regional facilities etc.

In addition a review of fostering services together with workshops on the themes of Edge of Care and Family Support Services are planned for late summer, early Autumn 2017. A further workshop on children missing from care, jointly delivered by HSCB and PSNI is scheduled for early Autumn 2017.

The emphasis going forward is on defining the strategic direction for placement services and the interface with Family Support and Edge of Care Services.

4 16 PLUS, YOUNG HOMELESS AND SEPARATED, TRAFFICKED AND UNACCOMPANIED CHILDREN

4.1. 16 Plus

At March 2017, there were 1,467 young people eligible for 16 Plus Services (as per Trust Corporate Parenting Reports) while this is a negligible decrease of 8 on the March 2016 figure the overall trajectory is upward. The largest number of care leavers reside within the Northern Trust and the lowest within the South Eastern Trust area.

Table 7 – Care Leavers by Trust as at 31st March 2017

Category	All Trusts						Total	%
	16	17	18	19	20	21+		
BHSCT	48	59	72	69	63	49	**360**	**24.5%**
NHSCT	60	64	84	74	62	30	**374**	**25.5%**
SEHSCT	20	41	50	47	40	19	**217**	**14.8%**
SHSCT	33	38	62	54	46	14	**247**	**16.8%**
WHSCT	28	43	61	50	60	27	**269**	**18.3%**
Total	**189**	**245**	**329**	**294**	**271**	**139**	**1467**	**100.0%**
%	**12.9%**	**16.7%**	**22.4%**	**20.0%**	**18.5%**	**9.5%**	**100.0%**	

One hundred and thirty nine young people aged 21+ continue to receive leaving care support, the majority of these are in the Belfast Trust.

Nine hundred and seventy three young people have the dual support of a social worker and personal adviser, a reduction on the March 2016 figure of 1026. Fifty seven young people have a person specific personal adviser. Provision of a person specific personal adviser is incorporated into the Regional Document on Deployment of Personal Advisers however the Belfast and South Eastern Trusts do not report that such arrangements are in place. HSCB will

address this issue with each of the Trusts in question at their interim DSF meetings.

All of the 1,467 young people have an allocated social worker, 228 are awaiting allocation of a personal adviser, the majority of these young people are eligible (i.e. Looked After aged 16/17). The majority of those awaiting the appointment of a personal adviser are in the Belfast Trust (147 young people which is a rise of 15 on the previous year).

The number of young people without a written pathway plan has reduced from 70 to 54 during this reporting period, 23 of those without a pathway plan are young people within the Belfast Trust. The HSCB has written to the Belfast Trust seeking an explanation for this situation and an assurance that the Trust is actively addressing this matter. The Trust has responded, advising that staffing issues and delays in recruitment had exacerbated the situation, the Trust is confident that resolution is in progress.

4.2. Care Placements

There are 413 eligible young people (LAC aged 16/17) while the majority continue to reside in a care placement, 42 are in jointly commissioned young people's projects compared to 28 noted in the previous reporting period and 24 (previously 25) are in unregulated placement arrangements. The HSCB, with Trusts and the Northern Ireland Housing Executive continue to drive the development of suitable jointly commissioned supported accommodation for vulnerable care leavers. A reduction in funding announced by Supporting People will adversely affect future developments of jointly commissioned services to meet the accommodation and support needs of this group of young people.

4.3 Post Care Placements

A further 78 young people aged 18+ (former relevant) reside in jointly commissioned accommodation to support the transition to the community and towards independent living. The Belfast Trust has the highest number, 25, of 18+ year olds in these living arrangements, followed by the Western Trust who has 23.

Based on Going the Extra Mile (GEM) monthly reporting by Trusts, 277 young people in foster care who reached 18+ were continuing to reside with these carers through the G.E.M. Scheme.

4.4 Young People in Education, Training or Employment

The majority of Eligible young people (LAC aged 16/17) are continuing in secondary or further education, over 13% are not engaged in any form of education, training or employment, 3% due to illness, caring responsibilities or disability. In terms of future outcomes and economic stability, this status gives cause for concern.

Across the 18+ care leaver population, the number of young people engaged in secondary, further or higher education is 262, with a further 168 young people not engaged in any form of education, training or employment.

4.5 Young Homeless

A total of 160 young people presented or were referred to Trusts as homeless during the reporting period.

4.6 Separated, Trafficked and Unaccompanied Children

For the period 1st April 2015 to 31st March 2016 there were 13 referrals in respect of separated children; for the same period during 16 /17 there were 12 such referrals. Work is ongoing in relation to the establishment of an Independent Guardian Service which will seek to ensure that these children are safeguarded.

5 FOSTER CARER POPULATION DATA

Regionally there were 1,999 registered carers, available to Looked After Children at the 31st March 2017 an increase of 49 from those registered at March 2016. Of those approved 772 are kinship foster carers. The number of placements provided by foster carers has increased from 2,532 at March 2016 to 2,688 at March 2017 an increase of 156 (6%). Kinship placements account for 1,027 (38%) of those available.

The Northern Trust has the largest proportion at 483 of foster carers, followed by the Western Trust with 431; the lowest is in the South Eastern Trust at 302.

The registration of kinship foster carers continues to grow with the Western Trust showing the highest number of kinship foster carers (223); it is notable that kinship foster carers now exceed the number of 'stranger' carers within the Trust. The South Eastern Trust report the lowest number of kinship foster carers at 89. Regionally 90 kinship carers are in the process of assessment.

The recruitment of foster carers to replenish placement supply presents an ongoing and significant challenge for Trusts. The Regional Adoption and Fostering Service are leading on the development of a long term regional recruitment strategy which will be taken forward in partnership with all Trusts. It is hoped this will be finalised in August 2017.

Kinship foster care, while a positive experience for many children, is resource intensive. Meeting the assessment and approval requirements along with the additional support needs of many kinship foster carers remains a challenge for Trusts. As part of the Care Proceedings Pilot the Western and South Eastern Trusts have been working to revise Standards, policy and procedures which it is hoped will minimise bureaucracy and any delays in decision making while ensuring the safeguarding of children and supporting carers. The Pilot will, it is intended, help improve service delivery and streamline processes regionally.

6 ADOPTION SERVICES, INCLUDING INTERCOUNTRY ADOPTION

Data for the reporting period April 16 to March 2017 shows a decrease in the number of inquiries from prospective adopters down from 543 to 383. Possibly aligned to this there is a reduction in both domestic and Intercountry adoption applications. The regional website and word of mouth remain the major source of inquiries, though number for both reduced in the past 12 months.

The number of adoptive families approved decreased from 134 to 120 for domestic adoptions however inter country adoptions increased by 3 to seven from 4 the previous year. Monitoring of this will continue.

Of these approved 65 were dually approved concurrent carers, 25 by the Northern Trust in comparison to the South Eastern and Southern Trusts who respectively approved 6 and 7 carers.

With regard to freeing applications the Western Trust had the highest number of successful freeing orders (22). Of a regional total of 79 freeing applications only 3 were not granted. At the 31st March 2017, 5 children freed for adoption, 3 Belfast Trust and 2 South Eastern Trust had not been placed with prospective adoptive carers. Three children had been without a placement for 12 month or more.

The number of Freeing Orders also decreased by 23 from 102 to 79, however there has been a significant increase (20) in the number of adoption orders made, at the end of March 2017. Forty eight of the 139 orders granted were granted in respect of children residing within the Northern Trust area.

Early placement is a good measure of stability for children and it is anticipated that the overall effect of the 'Home on Time' concurrent planning scheme will continue to have a helpful impact on securing early permanence for some of our most vulnerable young children.

In relation to intercountry adoption 15 applications were received during the reporting period, at the 31st March 2017 no applications for assessment were outstanding.

At the end of March 2017, 516 children were in receipt of adoption allowances, sixty six having commenced during the reporting period.

Post adoption contact and support present significant challenges for Trusts. Adjusting to changes in family structure and routine post adoption are substantial for many families. Adopted children continue to require support to address pre care issues and adoptive families need support to understand and manage the complex needs of the adopted child. Trusts have raised concern regarding the rise in adoption disruptions. Work to explore (and potentially address) this concern, led by the HSCB, is due to commence.

7 PRIVATE FOSTERING

A private fostering arrangement is essentially **one that is made privately** (that is to say without the involvement of the Trust) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative, with the intention that it should last for 28 days or more (Children (Northern Ireland) Order 1995 part 10).

Historically Trusts report exceptionally few notifications of private fostering. Of those received, they tend to be in relation to children being adopted from abroad.

Following publication of the Report of the Inquiry into Child Sexual Exploitation in Northern Ireland (November 2014) and the recommendation that the HSCB should monitor the arrangements for private fostering, to ensure that awareness of CSE is raised, significant efforts have been made to raise awareness of Private Fostering and therefore adhere to the recommendation, under the auspices of the Regional Adoption and Fostering Team (RAFT).

Monitoring will continue via the DSF mechanism.

8 EARLY YEARS SERVICES

8.1 Standards

In 2012 the Department published the Minimum Standards for Childminding and Day Care for Children under12 years of age. The publication of the Minimum Standards reflects the importance of having access to an up to date framework for the registration and inspection of childminding and daycare services. The Implementation Guidance (Version 3) issued since the last Delegation of Statutory Functions Report, was developed to be helpful to providers and registering social workers. The Guidance aims to promote a shared interpretation of the Minimum Standards for Childminding and Day Care for Children under Age12, by providing explanatory information.

8.2 Places Available

At the 31st March 2017 an additional 698 day care places were available in the region, providing a total of 60,903 from 4,524 service providers. This figure includes approved home care providers.

The number of registered day nurseries has increased from 333 at March 2016 to 337 at March 2017. While the number of playgroups registered decreased by 11 the number of places offered by this sector shows an increase of 478. Similarly, for out of school care the number of providers decreased by 6 but the number of places offered by the remaining providers increased by 1,123.

The number of childminders decreased by 90 across the region, however capacity increased by 152 places. As previously reported this may suggest that childminders are maximising the places they offer in order to become more viable.

8.3 Inspections

At the end of March 2017 there were 246 outstanding inspections compared to 378 in the same position at the same time last year. Of those outstanding 146 were in the Western Trust area, while Southern Trust had no overdue inspections. The Western Trust reported on measures being put in place to address outstanding inspections, for example monthly targets. During the reporting period a significant overall reduction in the number of outstanding Inspections has been achieved.

8.4 Application**s**

Seventy eight applications were unallocated at the 31st March 2017, 71 of these were applications from childminders. Most of these had been waiting for less than 3 months. There is a variable picture across the region with 31 of these applications being from the South Eastern Trust.

9 CHILDREN ORDER – COMPLAINTS AND REPRESENTATIONS

All Trusts have confirmed that they have a robust system in place, which promotes awareness of the Children Order Complaints and Representations Procedure to service users.

In addition, there is access to an independent advocacy and mentoring service provided by Voice of Young People in Care (VOYPIC). Monitoring returns on activity are received regularly and scrutinised to consider regional coverage and application.

It has also been recognised that Looked After Children can be particularly vulnerable and it is extremely important that engagement with children is transparent, that children fully understand how they can make a complaint and that staff are mindful as to the need to raise any matters of concern with Senior Managers. Each Trust has a Whistle Blowing Policy in place to facilitate staff in this regard.

ADULT PROGRAMMES OF CARE

1 KEY CHALLENGES ACROSS THE ADULT PROGRAMME OF CARE

1.1 Declaratory Judgements

Declaratory Judgements remain an issue for Trusts across Mental Health, Learning Disability and Dementia Services. Work has been undertaken regionally to explore the concerns and share learning. The DoH proposals to address this matter have been delayed by the government impasse.

Belfast Trust has had two useful Declaratory Judgements test cases for the region. One of these (locked door in Adult Family Placement), was deemed an appropriate case for a Declaratory Judgement, the other was not considered appropriate as Guardianship powers were sufficient to provide the necessary safeguards and were implemented correctly. The challenge to the Mental Health Review Tribunal was accepted. This is a useful experience for sharing with the region with Trusts and Mental Health Review Tribunal members.

1.2 Resettlement

While the resettlement targets are almost met there continues to be difficulties in securing suitable accommodation to meet the needs of people with mental health issues or learning disability who have challenging behaviours, long term care needs and/or forensic histories. This is exacerbated by the perceived poor negotiating position with specialist providers who appear to be inflating costs. The Trusts would like a regional approach to growing the market, exploring alternative models and providing more and greater variety of provision. There is also a concern about potential cost shifting due to cuts implemented by the Supporting People (SP) Programme. Some providers are already approaching Trusts seeking uplift in care costs to meet these shortfalls.

1.3 Service Demand

A number of Trusts highlighted the increase in demand across the full range of services, including short breaks, day care and residential and nursing homes. The increase in the number of people with complex needs who are living longer and the increasing complexity of those needs was noted. This is presenting the Trusts with additional challenges in meeting their Delegated Statutory Functions.

1.4 Approved Social Workers

Trusts are identifying concerns regarding the Approved Social Worker workforce. This includes the ageing workforce; staff moving posts, staff in other Programmes of Care requesting that they cease this role and low numbers applying for training. The role itself brings particular challenges including lone working; co-ordinating admissions under the Mental Health (NI) Order with GPs, PSNI and NIAS and the increased demand associated with, out of Trust or out of area placements.

2 MENTAL HEALTH AND LEARNING DISABILITY

2.1 Mental Health

2.1.1 Risk, Governance Issues and Service Pressures

Recruitment remains slow due to Trust “scrutiny” processes and delays within the Human Resources Payroll Travel and Subsistence (HRPTS) system. This has resulted in Trusts using Assessed Year in Employment (AYE) staff from agencies as an interim measure. This brings additional demands for professional supervision and also has implications for caseload management and investment in training for staff not directly employed by Trusts.

2.1.2 Professional Workforce Issues

There is a need for Mental Health Social Work workforce planning with further development of career pathways, in particular for staff in Band 7, professional and managerial roles, in preparation for implementation of the Mental Capacity Act. We understand that this work is being led by the Department of Health.

In addition the revised Adult Safeguarding Policy has put pressure on Social Work Team Leaders in Mental Health settings arising from the Designated Adult Protection Officers (DAPOs), role. In some Trusts this role has been combined with Band 7 ASWs.

There are a number of patients who have been "unexpectedly" discharged from in- patient psychiatry at a Mental Health Review Tribunal. The Trusts report that the term "unexpected" is no longer helpful as patients and staff will be prepared for the possibility discharge at every panel.

2.1.3 Service Developments

In the Belfast Trust there are a number of Innovations arising from seeking Accreditation for the Community Mental Health Services (ACOHMS) Programme via the Royal College of Psychiatrists website. These include: producing an information pack for service users and carers; an enhanced staff induction programme; development of the physical health care pathway; a renewed focus on outcomes, and increased access to psychological therapies within the Teams.

2.1.4 The Recovery College

Peer support workers are now employed in all Trusts following on from the Implementation of Recovery through Organisational Change (ImROC) approach. The Southern Trust has highlighted that they have employed: 3 peer support workers in Support and Recovery Teams; 4 in Acute in-patient wards, and are currently engaged in a recruitment process for 3 more.

Think Family focussed practice is gaining recognition and momentum across the Trusts with particular achievements noted in the South Eastern and Southern Trust reports.

2.2 Learning Disability

2.2.1 Risk, Governance Issues and Service Pressures

Short break provision, day care and domiciliary care continue to pose challenges for all Trusts and particularly in the Western Trust, as demand continues to far exceed capacity.
Adult Centre capacity is an issue in the Northern Trust, particularly due to the complexity of need of young people who are transitioning from school into adult services.

2.2.2 Professional and Workforce Issues

HSCB has led a regional drive to invest in 'Crisis Response' services for people with Learning Disability in each Trust area.

In the Belfast Trust there is a reported lack of demand for this service. However it is noted that there are an increasing number of inappropriate re-admissions to Muckamore, linked to behaviour challenges as opposed to an identified treatment requirement.

The HSCB recommend that the Crisis Response Teams across NI should be integrated with the Behavioural Support Teams to provide a comprehensive and complementary service. It is expected that this Team would work closely with the voluntary and independent sectors to provide up-front training for staff and support if deteriorating behaviours occur. It is anticipated that this will assist in avoiding unnecessary hospital admissions.

2.2.3 Service developments

The HSCB commend the co-production methodology employed with carers and service users in the review of day services in the Belfast Trust and the review of short breaks in the Northern Trust.
The approach taken by the Western Trust in implementing the Day Opportunities model working with all the partners was a very positive step forward.

2.2.4 Access to mainstream Mental Health services through Rapid Access

Intervention and Discharge (RAID) for people with Learning Disability in the Northern Trust is commended. Widening access to mainstream Mental Health services for people with Learning Disability is a key issue raised by the Bamford Monitoring Group this year which will require further consideration in 2017/18.

3 PEOPLE WITH A PHYSICAL AND OR SENSORY DISABILITY

3.1 Introduction

All 5 Trust reports are adequate with some Trusts providing more substantial information on the depth and breadth than others. Most reports explicitly reference the Physical and Sensory Disability (P&SD) Strategy and the positive impact of its associated Action Plan funding.

3.2 Risk and Governance

There is variability across Trusts in their risk reporting for this Programme of Care. In the introductory sections all five Trusts are consistent in highlighting the growing numbers of PSD service users with increasing complexity of need; however, there is a lack of detail provided in the DSF reports submitted.

3.3 Risk Issues

3.3.1 BHSCT has raised Adult Safeguarding and Deprivation of Liberty issues; and note that maintaining vulnerable adults and children who have complex health and social care needs and enhanced levels of risk within their own communities will require a sustained investment in community infrastructure and capacity.

3.3.2 SEHSCT continue to highlight the risk issue of providing safe care for service users who have Speech and Language Therapist assessed swallowing needs. The Trust also highlight the need for increased investment to address the lack of designated living and respite options for people under 65 with a physical sensory or neurological condition. This is compounded by the lack of additional funding through Supporting People to develop supported living options for people delayed in hospital or where their current home circumstances break down. This continued lack of investment will impact on the planning and development of options for adults with disabilities to live independently within the community.

3.3.3 NHSCT has flagged the safety of service users amidst the increasing referrals and management of service users with highly complex needs as an area that requires close monitoring.

3.3.4 SHSCT has identified that while the number of young people with Physical Disability in transition, remains low, there are some whose nursing needs are very complex and challenge the service in terms of provision of appropriate day opportunities and day care.

3.3.5 Similar to last year the WHSCT has cited a range of 'ranked' risk issues (inappropriate placements for ABI clients with challenging behaviour, community placements for people with complex and challenging needs, domiciliary care and complex care needs). This year they also highlight the complexity of referrals and note that the increased volume of young people transitioning to adult services, is causing workforce pressures given the need for suitably trained staff and appropriate specialist provision.

3.4 Governance

3.4.1 All Trusts confirm that they have robust supervision arrangements in place within the Service Area.

3.4.2 All Trusts report very strong activity level in their audit processes covering Social Work Supervision, Care Management, Direct Payments, Short Breaks, Case File Audits, and Day-care. Additionally Trusts have several professional fora in place which meet regularly.

3.4.3 Acquired Brain Injury - a number of the Trusts continue to reference the 2015 RQIA Review of Brain Injury, their participation in this and subsequent actions taken, Trust implementation groups continue to take forward the recommendations.

3.5 Professional and Workforce issues

3.5.1 Recruitment of staff is again reported by a number of Trusts as problematic either as the result of Trust scrutiny processes, vacancy control measures, HRPTS issues or wider regional skill shortages.

3.5.2 The NHSCT has again referenced the restructuring of Physical Disability service teams and their integration into the Older People services, Community Teams in October 2016. The NHSCT has advised that they maintain protected caseloads in three of the 4 localities within the Northern Trust so staff who were previously in Physical Disability Teams maintain a caseload of Service Users with a physical disability. This has had a mixed response from staff as some wished for full integration. Moving forward, a Task and Finnish Group will review practice since October 2016 to determine, what has gone well and what needs to be adjusted to enable the Trusts to continue to provide an excellent Social Work Service to this group of clients and to maintain good staff morale.

3.6 Service Developments and Innovations

3.6.1 Physical and Sensory Disability Strategy & Action Plan - it is encouraging that all 5 Trusts have reported positively on their participation in the Strategy workstreams and use of additional funding for targeted work and how targeted funding has been used to address need.

3.6.2 Carers – all Trusts reported on their efforts to ensure that carers' assessments, reassessments and reviews are consistently offered and recorded with a number of Trusts reporting improved performance;

3.6.3 Day-care and Day Opportunities modernisation is reported by Trusts and the continuing development of proposals on the transformation of Day Opportunities. Recurrent HSCB funding is acknowledged as a means of funding Community Access and Social Networking innovation. The SHSCT report that in their area the demand for centre based Day Care has reduced as Day Opportunities have increased in physical and sensory disability. The service user profile of attenders has simultaneously become more complex and dependant.

3.6.4 Most of the Trusts again report on the beneficial impact of the P&SD Strategy funding which has enhanced Sensory Services training in meeting the needs of people with sensory impairments. Quite a number of examples are listed, for example, staff attending deaf-blind, lip reading and tinnitus specialist training and the launch and circulation of an e-learning package to promote awareness on sensory support needs among Trust staff.

3.6.5 SEHSCT has reported on a new scheme (Meadowvale Court) which opened in October 2016, providing independent living opportunities for thirteen individuals with acquired brain injury, neuro-disability and physical disability.

3.7 Key Issues and Regional Service Pressures

3.7.1 Accommodation – four of the 5 Trusts highlight the lack of designated living and respite options for people under 65 years of age with a physical, sensory or neurological condition. The current funding uncertainty regarding Supporting People is impacting upon a number of proposals regionally.

3.7.2 Domiciliary Care provision – all 5 Trusts highlight the lack of capacity of domiciliary care provision in their Trust areas.

3.7.3 BHSCT and WHSCT both specify alcohol related brain damage as an ongoing key issue. Both Trusts are actively addressing this area of work in terms of how best to meet the needs people with such co-existing conditions.

3.7.4 Financial Pressures are reported by all Trusts.

3.7.5 Transition to and from Adult Services - the issue of high cost care packages being 'programme centred' as opposed to 'person centred' for example, funding linked to the Programme of Care not the individual, is a key issue for Trusts.

3.7.6 Day opportunities - all Trusts have previously received additional funding to modernise their provision of Day Opportunities and are at different stages of implementation.

4 OLDER PEOPLE

4.1 Risk, Governance Issues, and Service Pressures

The Western Trust has identified a number of challenges with regard to the discharge of Delegated Statutory Functions. The reform of day care services and the closure of statutory residential care homes are on hold pending a decision by the Minister.

A review of hospital social work has resulted in the development of two possible service models for the future. These are being tested at two sites within the Trust and progress will be reviewed at HSCB and Trust update meetings.

The Belfast Trust reported that they have to pay privately for capacity assessments, with an average fee of £500 being charged for each assessment. The HSCB believe that capacity assessments should be undertaken as part of normal work practices in-house.

4.2 Domiciliary Care Capacity

The Southern Trust notes there are some elements of some care packages outstanding on a daily basis. Assurances have been provided by the Trust that remedial plans have meant that all users are safe and that no-one is waiting for a core package. Some people are waiting for the remaining elements of their package to be implemented.

The Northern Trust reports there is currently no waiting list for social work assessment of people with critical care needs. On occasion there may be some delay in the delivery of the full level of Domiciliary Care support required, and the Trust has developed an escalation process to deal with these cases.

The Belfast Trust highlighted delays across the system (hospital discharge; intermediate care beds; Reablement schemes) due to lack of availability of Domiciliary Care packages. Procurement processes are contributing to delays and instability in the provider sector.

4.3 Professional and Workforce Issues

The Northern Trust's Reform and Modernisation Programme continues to roll out within the Community Care Division. There are now fourteen multi-disciplinary community care teams located in four localities across the Trust. The Southern Trust notes that there are no vacancy controls in place at present. Issues remain in recruitment of staff to short term or project posts.

The use of AYE Social Workers and their need for a protected caseload is also having a noticeable impact on caseload management.

The Western Trust highlights that vacancies in some areas of the Trust are proving difficult to fill and agency staff are being utilised. Concerns are being expressed about the implications for continuity of care and support for service users. The challenge is particularly apparent in rural areas.

A Workforce Review in the Belfast Trust is leading to a realignment of workloads with more focus on professional tasks and a reduction in administrative and transactional tasks, in line with the Gerontological model of social work. This workforce development programme will result in phasing out the Care Manager role in favour of an Advanced Practitioner role.

The appointment of eight Band 7 social work managers in the Western Trust is expected to address challenges identified in previous DSF reports regarding workload due to caseload management and 'high levels of bureaucracy.' The Trust reports improvements in respect of challenges identified in previous DSF reports concerning increasing case numbers and safeguarding issues.

The Western Trust reported an increase in the number of Designated Adult Protection Officers (DAPOs), the shortage of which had been highlighted as a concern in the 2016 DSF report.

4.4 Service Developments and Innovations

A Service Improvement Team has been established in the Western Trust within the Primary Care and Older People's Directorate to take forward recommendations arising from the Trust's 'Review of Older People's Journey through the Health and Social Care System.' To date, the Service Improvement Team has examined supervision and case load weighting and the Trust reports improvements in relation to supervision. The appointment of eight additional Band 7 managers is expected to take levels of supervision to 100% compliance.

New models of working are being tested and evaluated within hospital social work services across the Trusts, with a view to rolling out best practice across the region. The Community Discharge Coordinator post (NHSCT) has been developed following restructuring. This post maximises the acute to community interface, to contribute to safe and timely discharge of patients from the acute sector who require additional community support to facilitate their discharge.

Zoning is being explored as a means of improving how domiciliary services could be delivered more effectively and efficiently in the Northern Trust. This will require close partnership working with independent sector providers, contract departments and trades unions.

The Southern Trust is taking part in a European Partnership pilot of the Sunfrail Care Model which involves piloting a multi-domain screening tool and questionnaire, focussing on frailty and functioning in older people. Completion of this aims to generate alerts on conditions and suggests pathways for intervention, based on available resources. Further work is required to understand how this informs the Northern Ireland Single Assessment Tool (NISAT).

5 DEMENTIA

The injection of funding through the Delivering Social Change Programme to support the implementation of the Regional Dementia Strategy has had a significant impact on key areas such as (i) awareness raising, information and tackling stigma, (ii) staff training and development and (iii) short-breaks, information and support to carers.

Trusts have worked closely with the regional dementia project team to roll out a package of measures that has resulted in:

- appointment of 10 Dementia Navigators (2 per Trust);
- graduation of 256 Dementia Champions;

- more than 1,500 staff trained in the assessment and management of delirium;
- a range of innovative short-breaks and supports to carers;
- training programmes for carers of people with a dementia.

Initiatives within individual Trusts have, following evaluation, been rolled out across all other Trusts. These programmes included CLEAR training; recruitment of Dementia Companions in acute wards and Virtual training. Staff have also benefitted from the development of training apps (domiciliary care) and from direct investments in equipment, for example diversionary therapy materials.

5.1 Specific issues within Trusts include:

5.1.1 Belfast

The review of the long term use and viability of statutory care homes for people with a dementia. Falling occupancy, cost pressures and people with a dementia now choosing to remain at home is resulting in the Trust moving towards the provision of alternative arrangements, particularly supported housing.

A challenge reported by Belfast Trust is the lack of a psychology staff resource to be able to carry out assessments or provide psychological therapies.

5.1.2 Northern

The Northern Trust has begun work to support the roll out of the regional dementia collaborative on memory service design and dementia care pathway.

5.1.3 Southern

The Southern Trust has been instrumental in developing the Dementia Navigator role and developing supports for the roll out of the regional dementia care pathway.

5.2 General Issues

5.2.1 Trusts are reporting on-going challenges in relation to the provision of day care and day opportunities for people with dementia particularly those people under 65 years.

5.2.2 A further challenge relates to an ageing learning disability population and the increasing rate of dementia within that group. Trusts have established work groups within their respective geographies to address these issues and this work is co-ordinated regionally by the HSCB.

5.2.3 Behavioural and Psychological Symptoms of Dementia (BPSD) in care homes are resulting in some homes serving notice on residents to transfer. Trusts are working with homes to combat this by providing training and support.

5.2.4 The number of service and quality awards to Trusts for work in dementia care this year is evidence of increased commitment and service improvement and is to be commended.

5.2.5 All Trusts are working with other agencies to promote dementia friendly communities and within the Trusts to develop dementia friendly hospitals and public service facilities, for example GP Practices.

6 SELF DIRECTED SUPPORT (SDS)

SDS is progressing well across the region. The commitment to Personalisation, Co-production and Staff Training is cited across all HSC Trust DSF reports.
All HSC Trusts are reporting an uptake in SDS activity from the year 2015-16.
As a consequence the numbers receiving Direct Payments has fallen.
Some Programmes of Care have noted that they are working to address implementation issues within their internal project structures.

Factors noted in the reports which are impacting on implementation, include working into other Service Improvement Plans and Projects; Infrastructure changes and issues with SDS data collection. The Regional SDS Project Management team are aware of all of these through the PRINCE Risk Management protocol, and countermeasures have been established to minimise any negative impact.

6.1 Trust specific

6.1.1 Southern Trust information data is limited but they have identified issues due to limitations of their PARIS system.

6.1.2 Belfast Trust reports good progress; however it is noted that there is no mention of SDS within the Older Peoples POC.

6.1.3 South Eastern Trust is the only Trust to mention Outcomes (ASCOT) it should be noted that this would not have been a frontline focus for the other HSC Trusts in 2016-17.

6.1.4 In the Western Trust since the 'go live' date in November 2015, the Trust reports a significant increase in the take up of SDS.

7 SUPPORT FOR CARERS

7.1 The Belfast Trust reports good performance in carer's needs assessments and services offered in relation to both Mental Health and Learning Disability services; and increase in numbers of young carers being supported.

7.2 The Southern Trust has highlighted the difficulties in engaging with carers even though an active Carers Forum is in place. The HSCB are seeking assurance that the Trust will make the shift from consultation to Co-Production as a key priority area moving forward into 2017/18.

7.3 A pilot initiative in the South Eastern Trust has resulted in an increased awareness of carers needs and increase in the uptake of assessments.

The learning from this pilot is to be shared across the region to improve support for carers.

7.4 Carer Support Contract: The Western Trust notes that there had been challenges in relation to contract compliance with the current provider. These have now been resolved, and the Trust continues to monitor the level and type of support the provider offers to carers.

The Carers needs assessment Service Improvement Project in the Belfast Trust has led to a significant rise in needs assessment completed (9% to 46%).

8 EMERGENCY RESPONSES / REST CENTRES

Table 7 below shows the number of occasions each Trust has been called upon to support Emergency Support Centres (ESCs).

Table 7 – number of times Trusts called upon to support ESCs

DSF Period	BHSCT	NHSCT	SHSCT	SEHSCT	WHSCT	Total
2016-17	2	5	2	1	2	10
2015-16	5	4	2	2* (*4 in total - but only req'd for 2).	6	19
2014-15	5	4	2* (3 in total but not req'd for all)	2*(5 in total but not req'd for all)	3	17
2013-14	26	6	8	6	8	54
2012-13	14	7	8	0	10	39
2011-12	17	4	5	3	14	43
2010-11	9	3	1	4	6	23
Totals for 7 year period per Trust	78	33	29	18	49	205
Average per year (rounded)	11	5	4	3	7	31

Table 7 reflects a continuing reduction in the regional total of ESCs.

8.1 Emergency Planning

Again in this year's reporting, only BHSCT has made additional comments about Emergency Planning (all Trusts are required to submit an annual report to HSCB regarding emergency planning). BHSCT has advised of a change of internal responsibility in that responsibility for assisting with critical incidents now rests with the Community Development Team during daytime hours. The reduction in the need for ESCs as reported by Trusts is welcome, however, in

light of recent terrorist attacks across the UK it is imperative that all Trusts are in a state of preparedness to respond as required.

Additionally, in the aftermath of the Grenfell Tower fire in London, and the NIHE Mass Evacuation Protocol which is still being finalised, this remains an open and ongoing issue for Trusts and other agencies.

8.2 Palliative Care

Despite the ongoing work within the Regional Palliative Care in Partnership Programme following from the Living Matters Dying Matters work programme (also note the RQIA Review 2016), Trusts continue to under-report this area of Social Work practice. BHSCT and SEHSCT make reference to Palliative Care as part of core work within the Royal Belfast Hospital for Sick Children (RBHSC) and the Royal Jubilee Maternity Hospital (RJMH); SEHSCT reference it as part of core Hospital Social Work (HSW). Only SHSCT include additional narrative asserting the importance of the SW contribution (P.167): "…A number of important recent initiatives, which have advanced the profile and appreciation of palliative care social work within the Palliative Care Team are the weekly Multi-Disciplinary Team (MDT) case discussions and the co–working on the planning, development and delivery of training.

New initiatives:

8.2.1 Palliative care awareness training sessions throughout SHSCT for acute and community staff.

8.2.2 Sage and Thyme communication skills training to teach all levels of staff a model of "noticing" and "responding" appropriately to "distress" where they come across it.

8.2.3 Creating links with non-acute SW team in order to enhance SW role and develop service provision.

8.2.4 Contributing to the revised “your life your choices” booklet due to be launched by PHA soon and ensuring Social Work role is explicit and visible in that publication.

8.2.5 Participating in a peer social work supervision pilot as a positive source of professional support and learning…”
All Trusts should make explicit reference to what is happening in this increasingly challenging work.

8.3 Hospital Social Work (HSW)

As in previous years, there continues to be no consistency across the region as to where HSW is located in terms of Directorate structure within Trusts. Three services are managed within Older People Service Directorates (BHSCT, SEHSCT and WHSCT) and two within Acute Hospital Directorates (SHSCT and NHSCT).

Table 8 – Hospital Social Work – location within Directorates within Trusts

Trust	Hospital	Referrals 2013/14	Referrals 2014/15	Referrals 2015/16	Referrals 2016/17
SEHSCT	Ulster Hospital; Lagan Valley; Downe	8100	7208	7011	7078 (+67)
BHSCT	Belfast City; Musgrave Park; Royal Victoria; Mater & Valencia Ward (Dementia Project)	15176	14784	13593	11985 (-1608)
NHSCT	Antrim; Whiteabbey; Causeway; Mid Ulster; Braid Valley	8023	7807	7968	8158 (+190)
SHSCT	Craigavon Area Hospital; Daisy Hill; Lurgan Hospital	9172	8340	7488	8126 (+638)
WHSCT	Altnagelvin; Waterside; South Western	4286	4,853	4096	5118 (+1022)

Key Issues:

8.3.1 HSW departments appear to be almost exclusively focused on discharge planning, except for some specialized areas of work.

8.3.2 Lack of consistency – whilst all 5 Trusts have provided narrative on HSW, there is a lack of consistency in the level of detail reported across the region. It is noteworthy that the 2 Trusts that have reported consistently well over the past number of years have been those embedded in the Hospital service, that is NHSCT and SHSCT.

8.3.3 Discharge planning is reported across all HSW departments to highlight this work in the context of regional discharge targets.

8.3.4 The interface issue between BHSCT and SEHSCT re discharges continues to be an issue despite years of effort to resolve.

8.3.5 7 Day working is now established within most HSW departments to reflect the regional drive to move patients more efficiently through the hospital system, either to home or to an interim care location.

8.3.6 There is still no consistent statistical information provided for HSW departments across the region and this makes any analysis of activity or performance impossible. There has been a general reversal in the volume of referrals since last year, see Table 8, with four of the Trusts showing increased referrals. SEHSCT is virtually static although they have highlighted an increase in complex discharges from 204 up to 309 in the past 12 months, NHSCT is up by 2% and report an increase in the complexity of discharges, SHSCT is up by 8.5% (638), WHSCT has increased by a staggering 25% (1,022), but, BHSCT shows a drop of 12% (1,608).

8.3.7 A number of the Trusts have indicated previously and currently that they wish to or have carried out a review of their HSW service. There has been no outcome to these activities. WHSCT has advised that two pilots should be completed in May 2017.

9 ADULT SAFEGUARDING

9.1 Introduction

This overview is based on the contents of the Local Adult Safeguarding Partnership (LASP) Annual Reports and activity data submitted by the 5 HSC Trusts.

The overview considers the key issues and emerging pressures within adult safeguarding, presents an analysis of activity based on Programmes of Care, highlights key workforce issues and evaluates each LASP Trust performance in 2015-16.

9.2 Key Issues and Pressures

9.2.1 Procedures

The implementation of the new Policy and associated procedures has resulted in a significant programme of service re-engineering within each HSC Trust LASP. In addition to the introduction of new roles such as the Designated Adult Protection Officer (DAPO) and the Adult Safeguarding Champion (ASC), HSC Trusts are developing new working arrangements internally and in partnership with other agencies such as the PSNI. HSC Trusts are also developing innovative alternative safeguarding responses to provide adults in need of protection with more person-centred and proportionate options and choices. Devising an activity return that captures these alternative responses will be a significant task for NIASP in 2017/18.

9.2.2Multi-Agency Risk Assessment Conference (MARAC) and Domestic Violence

Adult Safeguarding services continue to contribute significant levels of resource to MARAC meetings and to responding to issues of domestic violence and abuse. This area remains a very high priority, but it is becoming increasingly difficult for HSC Trusts adult services to absorb the demands of this work.

9.2.3 Financial Abuse

In 2016-17, each HSC Trust LASP dealt with complex safeguarding investigations involving different types of financial abuse. There are significant challenges in this work, both in recognition of abusive situations and identifying the correct source of assistance or support, which may well sit

outside the HSC Trust structures. Further work will be done in 2017/18 to provide improved guidance for social work staff on this topic.

9.2.4 Prevention Agenda

Each HSC Trust LASP has reported on prevention activity undertaken in 2016-17. The majority of activities to date have focussed on prevention at an individual service user level, with only a small number of more strategic approaches being undertaken. It is acknowledged that some of this work is dependent on the production of a regional prevention plan through the Northern Ireland Adult Safeguarding Partnership (NIASP). Once this is available, LASPs will reflect those requirements in their own plans. In the meantime, however, LASPs are encouraged to think more creatively about how to use the partnership more effectively to promote the prevention agenda.

9.2.5 Audit

The main focus of regional safeguarding audits this year has been in rolling out the survey of user experience using the tool devised with service users and based on the 10,000 Voices methodology. Information available to date has provided important feedback on user experiences and has also provided invaluable information on service user based outcomes from the adult safeguarding process.

9.2.6 Research

In 2016-17, 2 papers on adult safeguarding in Northern Ireland have been accepted for publication by peer reviewed journals. These are scheduled to appear in print in 2017-18.

9.3 Activity

Activity collection and analysis was influenced by a number of significant challenges in 2016-17:

9.3.1 New procedures are influencing practice, but the current data return does not capture new activity, for example it does not provide information on the use of alternative safeguarding interventions. HSCB and HSC Trusts have not yet reached agreement on the core data set under the new procedures and this is a priority for 2017-18. Resources to develop a revised data return are very limited; and

9.3.2 the transition from a manual to an electronic data collection is proving problematic as the new systems are being introduced within HSC Trusts on an incremental basis. This means that some service areas in HSC Trusts are progressing electronic recording, while other service areas in the same HSC Trust are still reliant on a manual return.

In 2016/17, 6,579 referrals were received. This is a fall of 1,200 referrals (15%) compared to 2015/16.
This represents 46 in every 10,000 of the 18+ population or 1 referral to every 215 people aged 18+ of the projected referrals for 2016/17.

There are a number of possible reasons for this decrease in numbers, including:

9.3.3 The phased implementation of the new procedures and the transition to the use of new definitions is resulting in higher numbers of concerns being “screened out” of the safeguarding system;

9.3.4 The gradual move to Adult Safeguarding Gateway Teams has resulted in the concentration of expertise and experience in scrutiny of referrals, with more concerns being re-directed back to core services than in previous years;

9.3.5 An increase in the number of concerns being dealt with in core services has made staff more confident in dealing with the presenting issue; and

9.3.6 The development of alternative safeguarding responses such as the use of Family Group Conferences has meant that more users are being offered proportionate and effective responses without having to enter the protection system.

As in previous years, the highest percentage of referrals was received from Older People 2,407 (37%) followed by Learning Disability 2,296 (35%).

For the first time, a small number of referrals were received from colleagues in the Primary Care Programme. This is reflective of the requirements of the new policy and the increasing levels of awareness among colleagues working in primary care settings.

Belfast Trust continues to receive the highest number of referrals, 2,934 (45% of the total). The Western Trust continues to report the lowest number of referrals, at 545 (8% of the total).

Regionally, almost 1 in every 2 referrals has a care and protection plan implemented. In the Northern trust, however, 73% of all referrals result in a care and protection plan being put in place.

Twenty eight per cent of all investigations took place in residential or nursing homes, and 27% involved adult mental health units, including assessment and treatment facilities for people with Learning Disabilities.

In 2016-17 there were 383 investigations carried out under the Protocol for Joint Investigation. Analysis of the activity shows a decrease of approximately 40% in Joint Protocol activity every year over the last 3 years. While this requires continued careful monitoring, it is likely that this decrease is a reflection of the thresholds for referral set out in the revised Joint Protocol and the concentration expertise and decision-making in the Central Referral Unit of the PSNI.

In 2016-17, 1527 cases were closed to adult safeguarding. Again there is variation in the number of cases closed across the region which reflects the

pattern of referrals, with the Belfast Trust closing nearly 50% of cases in-year, and the Western Trust closing approximately 14% of cases.
Physical abuse was the presenting cause for concern in 2,954 (45%) of the referrals made to adult safeguarding. Of these, almost 80% were in relation to older people or people with a learning disability.

Financial abuse accounted for 772 or 12% of referrals.

However, it should be borne in mind that the current system of data collection only allows the Trust to record the presenting or primary type of abuse experienced by the individual and it is highly likely that an individual will experience more than one form of abuse.

There is anecdotal evidence that the new definition of an adult at risk is starting to have an impact on HSC Trust core services and referrals in relation to people who do not meet traditional PoC thresholds or definitions are increasing from the Ambulance Trust and local Concern Hubs .

9.4 Programme Specific Issues

9.4.1 Older People

The number of referrals involving older people has reduced regionally. However, it is noticeable that the number of referrals from services supporting people with cognitive decline has increased slightly.

HSC Trusts continue to be challenged by the number and complexity of safeguarding investigations that area occurring in residential or nursing care settings. While the primary focus of any investigation is on ensuring that the adult at risk is safe from further harm, HSC Trust responses frequently require significant resource commitment from a range of functions and services such as Finance, Quality Assurance, specialist Nursing etc. HSC Trusts must also work with and respond to concerns and requirements of other agencies such as Regulation and Quality Improvement Authority (RQIA).

The Commissioner for Older people in Northern Ireland (COPNI) is currently conducting an enquiry into a facility on the outskirts of Belfast. The relevant HSC Trusts are seeking to respond as fully as possible while maintaining other protection regulatory activities in the facility.

This is the first time that COPNI has exercised this power and the learning from the enquiry will undoubtedly have implications across the HSC.

9.4.2 Mental Health

Referrals from the Mental Health Programme of Care remain low when set against the number of adults accessing treatment and support. HSC trusts have worked hard to increase awareness of adult safeguarding with this user population and colleagues within the multi-disciplinary teams.

It is possible that more safeguarding activity within Mental Health will be captured as HSC Trusts develop methods of capturing information on alternative safeguarding responses. HSC Trusts are also taking a variety of steps to ensure that there are adequate numbers of Band 7 Social Workers in place with the Programme to take on the requirements of the DAPO role and provide the necessary leadership in adult safeguarding.

9.4.3 Learning Disability

Referrals in relation to people with a Learning Disability (2,296) remain the second highest for the region. The most common presenting issue remains physical abuse, but it should be borne in mind that this can vary from slapping and pinching through to a serious physical assaults. It should also be remembered that most people will experience more than one form of abuse.

The pattern of referrals in relation to people with Learning Disabilities is similar to safeguarding information available from other jurisdictions, for example Wales and is reflective of the limited prevalence data for this client group.

That does not mean that HSC Trusts and other providers are complacent about the number of service users experiencing some form of abuse neglect or exploitation every year. Information from the service user survey (see above) will be used to further develop prevention activities targeting people with learning disabilities in 2017-18.

9.4.4 Physical Disability and Sensory Impairment

The number and type of referrals to adult safeguarding from this Programme of Care remains steady, with only small fluctuations in activity.

In 2016-17 HSC Trust LASPs sought new ways to inform people with sensory impairments about adult safeguarding and the options available to them. The production of material for use by talking Newspapers is a very concrete example of an initiative originating in one HSC trust area being shared on a regional level.

9.4.5 Acute

Referrals originating in the acute sector remain low. This is surprising given the number of people who use acute sector services.

The referrals made to adult safeguarding services are all appropriate and have in some cases highlighted significant issues within community settings.

It is possible that the low level of referrals is due to lack of awareness of adult safeguarding amongst healthcare professionals. In the absence of any additional funding to support training and awareness-raising activities, HSC trust training teams continue to prioritise safeguarding training for social care staff in the community.

9.5 Professional Workforce Issues

In previous years, HSC Trusts had highlighted a concern that there are insufficient numbers of appropriately trained and experienced social workers in post within adult services to meet the requirements of the new adult safeguarding policy and associated procedures.

In the absence of dedicated new resources, HSC Trusts have, in general, been flexible and innovative in addressing this issue through: internal re-structuring; the development of new job descriptions to include Investigating Officer and Designated Adult Protection Officer roles, and, the use of rotational arrangements.

Challenges remain in relation to the Mental Health Programme of Care where the available social work resource is already limited and this is an area that could usefully be addressed through regional workforce planning mechanisms.

The new Policy and the related procedures have placed significant demands on HSC Trust training teams. The lack of additional resource to support policy implementation has meant that training at Investigating Officer and Designated Adult Protection Officer roles has been prioritised along with training in the new requirements under the Joint Protocol. As a result some other, more generic adult safeguarding training has not been delivered.

It has proved increasingly challenging for HSC Trusts to continue to provide multi-disciplinary training in adult safeguarding from within the social services training budgets. Trust training teams are committed to the concept of multi-disciplinary training wherever possible, but providing this training on behalf of the Trust by drawing exclusively on social services training budgets is no longer a sustainable position.

9.6 Trust Specific Commentary

9.6.1 Southern Trust

The Southern LASP has a well-developed culture of partnership working and this is clearly reflected in its Annual Report.

The LASP provides strong and clear leadership in relation to adult safeguarding across sectors and user groups. As a result, the LASP is well placed to develop positive "prevention" activities or interventions through the work of the local Councils, Police and Community Safety Partnerships and local community groups.

The LASP has a clear strategic focus, as evidenced through the SHSCT corporate blueprint for implementation of the new procedures and the production of practical advice for practitioners, for example the Domestic Violence Legal Remedy Workshops.

The LASP and the HSC Trust have a number of initiatives underway which will require closer scrutiny in 2017/18. These include the roll-out of the proposed Achieving best Evidence Rotation Pilot and the adoption of the corporate blueprint for policy and procedures implementation.

9.6.2 Northern Trust

The Northern LASP continues to meet on a regular basis, although it has faced some challenges to its effectiveness due to organisational changes within some partner organisations. Nevertheless, the members continue to display a strong commitment to partnership working. This is evidenced by a number of successful local initiatives.

The LASP has a history of delivering high quality training in adult safeguarding and is to be commended for the willingness with which it has led on such regional priorities as training for F2 Grade doctors and dentists.

The LASP, in common with all partnerships, struggles to meet the increasing demands of adult safeguarding with, at best, static and frequently reducing resources. The strong and effective governance arrangements in place have contributed to the successful identification of some additional resources for adult safeguarding.

The LASP has also developed a very effective and inclusive approach to the issue of inappropriate management of patient anduser finances. The approach models a "working together" approach and has been evaluated very positively by independent sector colleagues.

9.6.3 Western Trust

The Western trust LASP Report outlines how the Trust and its partners have delivered improving adult safeguarding services over the last year. However, the LASP met formally on only 2 occasions in 2016/17 which makes true partnership working more challenging. Nevertheless, the LASP has developed some very positive initiatives, most notably in relation to the Working Together to Keep Me Safe Programme which primarily targets older people.

Appropriate governance arrangements appear to be in place to support practice, enhance accountability and improve outcomes for service users.

The Trust has been involved in a number investigations involving cross-boundary working. These investigations are inevitably complex and resource intensive and it is important that any potential barriers to full and complete communication are minimised. The HSCB would therefore recommend that the Western HSC Trust and LASP standardise the title of specific adult safeguarding functions and tasks as outlined in the regional policy and associated procedures.

9.6.4 South Eastern Trust

The South Eastern LASP continues to build on a strong culture and tradition of partnership working and is particularly active in terms of awareness-raising and prevention activities.

The LASP has cultivated a very positive working relationship with local councils and the benefits of this relationship are clearly evidenced throughout the report.

The LASP has very clear governance and accountability systems in place. These have greatly assisted the LASP in the promotion of adult safeguarding in general and the implementation of new procedures in particular.

The LASP is working effectively on both a strategic level through the development of quality assurance tools and the annual workplan, and on a very practical level through the production of awareness raising material for Talking Newspapers.

9.6.5 Belfast Trust

The Belfast LASP continues to provide leadership and support to a range of partner organisations through regular meetings and sharing of practice and experience.

The Report records some apprehension that the new policy and associated procedures will lead to increased numbers of referrals and associated increases in workloads. To date this has not proved to be the case but will require careful monitoring.
The Trust notes that internal governance arrangements in relation to adult safeguarding have been further strengthened by the establishment of a Trust Adult Safeguarding committee which feeds in to key social care governance structures.

It is concerning to note that there appear to be 3 distinct pathways for Adult Safeguarding referrals within the Trust. A more streamlined approach would not only assist external bodies and agencies in making referrals, but also maximise use of existing resources within the Trust.

The LASP continues to play a leading role in relation to developing responses to adult victims of human trafficking.

CONCLUSION

This report provides an overview of the Trust monitoring reports. The HSCB has determined that each Trust has submitted a satisfactory report supplemented by statistical data with the exception of those Trusts that have not returned data on Personal Advisers. This will be addressed with the Trusts concerned. It should be noted that these returns are currently collated manually and consequently are resource intensive for the Trusts. The statistical information is published by DoH and contributes to benchmarking across the four countries.

A number of issues are highlighted in individual Trust reports and these will be reflected in Trust Action Plans and progress monitored on a regular basis.

The report also highlights a number of service developments in areas such as CAMHS and inter agency working.

In addition, there are issues highlighted by each Trust as challenges and pressures including:

- Domestic Violence – linking with the DoH work on the implementation of the regional strategy;
- Transition of young people into adult services;
- Post adoption support;
- Children with complex needs, including placement options;
- Meeting the needs of adults with complex and long term mental health needs, and learning disability including accommodation support;
- Approved Social Work and workforce planning;
- Domiciliary care and short breaks – meeting the increasing complexity of care required for people at home;
- Workforce pressures in relation to Adult Safeguarding.

Overall, Trusts report increased pressures due to rising demand and complexity of need across all Programmes of Care.

It should be noted that each Trust has included a range of innovative projects to improve the delivery of statutory functions and the outcomes for service users and cares. These are being collated with a view to sharing the learning across Trusts.

As we move forward, and reflecting the renewed focus on outcomes within the Programme for Government the HSCB will build on its current work on outcomes based monitoring and review the DSF reporting arrangements accordingly.

MAHI - STM - 089 - 6608

From: **JACKIE MCILROY**

Date: **31 OCTOBER 2017**

To: **SEÁN HOLLAND**

SUMMARY **DELEGATED STATUTORY FUNCTIONS**

Issue:	HSCB Overview Report regarding Discharge of Delegated Statutory Functions (DSF) 2016/17
Timescale:	Immediate
Presentational Issues:	N/A
Freedom of Information:	
Legislation Implications:	The Office of Social Services (OSS) is responsible for the professional oversight of the Health & Social Care Board's (HSCB) performance management and quality assurance arrangements for its oversight of the discharge of DSF by the Trusts.
Financial Implications:	None
Executive Referral:	
Recommendations:	That you:

i. Note this briefing
ii. Consider the findings based on an analysis of the HSCB DSF report carried out by OSS professional officers **(TAB B)**.
iii. Agree to the recommended actions; and
iv. Arrange to have the letter issued to HSCB **(TAB A)**.

1.0 BACKGROUND

1.1 Professional oversight of DSF is an ongoing process by Trusts, the HSCB and Department and takes place throughout the year. Processes are in place, in line with normal Departmental governance and accountability arrangements, which enables any significant issues regarding DSF to be brought to the attention of the HSCB and/or Department by Trusts, as and when they arise, and for such issues to be dealt with in 'real time'. Where appropriate issues may also be included as agenda items as part of HSCB/Trust ground clearing meetings and depending on risk, escalated and included on the agenda of Permanent Secretary's mid and/or end year accountability meeting(s) with the HSCB/ Trusts.

1.2 The HSCB submitted its Final End Year DSF Overview Report for 2016/17 on the 15th September 2017. An analysis of the Report has been carried out by OSS officers, in line with the agreed DSF timelines set out in the OSS DSF internal guidelines.

1.3 Based on an analysis of the HSCB DSF End Year Report six professional and governance matters have been identified and are recommended for escalation to the Chief Social Work Officer and these are set out below. Further information on these issues can be found in Section 2 of the OSS Report Card**. (Tab B)**

HSCB / HSCT	**ISSUE**
Information Management Information/ HSCB/HSCTs DSF overview and statistical reports HSCB Social Work Workforce data/ BHSCT Unallocated Children's Cases reporting	The data contained in this year's HSCB overview and statistical reports presented some quality issues with regards to both accuracy and completeness. Problems with data collection are acknowledged by the HSCTs and the HSCB, and plans to address the difficulties largely through IT solutions are noted in the DSF overview report. Also OSS have noted other difficulties in the quality of data collected in respect of: • **Corporate Trust records of social work absenteeism.** There may be an emerging issue in relation for the amount of sick leave taken by Social Workers in HSC Trusts. This has come to light as a result of a planned media item that has not as yet aired. It would appear that the information provided by HSCTs Corporate Information Branches has inflated the true picture of sickness absence amongst Social Workers. The DCSWO has written to each of the Directors to request that the information is quality assured to get a more accurate picture. • **BHSCT Reporting of unallocated cases** OSS have followed up a query with BHSCT regarding its reported Unallocated Children's Cases Information Oct / Nov / Dec 2016 / Jan 2017 as the reported number was the same for each month and the query resulted in OSS discovering (from Excel Spreadsheet) that "Numbers copied from last month as current numbers unavailable". • **You should note the opportunity to impress upon the HSCB**

	and the Executive Directors the importance of ensuring accurate reporting in relation to the delivery of DSFs, the social work workforce, and also in relation to any responses to media requests regarding these. **You should seek the assistance of the HSCB in OSS's efforts to now clarify the Trusts levels of sickness absence.**
HSCTS/HSCB Domiciliary care packages	The numbers of domiciliary care packages in place (both Care Managed and Non Care Managed) has grown since the previous reporting year, (14.42% and 31.45% respectively). Domiciliary Care packages as percent accounted for 65.53% of all types of all community care packages in 2016-2017, increasing from 59.14% in the previous year. **You should note that HSCB reported that all five HSCTs are experiencing challenges in relation to the provision of domiciliary care services, and that there are understood to be significant pressures across the system in relation to both**
WHSCT/BHSCT Adult Safeguarding	With regards to the numbers of adult safeguarding referrals made in year, the WHSCT and BHSCT are outliers having the fewest (WHSCT 8%) and greatest (BHSCT 45%) number of safeguarding referrals in year respectively. This has been a consistent trend in both the WHSCT and BHSCT in previous DSF reporting years and the HSCB suggest that this pattern is reflective of other trends, such as referral rates for psychological therapies in the WHSCT and BHSCT. This does not appear be borne out by a trend analysis of the referrals rate for social work assessment in the two respective HSCTs during the same period. **You should enquire with the HSCB as to whether any further analysis is required, and whether there are any practice implications arising or not, with regards to implementation of the Adult Safeguarding policy.**
HSCB /HSCTs Deprivation of Liberty Safeguards	The Board overview report notes that declaratory judgements in relation to deprivations of liberty remain an issue for Trusts across Mental health, Learning Disability and Dementia Services. A very conservative estimate considers that 6500 people in N.I. should be considered deprived of their liberty The DoH is liaising with the DoJ to see if it is possible to establish a mechanism for applications to be heard and decided upon using a paper process only. Such a streamlined process would be of significant help in addressing the resource challenges. However, initial indications from the DoJ are that this may not be possible. The DoH is engaged in some early internal discussion about updating the DoH: Deprivation of Liberty Safeguards (DOLS): Interim Guidance 2010 in line with recent judicial developments which would emphasise the requirement on Trusts to seek declaratory judgements to authorise deprivations of liberty. **You should continue to raise with the HSCB and the executive directors their responsibilities to have arrangements in place regarding DOLS, and that while the potential resource implications for Trusts remains a significant challenge, the legal imperative for judicial authorisation in these cases is clear.**

HSCB/HSCTs Article 15 Payments under the Health and Personal Social Services (NI) Order 1972	The Board's statistical report shows considerable variation in the use of this provision with some Trusts making no or very little use of it. You should note that there is an inequity of access to this provision depending on a person's geographical location **You may wish to draw to the attention of the HSCB and Executive Directors their responsibility to ensure equitable arrangements are in place regarding this provision across all HSCTs. Further analysis by the HSCB may be helpful in understanding the significant difference in application.**
HSCB/HSCTs Approved Social Work Workforce	The HSCB reports that the Approved Social Work workforce continues to be under strain. While the number of active ASWs shows a welcome increase this year, these staff are reporting significant stress. Wider systemic issues are a major contributory factor to this stress including difficulties in accessing psychiatric admission beds and the GP, PSNI and NIAS interfaces. Trusts to a greater or lesser degree are finding it challenging to maintain a sufficient ASW workforce. The DoH continues to work on the regulations for the Mental Capacity Act which will specify roles however the current lack of certainty about the future of the ASW role under the Mental Capacity Act is making forward planning for this workforce difficult. OSS is providing professional input into this process. The OSS has put forward a bid under mental health transformation monies for a pilot project which would employ ASW support workers with the dual aims of improving the service user experience of the admission process and improving recruitment and retention of ASWs by providing them with more support. **This issue was identified as a priority by the HSCB following last year's overview report and you may wish to enquire as to how this work has been progressed.** **You should draw to the attention of the executive directors and the HSCB the importance of sharing best practice in relation to ASW recruitment, retention, and regional workforce planning.**

1.4 An analysis of the HSCB Overview Report is available in **TAB B**.

2 SUMMARY

2.4 The HSCB's DSF End Year Overview Report has been analysed by OSS and a number of issues have been identified as areas of concern. It is recommended that you seek clarification from HSCB on those issues escalated to you by way of this submission; that you meet with HSCB to discuss those issues and that a record is kept of that meeting including any actions agreed at the accountability meeting, for monitoring purposes.

3 Recommendations

It is recommended that you:

MAHI - STM - 089 - 6612

i. Note this briefing
ii. Consider the findings based on an analysis of the HSCB DSF report carried out by OSS professional officers **(TAB B)**.
iii. Agree to the recommended actions; and
iv. Arrange to have the letter issued to HSCB **(TAB A)**.

JACKIE MCILROY
Deputy Chief Social Work Officer
Ext: 20729
Copy distribution

cc. OSS Prof Officers/Lorraine Conlon

(TAB A)

From the Deputy Secretary, Social Services
Policy Group/
Chief Social Work Officer
Mr Seán Holland

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

Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Chief Executive, HSCB
Director of Social Care and Children, HSCB

[redacted]

Date: xx November 2017

Dear Colleagues

DELEGATED STATUTORY FUNCTIONS – OVERVIEW REPORT 2016/17

Thank you for receipt of the HSCB DSF End Year Overview Report for 2016/17 received by the Department on 15th September 2017.

I very much appreciated the efforts made by you and your staff to provide the Department with a copy of the draft DSF End Year Overview Report which was received on 25th August 2017. This assisted our internal DSF processes.

I would also like to acknowledge developments in the overall quality of the Overview Report, however, there are some areas which would benefit from further improvement. I look forward to discussing those issues with you in due course.

A number of professional and governance matters have been identified with regards to the delivery of DSF in Children's and Adult Services and these are set out below:

- Information management and the collection of accurate data in respect of DSF overview and statistical reports, Social Work Workforce and BHSCT Unallocated Children's Cases Information.
- Domiciliary care provision
- WHSCT/BHSCT Adult Safeguarding Referrals
- Deprivation of Liberty Safeguards
- Article 15 Payments under the Health and Personal Social Services (NI) Order 1972
- The Approved Social Work Workforce

I am aware that in some areas work is ongoing to progress DSF identified by Trusts/HSCB in the Report, however in line with professional governance and

accountability arrangements I am seeking a meeting with you to discuss the overall performance of Trusts in respect of DSF and to obtain assurance that appropriate actions are being taken to mitigate risks and impacts on service delivery for both users and carers in relation to the provision of social care services.

I have asked my secretary to make arrangements as soon as possible.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer/Deputy Secretary

Cc Chief Executives, HSCTs
Directors of Children's Services/Executive Directors of Social Work, HSCTs
Social Care Governance Leads, HSCB and HSCTs

(TAB B)

DSF Report Card

April 2016 - March 2017

Contents

MAHI - STM - 089 - 6618

Introduction

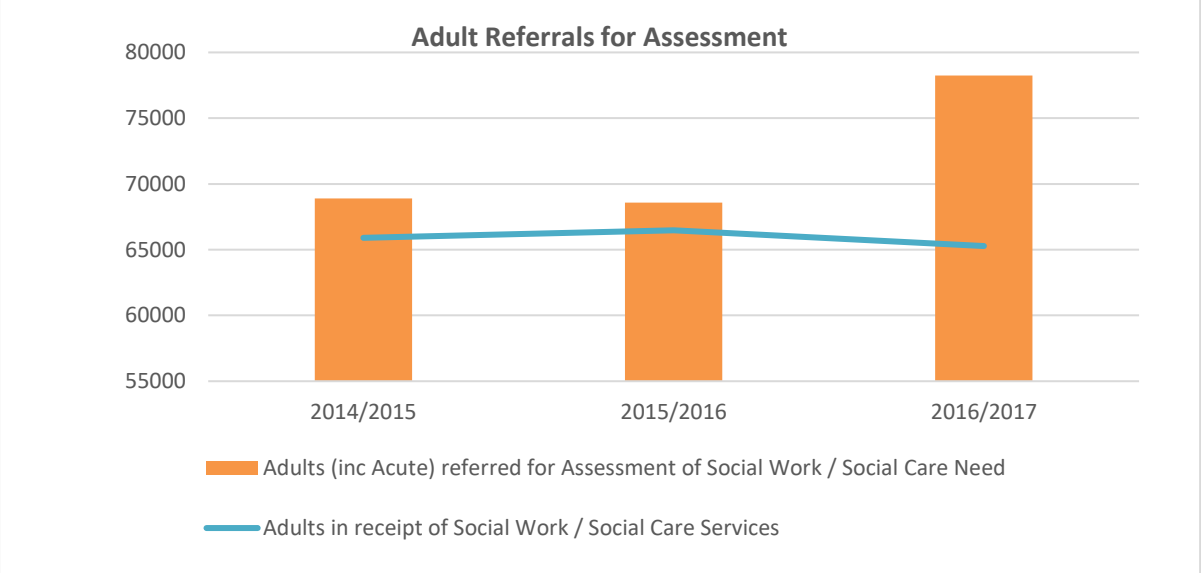
The professional Officers have analysed the HSCB Overview Report for 2016/2017 as set out in the OSS DSF guidelines.
Based on this analysis, Professional Officers have produced a report card highlighting a number of points in relation to;

- Analysis and commentary
- Professional and Governance Issues.

1. Analysis / Commentary

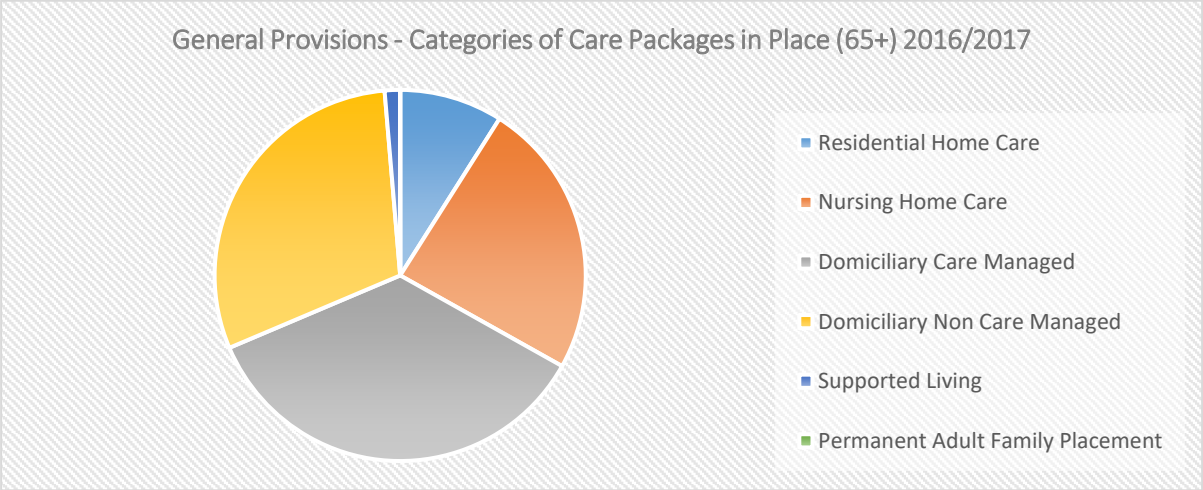
ADULT ANALYSIS / COMMENTARY

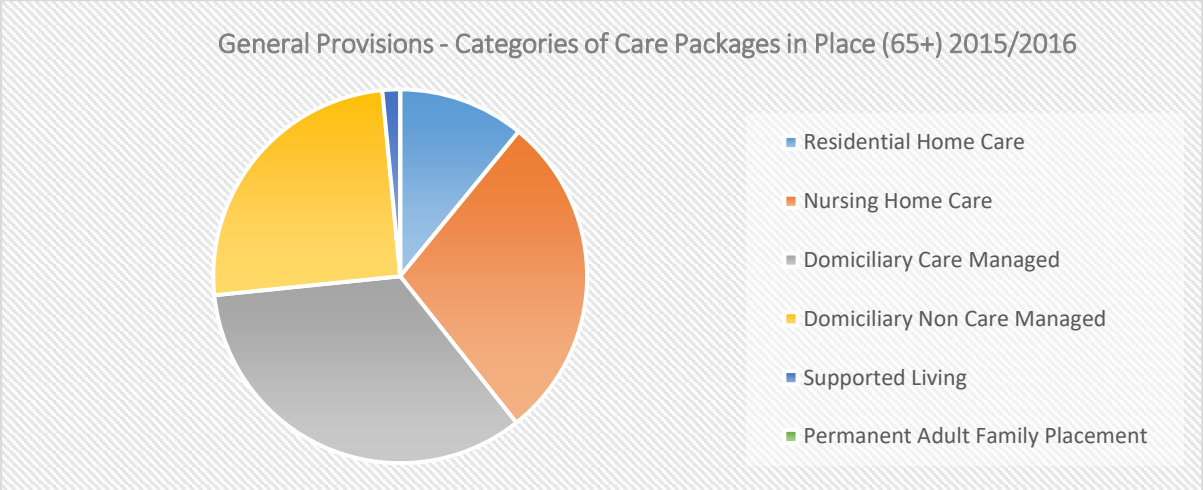
1.1 Adult Referral Assessment



The total number of adults referred to the HSCTs for assessment by social work / social care, has increased considerably in year, rising from *68,585* in 2015/2016 to *78,237* in 2016/2017, an increase in demand for assessment of 14.07%.
During the same period the number of adults receiving social work /social care services has decreased by 1.83%.

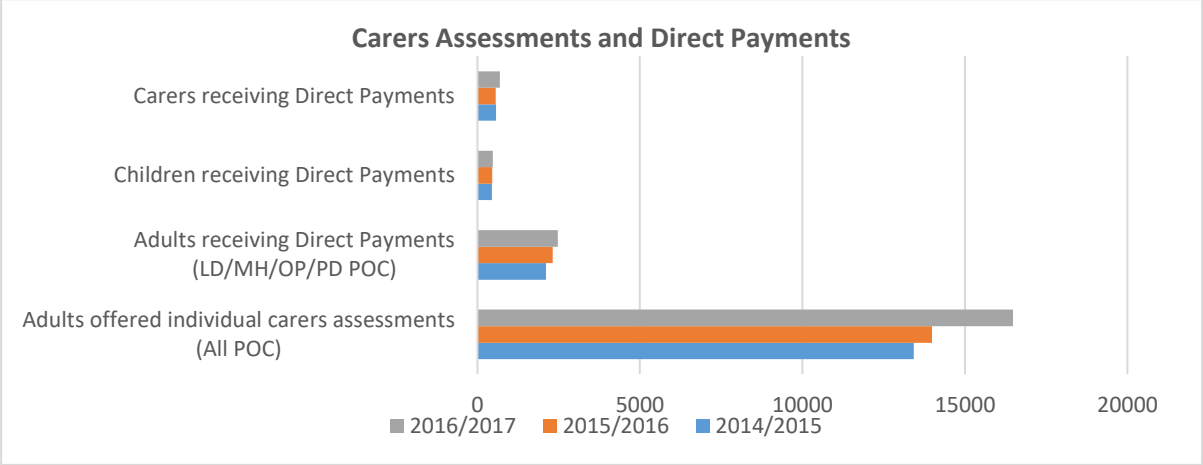
1.2 General Provisions





The numbers of domiciliary care packages in place (both Care Managed and Non Care Managed) has grown since the previous reporting year, (14.42% and 31.45% respectively).
The total number of all types of packages (nursing/residential/domiciliary/supported living/permanent adult family placement) has risen 9.81% in year, to **31,784** packages.
Whilst the amount of domiciliary care packages being provided has increased, there has been a simultaneous decline in the overall number of Residential, Nursing and Supported Living packages being provided.
Domiciliary Care packages accounted for 65.53% of all types of community care packages in 2016-2017, increasing from 59.14% in the previous year.
BHSCT, SHSCT & NHSCT were reported as having particular challenges in relation domiciliary care capacity, and BHSCT, SHSCT and SEHSCT were also reported to have specific challenges in regards to securing packages for adults under 65 with complex needs. However there are understood to be significant pressures in domiciliary care services across all five HSCTs in relation to demand and capacity.

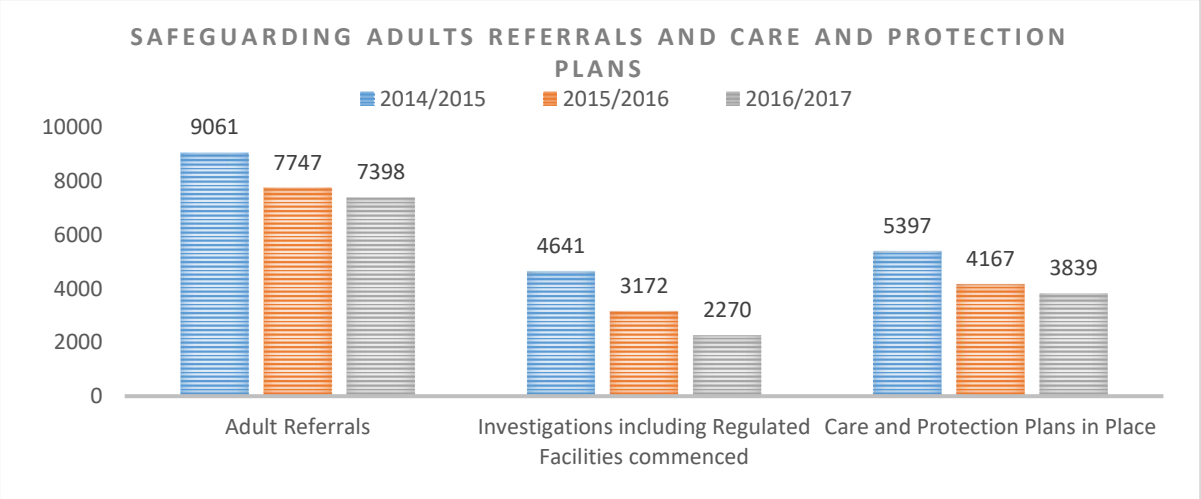
1.3 Carers Assessments and Direct Payments



Whilst there have been large increases in the numbers of domiciliary care packages in place, and also in the numbers of people referred for assessment 2016/17, the HSCB reported a *decrease* in the numbers of people receiving a Direct Payment. This was at variance with the HSCBs own statistical report which reported a small increase. However there were significant gaps and missing data noted in the HSCB and HSCTs statistical returns regarding Direct Payments, particularly in the data provided by BHSCT and SHSCT.

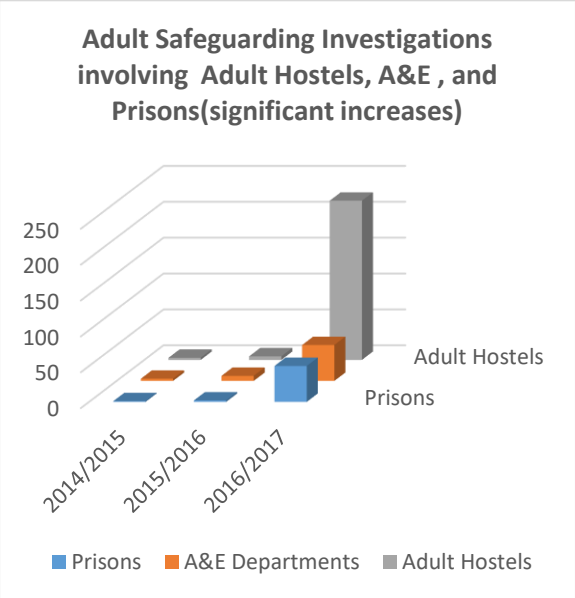
The number of people receiving Direct Payments in the Trusts as a percentage of the total number of adults receiving a social work or social care service is around 6%. This may suggest that as an outcome of social work / social care planning, 3 out of 50 service users may go on to receive a direct payment. Caution is necessary around this given the issues noted with the data, and that SHSCT could not report on the number of new approvals and requests made for direct payments in the year.

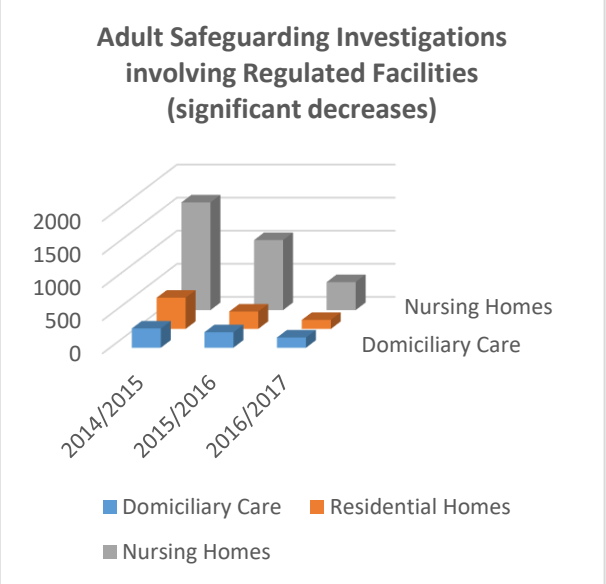
1.4 Safeguarding Adult Referrals



- The Commissioner for Older People in Northern Ireland (COPNI) has conducted an enquiry into a private nursing home on the boundaries of BHSCT and SEHSCT.
  It is understood a draft report is being prepared by COPNI. HSCB have noted that the outcomes of this enquiry are likely to have wider implication across the HSC system.

- Local Concern HUBS - HSCB report they are monitoring the impact on safeguarding referrals to the HSCTs as a result of implementation of multi- agency Local Concern Hubs by PSNI.

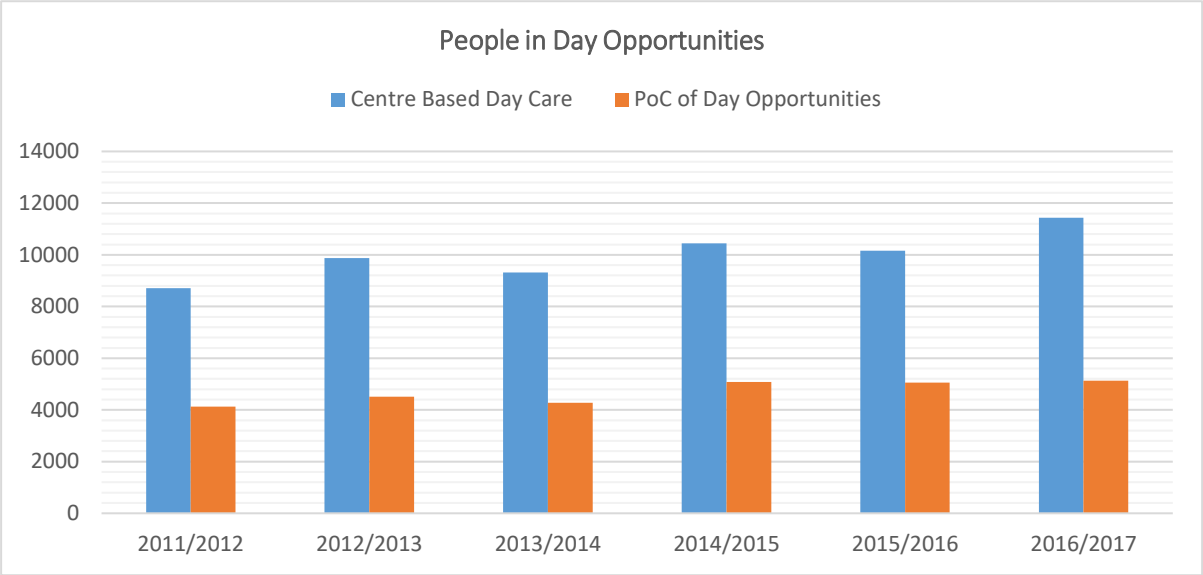




During 2016/17 Prisons, A&E Departments and Adult Hostel all reported a marked increase in the number of Adult Safeguarding Investigations commenced in each of these settings.

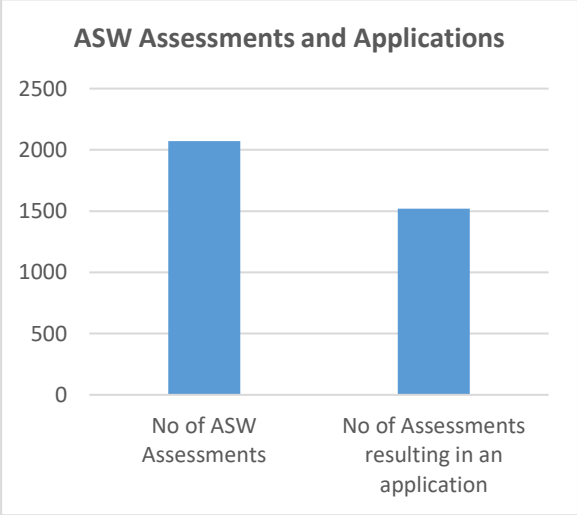
Nursing Homes, Residential Homes and Domiciliary Care settings reported a sharp decrease in the number of Adult Safeguarding Investigations commenced in year.

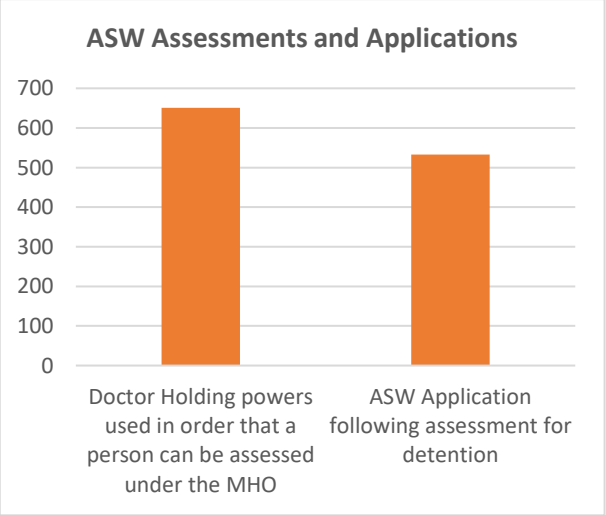
1.5 People in Day Opportunities



There has been a 24% increase over a 6 year period in the number of people accessing day opportunities. This very welcome increase is in line with policy to improve community inclusion. However, there has also been an increase of 31% increase of people accessing more traditional buildings based daycare. This is probably reflective of increased population size and increased complexity of population. It would also suggest the need for ongoing investment and emphasis on the development of day opportunities provision.

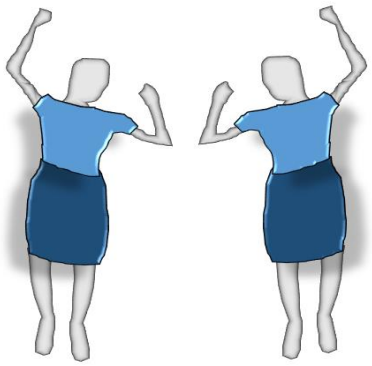
1.6 Independence of ASW Workforce





The figures for compulsory admission for assessment following either an ASW assessment in the community or the use of a doctor's holding powers in hospital continue to show the independence of ASW decision-making. The social model and a human rights informed social work perspective brings balance to the decision-making.

1.7 Service User Engagement and Coproduction



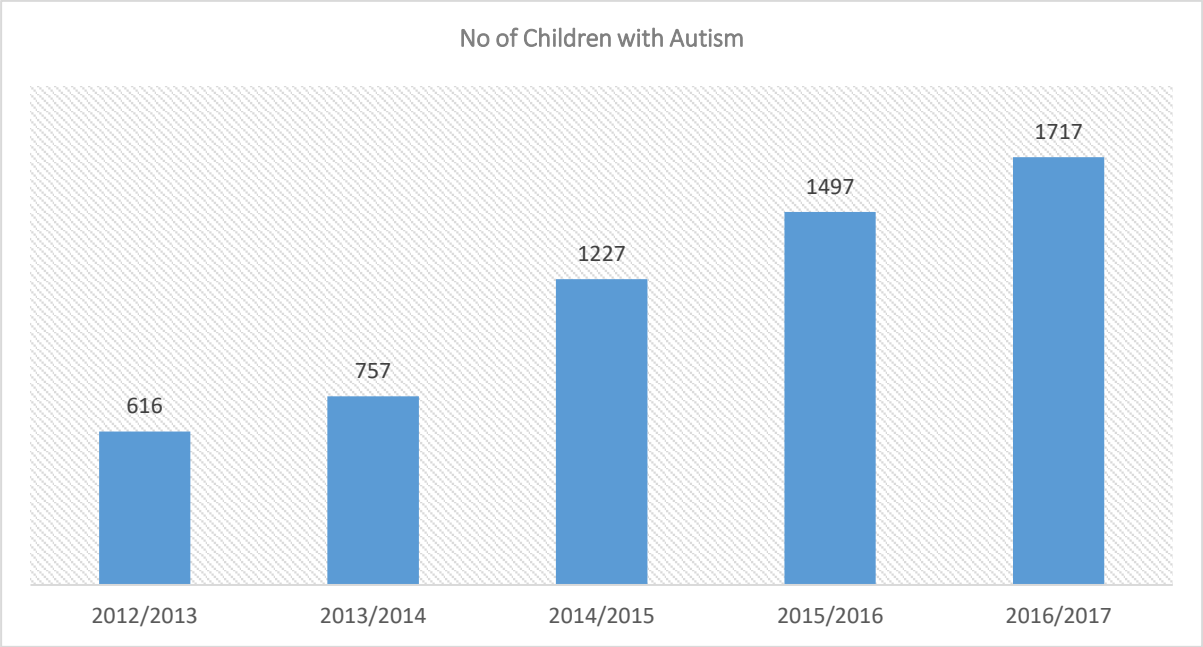
All HSCTs report increased emphasis on working in partnership with services users and carers, examples of this are the peer support workers employed in all HSCTS mental services, developments in day services being widely coproduced, and a reported up take in SDS activity.

1.8 Service Developments

A range of innovative service developments are reported, as the HSCTs strive to improve the quality and effectiveness of their models of delivery. These include the development within particular HSCTSs of, as examples, physical healthcare pathways with people who have mental health problems, the RAID model for people with learning disabilities, the development of primary care aligned integrated care teams, a social work led hospital discharge coordination scheme, and a range of service area specific strategies and action plans.

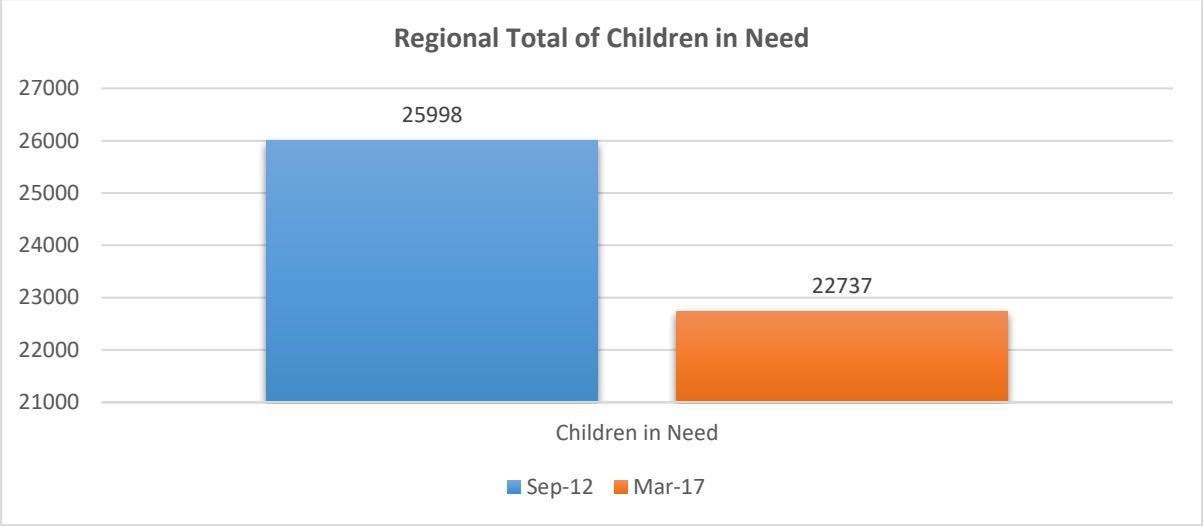
CHILDREN ANALYSIS / COMMENTARY

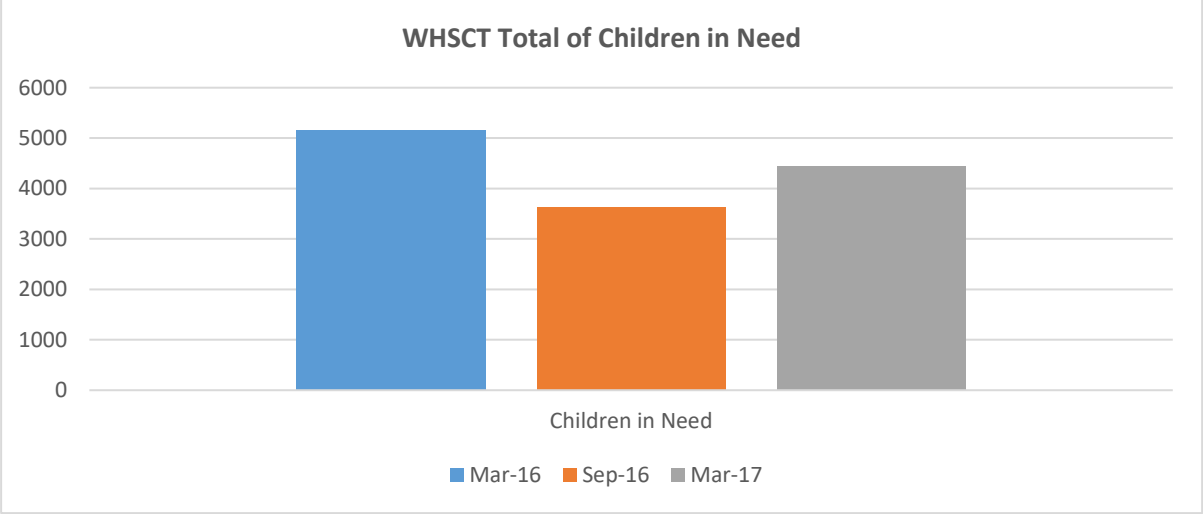
1.9 Children with Autism



The number of children with autism known to Trusts continues to rise with a further increase of 220 children this year. There has been a 179% increase since 2012/2013. The reasons for this continuing increase are believed to be a combination of increased awareness, changes in diagnostic parameters and shifts in demand from one service area to another. An additional £2 million funding was allocated in April 2016 to help address the demand. However, waiting times remain a difficulty. Despite a decrease of 10% in March 2017 on the June 2016 figures, 2019 children were waiting to access Children's Autism Services for diagnostic assessment in March 2017; 1372 of these had been waiting in excess of 13 weeks and 204 had been waiting in excess of 52 weeks. However, the Trusts are continuing to build their service capacity using the additional funding and it is hoped that this will continue to reduce waiting times. The HSCB Overview Report also notes a 17% increase in CAMHS referrals. Work is progressing on a new Neuro-developmental and Emotional Wellbeing Services Framework which will provide for children and young people with neuro-developmental (Autism & ADHD), emotional, behavioural and mental health needs. The framework aims to strengthen the integration of CAMHS, ADHD and ASD services in the first instance but also seeks to strengthen greater partnership and better integrated working across universal and early intervention services. This approach recognises the importance of prevention for developmental and emotional difficulties arising in childhood and the positive impact of timely support.

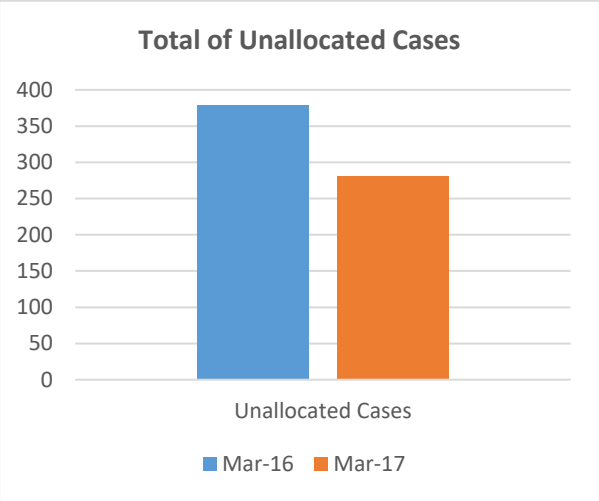
1.10 Children in Need

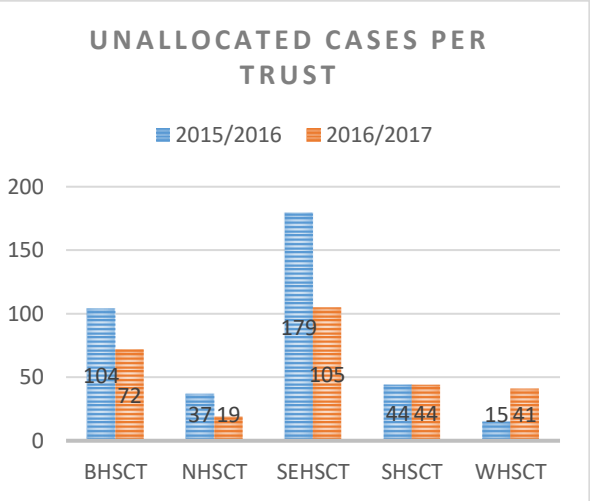




There has been a reduction of 12.5% of the total number of Children in Need from 25,998 in September 2012 to 22,737 in March 2017. This is contrary to the expectation in the context of increasing austerity and contraction of public services.
Within the reporting period the WHSCT recorded a decrease of 1,517 of Children in Need (29.46%) within the 6 month period from March 2016 to September 2016 followed by a subsequent increase to 4,437 in March 2017 (an increase of 22.16% during that 6 month period). An explanation should be sought for this significant variation.

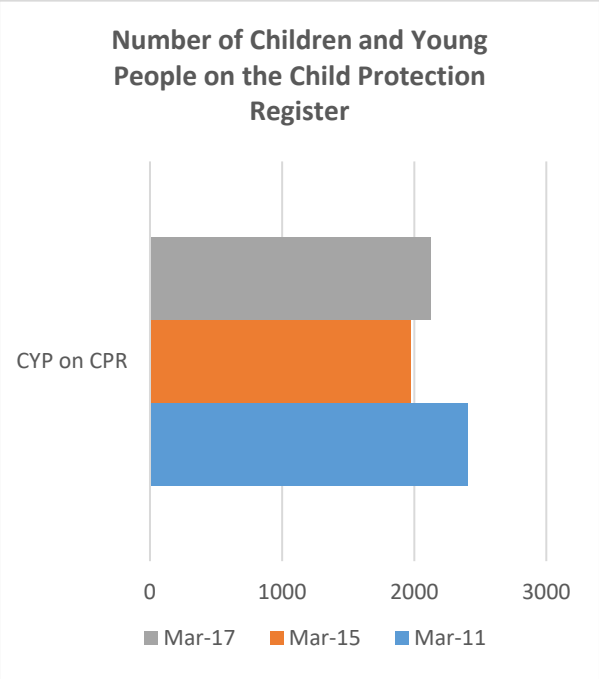
1.11 Unallocated Cases





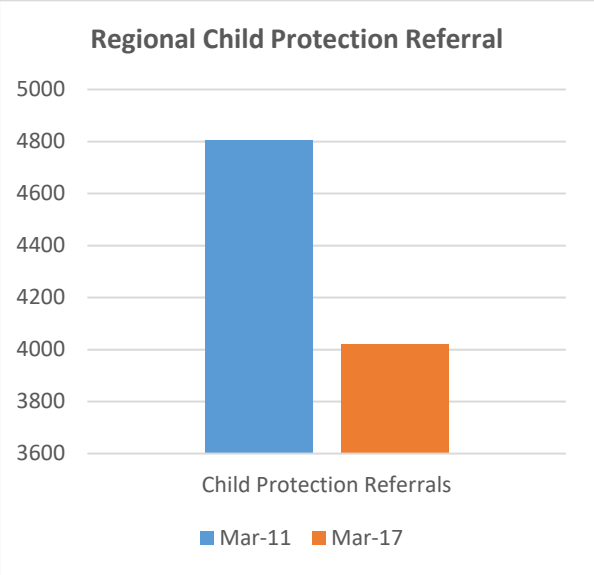
HSCB had undertaken a programme of work on a regional basis with the five HSC Trusts to achieve a sustainable decrease in the number of Unallocated Children's Cases.
There has been a reduction by 26% from 379 to 281 in the number of Unallocated Cases overall within the region from March 2016 to March 2017.
Three out of the five Trusts have seen a reduction in their numbers and the SHSCT numbers have remained static.
The WHSCT is the only Trust were there numbers of Unallocated Cases have risen in the year from 15 to 41; this is an increase of 173.33%.
The SEHSCT remains significantly higher than the other Trusts in their total of Unallocated Cases. In March 2016, the SEHSCT had 179 Unallocated Cases which accounted for 47.23% of the Region's Total and in March 2017 they had 105 that accounted for 37.37%. In the reporting Period there has been a 41.34 % reduction in SEHSCT's total from 179 to 105.
This issue has been previously raised with the HSCB and the SEHSCT and assurances should be sought that actions continue to be taken to address this issue with SEHSCT.

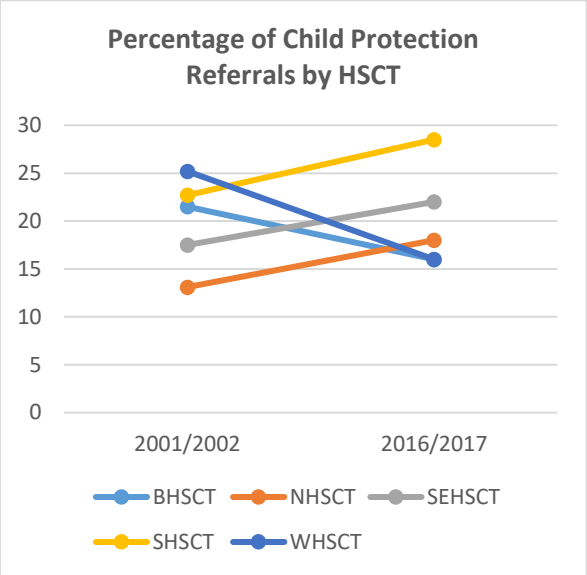
1.12 Child Protection Register



The number of children and young people on the Child protection Register fell 18% from 2,401,in March 2011 to 1,969 in March 2015 with a subsequent increase of 9.6% to 2,123 in March 2017.
Of those children's names included on the Child Protection Register between 1 April 2016 and 31 march 2017, 18.5% of the children or young people names have been on the Child Protection Register previously.
Assurances should be sought from HSCB that Child Protection thresholds are adequately and consistently applied within and across the 5 HSCTs, that Child Protection plans are sufficiently robust to afford necessary protection to children and young people and that it understands the reasons for the high incidence of re-registration to the Child Protection Register.

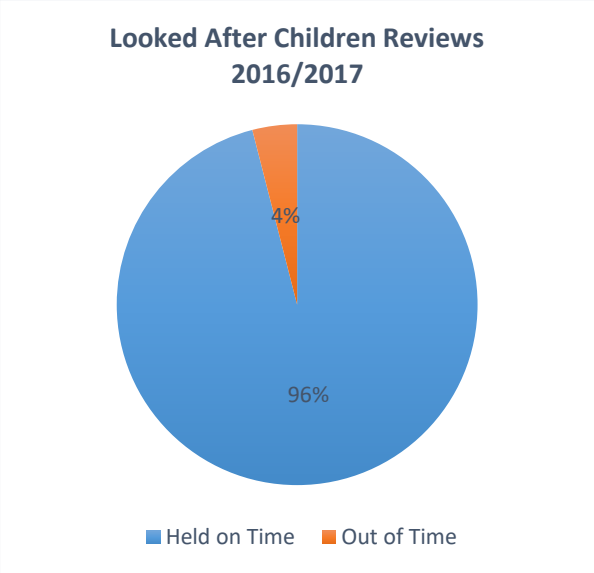
1.13 Variations in Child Protection activities between HSC Trusts





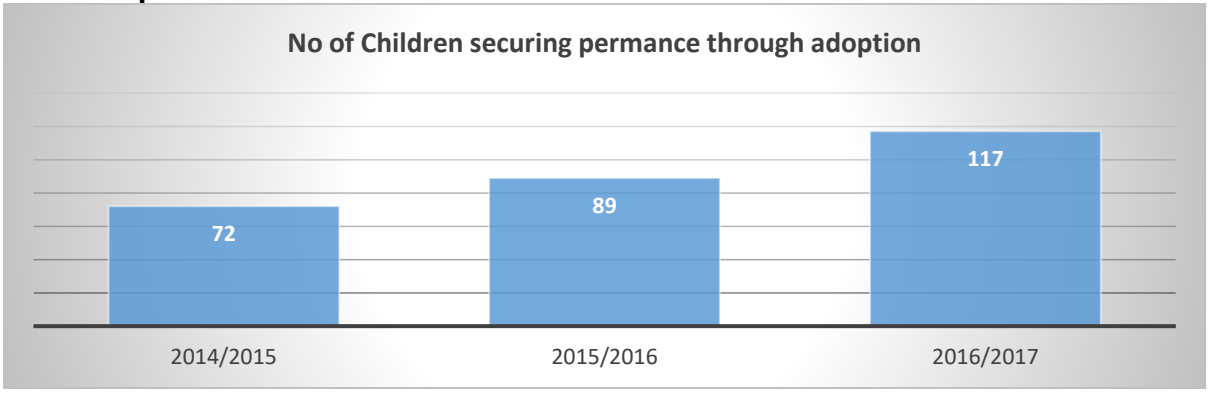
The number of Child Protection Referrals has fallen from 4,804 in 2010/11 to 4,021 in 2016/17, a reduction of 16.30%.
Since 2001/2002 the NHSCT, SEHSCT and SHSCT have seen a rise in their percentage share of the total number of Regional Child Protection Referrals whilst the BHSCT and WHSCT have seen a reduction. The SHSCT have had the biggest increase of 5.8% of the Region's total number of referrals. The biggest drop of percentage of referrals in a Regional context is 9.2% within the WHSCT.
This may give rise to questions in relation to the consistency of applications of Child Protection "thresholds" across the 5 HSC Trusts.

1.14 Looked After Children Reviews



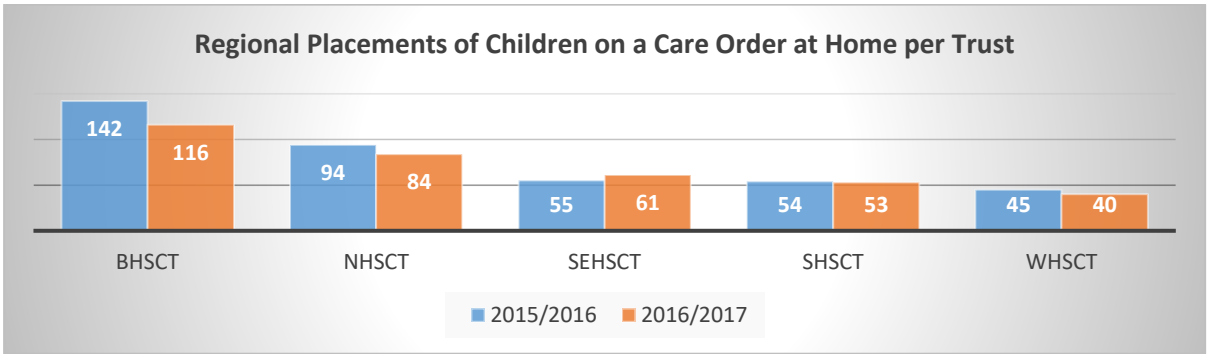
96% of Looked After Child Reviews were held within the required Statutory Timeframes and all looked After Child had an allocated Social Worker.
This evidences a continued high level of compliance with the statutory Looked After Child requirements within the HSC Trusts.

1.15 Adoption



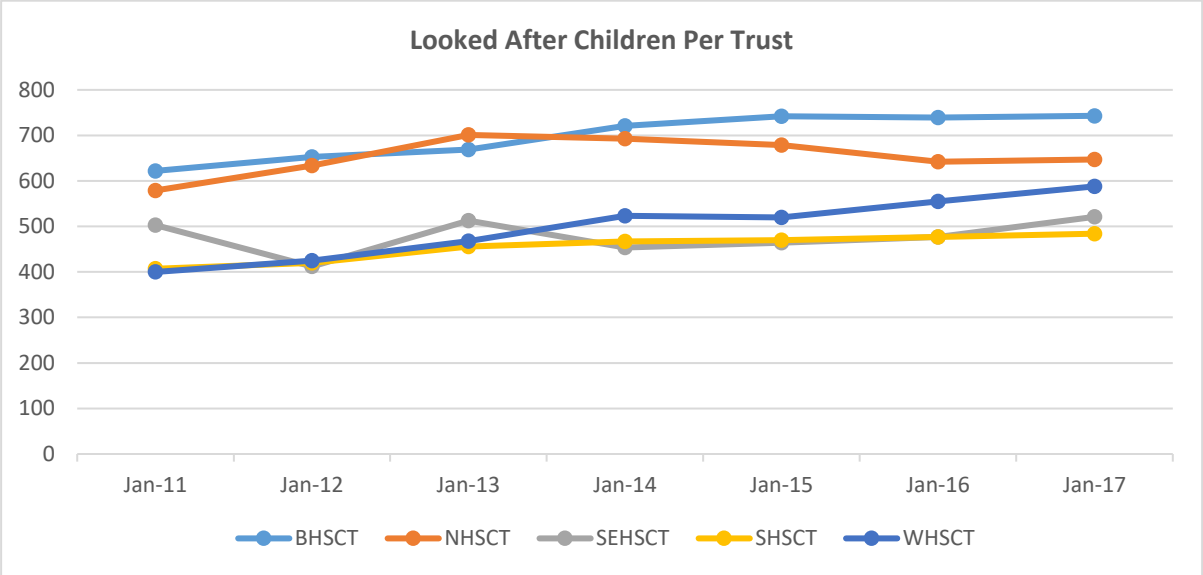
In 2016/2017, 117 Looked After Children secured permanence through adoption. This represents a 31.46% increase in the numbers of Looked After children who were adopted in 2015/2016 and seems likely to be in part attributed to the Early Intervention Transformation Programme's Regional Home on Time Programme.
Whilst this is a positive permanency outcome, the outcome may decrease in coming reporting period, due to an increased focus on permanency for children through Kinship Care planning arrangements.
Adoption Enquiries decreased from 543 to 383 and number of families approved to Adopt decreased from 134 to 120.
WHSCT had highest number of Freeing Orders at 22 (HOT influence). 3 out of 79 applications for freeing orders were not granted.
3 children from BHSCT and 2 from SEHSCT have been freed but not placed for Adoption on 31.03.2017 (3 of these children waiting over 1 year for placement). Specialist recruitment needed.
Number of Freeing Orders granted down from 102 to 79.
516 children in receipt of Adoption Allowance (66 of these commences during 2016/2017 year).
Adoption support in general is an issue that will be addressed via Adoption and Children Bill. HSCB undertaking work to quantify anecdotal evidence re more Adoption Disruptions.

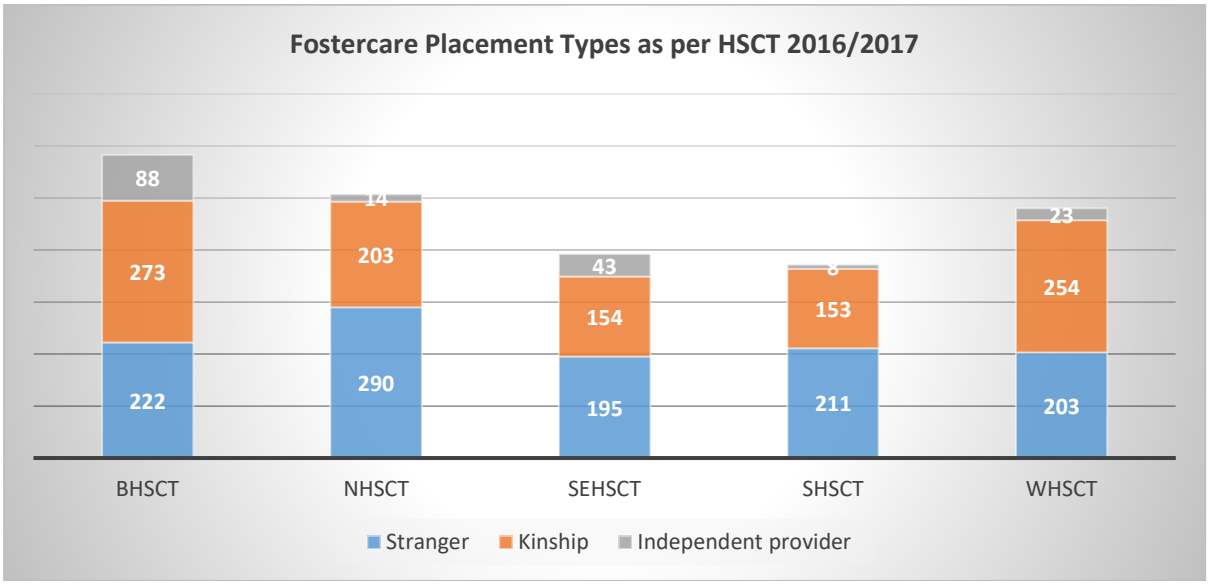
1.16 Children subject of a Care Order placed with parents



There are 364 (12.2%) Looked After Children on a Care order recorded as being Placed at Home with a Parent in the 2016/2017 period. This a decrease of 26 placements from the previous year.
Following concerns about the significant numbers Placed with Parents last year, DoH undertook an audit in respect of these placement as of 31/12/2016 - The figures for end of March 2017 show a slight increase from end December of 18 children. Further clarification in respect of some information contained in the audit has been sought through HSCB. It is of note that 89 of 859 children admitted to care during 01.04.2014-31.03.2017 were "placed with parents" - presumably Care Orders granted while they remained "Placed with parents". 42 of 89 where aged under 5.
The BHSCT and NHSCT are responsible for 31.86% and 23.08% respectively for the regional total of Care Order Placements at Home with a Parent.
The BHSCT, NHSCT and WHSCT reported a drop in their figures from 2015/2016, were the SEHSCT and SHSCT reported an increase in their figures from 2015/2016.
Additionally there has been any increase of 18 children/young people (14 from September to March) deemed to be in an inappropriate placement. SEHSCT have 16 such placements and WHSCT have 18.

1.17 Looked After Children





The volume of Looked After Children has steadily increased since 2011. As of 31st March 2017, 78% of LAC are placed in fostercare, 35% of placements were in Kinship fostercare.
BHSCT has the highest number of Kinship Foster Placements at 273, with WHSCT second highest at 254.
In summary, 44% of LAC are placed Trust 'stranger' foster carers or independent providers. As the number of Kinship fostercarers has reached its highest, it may be time to review the arrangements for supporting these carers and children, particularly in BHSCT and WHSCT. Additionally as 12.2% of LAC are "Placed with Parents" the level of support for these children and parents may need further scrutiny.
In relation to fostering assessments, BHSCT undertook the greatest number of assessments. 71 Kinship and 72 non-kinship. WHSCT undertook 89 kinship assessments and 24 non-kinship in the reporting period.
Within the reporting period, the issue of unregulated placements has already been the subject of a letter from the CSWO to the HSCB.

2. Professional and Governance Issues

This section provides further analysis of the issues that are recommended for escalation to the Chief Social Work Officer.

1. **Social Work Workforce**

   There may be an emerging issue in relation for the amount of sick leave taken by Social Workers in HSC Trusts. This has come to light as a result of a planned media item that has not as yet aired. In response to a FOI request from the BBC all of the Trust's Corporate Information Branches provided data on Social Workers' absences from work due to sick leave. The request sought more detail on the proportion of sick leave that related to mental health issues. It is not known what led to the request for this information.

   Initial examination of the data provided by Trusts to the BBC suggest some substantial inaccuracies, leading to erroneous and inflated figures. OSS is currently attempting to obtain an accurate picture of the situation, and more information will follow once it has been verified.

2. **BHSCT Unallocated Children's Cases Information**

   BHSCT's Risk Register indicates that the Trust cannot stand over the veracity of its DSF Information. We had followed up a query with BHSCT re its reported Unallocated Children's Cases Information Oct / Nov / Dec 2016 / Jan 2017 as the reported number was the same for each month and our query resulted in us discovering (from Excel Spreadsheet provided by the Trust) that "Numbers copied from last month as current numbers unavailable".

3. **Domiciliary care packages**

   The numbers of domiciliary care packages in place (both Care Managed and Non Care Managed) has grown since the previous reporting year, (14.42% and 31.45% respectively). The total number of care packages has risen 9.81% in year, to 31,784 packages. Whilst the amount of domiciliary care packages being provided has increased, there has been a simultaneous decline in the overall number of Residential, Nursing and Supported Living packages being provided.

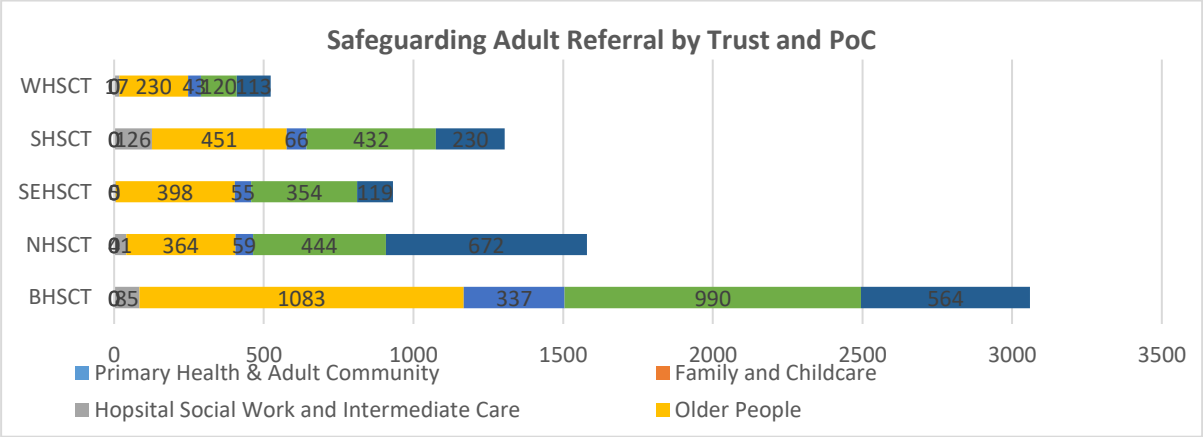
Domiciliary Care packages as percent accounted for 65.53% of all types of care packages in 2016-2017, increasing from 59.14%

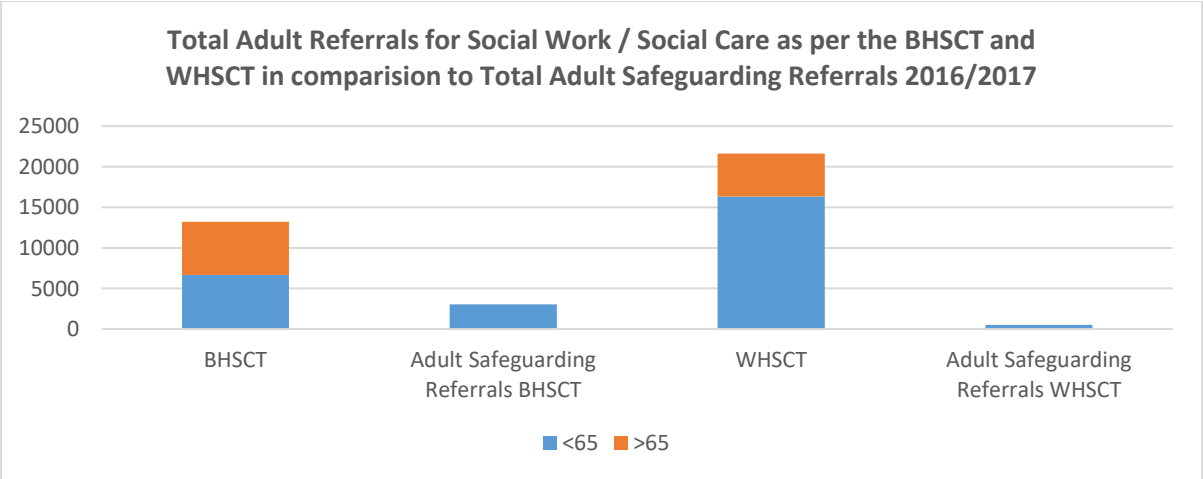
The BHSCT, SHSCT and SEHSCT had specific challenges in regards to securing packages for adults under 65 with complex needs.

4. Adult Safeguarding WHSCT /BHSCT

With regards to the numbers of adult safeguarding referrals made in year, the WHSCT and BHSCT are outliers having the fewest (WHSCT 8%) and greatest (BHSCT 45%) number of safeguarding referrals in year respectively. This has been has been a consistent trend in both the WHSCT and BHSCT in previous DSF reporting years, and further analysis would be required in order to understand this.

HSCB suggest that this pattern is reflective of other trends, such as referral rates for psychological therapies in the WHSCT and BHSCT. However this does not appear be borne out by a simple trend analysis of all referrals made for social work assessment in the two respective HSCTs during the same period.





5. Deprivation of Liberty Safeguards

The Board overview report notes that declaratory judgements in relation to deprivations of liberty remain an issue for Trusts across Mental health, Learning Disability and Dementia Services.

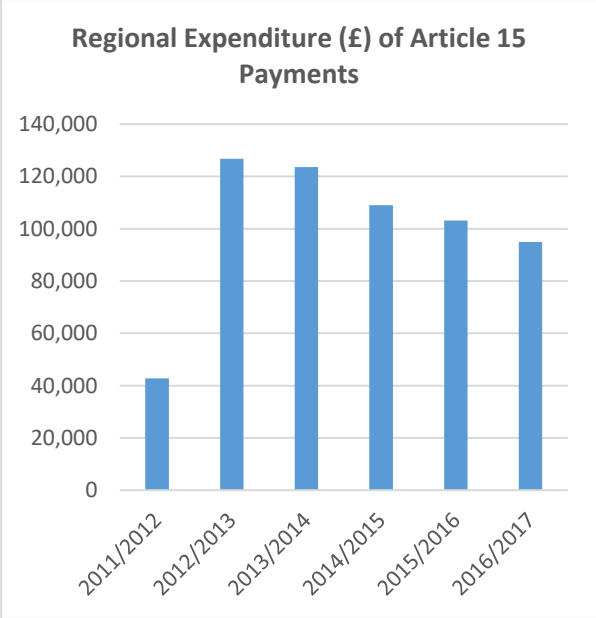
The High Court in N.I. has this year given declaratory judgements in a number of cases to provide legal authority for Trusts' actions in depriving someone of their liberty. This has clearly established the jurisdiction of the High Court to do so in the absence of any other statutory framework that could provide legal authority. Furthermore, the Mental Health Review Tribunal has made it very clear that it does not have the power to authorise a deprivation of liberty where this might form part of a care plan under guardianship.

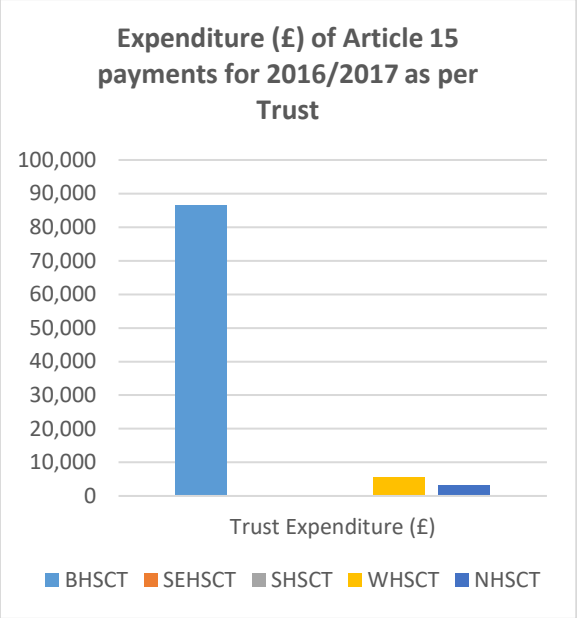
While the legal imperative for judicial authorisation in these cases is clear, the resource implications for Trusts and the courts remain a significant challenge. A very conservative estimate considers that 6500 people in N.I. should be considered deprived of their liberty as per the Cheshire West criteria.
The Mental Capacity Act will provide a statutory framework that will address the current gap in legislation but the provisional implementation date is April 2020.You should note that the DoH is liaising with the DoJ to see if it is possible to establish a mechanism for applications to be heard and decided upon using a paper process only. Such a streamlined process would be of significant help in addressing the resource challenges. However, initial indications from the DoJ are that this may not be possible.

The DoH is giving some consideration to updating the DoH Deprivation of Liberty Safeguards (DOLS): Interim Guidance 2010 in line with recent judicial developments which would emphasise the requirement on Trusts to seek declaratory judgements to authorise deprivations of liberty.

6. Article 15 Payments under the Health and Personal Social Services (NI) Order 1972

The Board's statistical report shows considerable variation in the use of this provision with Belfast Trust making the most use of this provision, the Southern trust making no use of it and other Trusts making very little use of it.



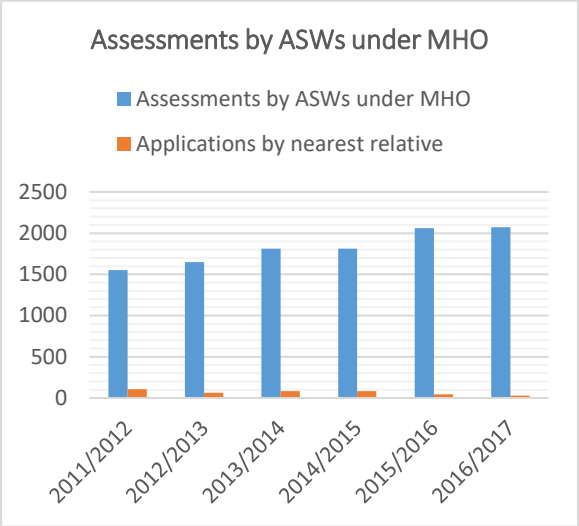


7. Approved Social Work

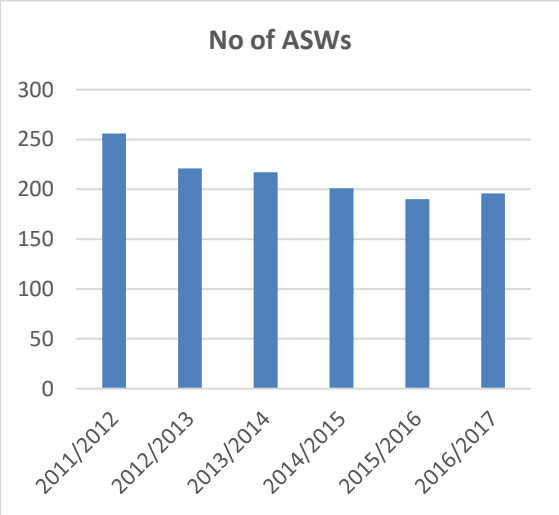
The Board overview reports that the Approved Social Work workforce continues to be under strain. While the number of active ASWs shows a welcome increase this year, these staff are reporting significant stress. Wider systemic issues are a major contributory factor to this stress including difficulties in accessing psychiatric admission beds and the GP, PSNI and NIAS interfaces. Trusts to a greater or lesser degree are finding it challenging to maintain a sufficient ASW workforce. The current lack of certainty about the future of the ASW role under the Mental Capacity Act is making forward planning for this workforce difficult.

The OSS has put forward a bid under mental health transformation monies for a pilot project which would employ ASW support workers with the dual aims of improving the service user experience of the admission process and improving recruitment and retention of ASWs by providing them with more support. The OSS has begun a process of engaging with the HSCB and the Trusts to share

good practice in relation to ASW recruitment and retention and to support regional planning in this regard.



There has been a steady increase in the demand for the ASW service. A proportion of this is explained by a decrease in the number of nearest relative applications. However, this by no means explains all of the increase. The increase evidences the pressures reported by the Trusts in relation to the provision of an ASW service, the availability of psychiatric admission beds and an increase in the acuity of the admission population. This trend requires ongoing monitoring and service planning.



The 2016/2017 reporting year has shown a small but welcome increase in the total number of ASWs for the first time since 2011/2012. Trusts have been working to address ASW capacity issues with some success. However the demand for an ASW service continues to rise as shown in the table above and the service as a whole remains under significant pressure.

8. HSCB/HSCTs DSF overview and statistical reports

The data contained in this year's HSCB overview and the statistical reports presented some quality issues with regards to both accuracy and completeness. Problems with data collection were acknowledged by the Trusts and the Board, and their plans to address the difficulties largely through IT solutions are noted in the overview report.

MAHI - STM - 089 - 6636