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

HSC BOARD MEMBER HANDBOOK

A resource to support the delivery of safe and effective care

May 2021

Foreword from Robin Swann MLA

Minister of Health

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

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

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

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

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

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

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

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

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Preface

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

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

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

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

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

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

Solihull Hospital Kennedy Breast Care Review 2013

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

> *"Building a culture where the natural response to error is to learn from it is …the responsibility of leadership at every level. Change in culture will take time and expert leadership.*
>
> *The directors of each HSC Trust now have the major role to play in achieving the appropriate learning culture within each organisation. The best leadership is critical and there should be investment in the best.*
>
> *The Permanent Secretary observed that 'leadership is not about position, it's about behaviours that drive each individual to do the right thing all the time…' I believe that to achieve the 'right thing' that there should be visible leadership at every level of an organisation. Leaders at all levels and especially at Board level must not be inaccessible. They should do more than appear on the occasional senior management walk-round."*

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

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

HSC Board Member Handbook

SECTION 1: Introduction

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

In this introductory section, you can find information on:

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

1.1 Structure of the HSC system in Northern Ireland

1.1.1 Northern Ireland Assembly and Health Committee

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

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

Programme for Government

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

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

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

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

1.1.2 Department of Health including the Minister and Permanent Secretary

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

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

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

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

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

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

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

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

1.2 Appointment of HSC Non-Executive Board Members

1.2.1 Representing the interests of the Minister

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

1.2.2 Appraisal and reappointment to the Board

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

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

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

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

1.3 Legal framework

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

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

1 Under review in 2019 and subject to change.

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

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

The Reform Act defines HSC bodies as:

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

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

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

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

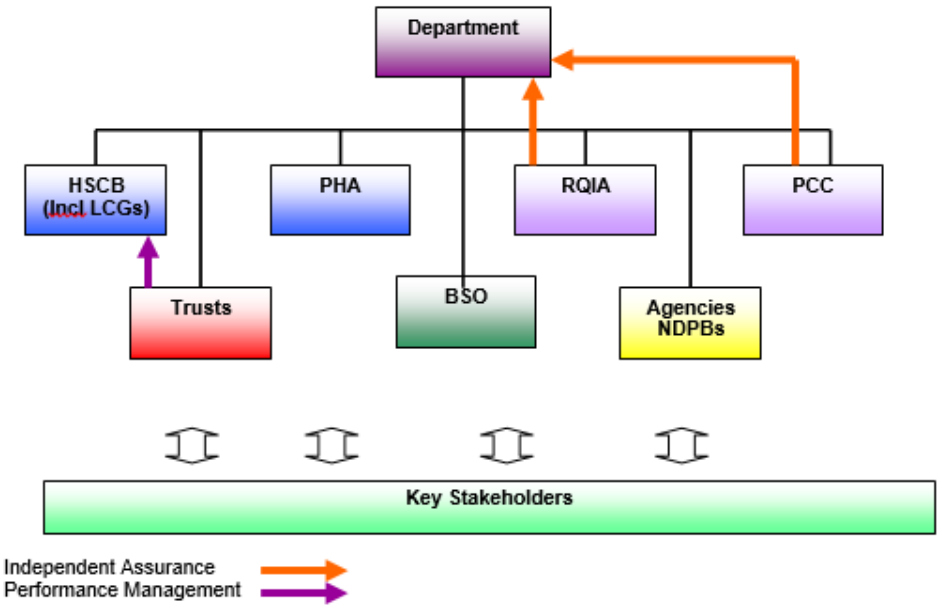


Figure 1: Structure of the Health and Social Care system

The Framework can be found here.

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

Definitions

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

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

1.3.2 Health inequalities

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

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

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

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

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

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

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

1.4 HSC ALBs

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

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

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

1.4.1 Health and Social Care Board

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

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

1.4.2 Regulation and Quality Improvement Authority

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

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

1.4.3 The Patient and Client Council

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

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

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

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

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

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

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

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

1.4.4 Northern Ireland Social Care Council

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

1.4.5 Health and Social Care Trusts

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

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

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

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

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

1.5 Accountability within HSC system

1.5.1 Accountability of HSC organisations

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

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

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

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

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

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

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

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

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

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

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

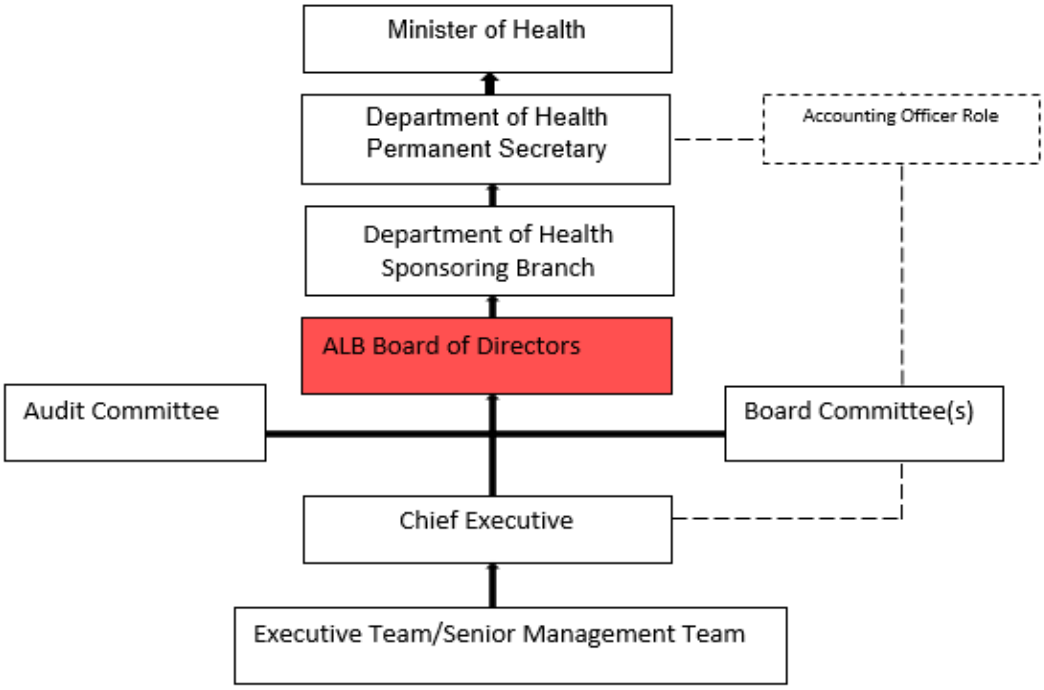


Figure 2: Accountability process for HSC ALBs

1.5.2 Autonomy for ALBs

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

Proportionate autonomy

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

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

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

1.5.3 Accountability of individual HSC Board Members

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

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

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

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

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

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

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

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

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

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

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

Comply with the charity's governing document and the law

Trustees must:

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

Act in the charity's best interests

Trustees must:

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

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

Manage the charity's resources responsibly

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

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

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

Act with reasonable care and skill

As those responsible for governing a charity, Trustees:

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

Ensure the charity is accountable

Trustees must ensure compliance with statutory accounting and reporting requirements. Trustees should also:

- Be able to demonstrate that the charity is complying with the law, is well run and effective;
- Ensure appropriate accountability to members (if the charity has a membership separate from the Trustees); and
- Ensure accountability within the charity, particularly where Trustees delegate responsibility for particular tasks or decisions to staff or volunteers.

Any breach of these legal responsibilities could have serious consequences for a Trustee personally.

Likewise, Board Members who are nominated as Directors to any organisation constituted as a company will have legal duties as Directors.

It is essential that anyone appointed to a charity or separate company by reason of their role as a Board Member (or staff member) of an ALB receives induction and ongoing training on their roles and responsibilities. If a Board Member is in any doubt as to their position, they should take legal advice and discuss with their Chair.

1.6 Strategic documents and founding legislation

- HPSS (NI) Order 1991 establishment of the Health and Social Services Boards and Trusts then augmented by;
- HPSS (NI) Order 1994 (to include the Scheme of Delegation of Statutory Functions);
- HPSS Quality, Improvement and Regulation (NI) Order 2003 defined the arrangements for improving the quality of provision measured through clinical and social care governance;
- Quality Standards for Health and Social Care-Supporting Good Governance and Best Practice in the HPSS (DHSSPS, 2006); and
    - Departmental Circular, HSS (Statutory Functions) 1/2006;

- Health and Social Care (Amendment) Act (Northern Ireland) 2014 to properly reflect the purpose of the Business Services Organisation;
- DoH Integrated Governance Handbook February 2006; and
- The New Integrated Governance Handbook 2016: developing governance between organisations (GBO) by Dr John Bullivant Chairman GGI.

1.7 A Strategic Framework for Rebuilding Health and Social Care Services June 2020

COVID-19 posed unprecedented challenges for the HSC system in 2020, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within Health and Well-being 2026: Delivering Together. This is against a backdrop of financial constraints and single year budgets. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

The impact of COVID-19 on HSC has been profound and will be long lasting. Services have not able to resume as normal for some time due to the continued need to adhere to social distancing and for personal protective equipment (PPE) at volumes not required prior to the pandemic. The Department has collated a comprehensive assessment of the impact of COVID-19 across primary care and community services; secondary care; and a wide range of programmes and projects. This detailed assessment can be found here.

Other strategic documents – Health and Well-being 2026: Delivering Together

1.8 HSC governance during the COVID-19 pandemic

Given the unprecedented challenges posed by COVID-19 a number of changes to the governance framework have been implemented. The Department, through temporary amendments to the framework document, and the establishment of a **new management Board**, will give clear direction to the HSCB, Public Health Agency, HSC Trusts and the Business Services Organisation to reflect the Minister's priorities. In addition, the Minister will meet with the Chairs of the respective organisations on a regular basis to ensure that Non-Executive colleagues are clear as regards ministerial priorities, and have the opportunity to raise any areas of concern.

These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision-making in rebuilding HSC services.

The rebuilding of services will take some time and will require a response that is both agile and adaptable to ensure the system can respond to further surges of COVID-19, whilst optimising its ability to stabilise and move forward. The HSC system will continue to be significantly constrained in the delivery of services due to the ongoing prevalence of COVID-19. In this context the analysis of performance levels against pre-COVID-19 indicators and targets would be not be an appropriate basis for performance monitoring and management in the current environment.

The performance targets will therefore need to be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

1.9 HSC Board Members

All Board Members of HSC organisations have a crucial role to play in ensuring that their organisation is run efficiently and effectively and delivers high-quality health and care services. You have been appointed as a Board Member to bring your personal expertise and experience to the boardroom and you are personally as well

as corporately responsible for your actions and decisions as a Board Member. To facilitate the effective participation of HSC Board Members in the discharge of their responsibilities, this HSC Board Member Handbook includes the following information.

Leadership (section 2)

A summary of the HSC Collective Leadership Strategy and key role for HSC Board Members in developing maintaining a leadership culture as well as promoting openness and candour.

Roles and responsibilities of HSC Board Members (section 3)

What you do as an HSC Board Member and the specific accountabilities of Boards as well as a set of principles for how Board Members undertake these responsibilities.

Assurance and scrutiny (section 4)

The most comprehensive section of the handbook with information on: duty of quality; quality improvement and measurement; quality and safety; clinical governance, social care governance risk management; financial stewardship; being open and the duty of candour; internal and external involvement; professional regulation; scrutiny and challenge. For each of these, prompts are given to assist Board Members in exercising their scrutiny function.

Case examples (section 5)

Case studies are set out in summary, representing different aspects of good governance that enables Board Members to consider their role in scrutiny and assurance. Tips and prompts are provided.

Training and development (section 6)

Requirements for induction and continuous development for HSC Board Members. This section provides checklists of the areas to be covered, the aspects of appraisal and development of a personal development plan. It also provides information on self-assessment for HSC Boards.

HSC Board Member Handbook

SECTION 2: Leadership and culture

2.1 HSC Collective Leadership Strategy

The importance of leadership in HSC services has been highlighted by many reports and recommendations during recent years. As a response to this, the Northern Ireland Executive committed itself to:

> *"Develop an HSC-wide leadership strategy, to consider a five year approach and plan for development of collective leadership behaviours across our system".*

Health and Well-being 2026: Delivering Together (October 2016)

As a result, the HSC Collective Leadership Strategy[5] was launched in 2017. Based on evidence from the best-performing HSC organisations, it has identified leaders who have prioritised the development of a **common vision** for the service and focused on high-quality compassionate care and support.

Such organisations are characterised by a culture of collective leadership 'a community of leaders' as opposed to command and control. It also shows that it is **compassionate** leadership behaviours combined with a strong focus on quality improvement that creates cultures where people who work across Health and Social Care are able to deliver high-quality, continually improving, compassionate care and support.

The HSC Collective Leadership Strategy consists of four components

- Leadership is the responsibility of all;
- Shared leadership in and across teams;
- Interdependent and collaborative leadership; and
- Compassionate leadership.

5 HSC Collective Leadership Strategy Department of Health 2017

Figure 3: HSC Collective Leadership Strategy components

2.1.1 Leadership is the responsibility of all

The leadership task is to ensure direction, alignment and commitment within teams and organisations. Collective leadership means that all share in leadership responsibility across the organisation to ensure commitment comes from everyone in the organisation.

Each individual takes responsibility, with a knowledge and understanding of the common vision, and makes it a personal priority to ensure the success of the organisation as a whole, rather than focusing only on their individual or immediate team's success in isolation.

In practice, this means that those leaders in formal roles must create the conditions in which power, authority and decision-making are distributed to all levels within and across the organisation. In developing leadership at all levels people need to be informed, enabled and empowered to deliver high-quality, continually improving, compassionate care and support.

2.1.2 Shared leadership in and across teams

Increasingly healthcare has to be delivered by an interdependent network of teams and organisations. This requires that leaders work together, spanning boundaries both within and between organisations, prioritising overall patient care rather than the success of their component of it. That means leaders working collectively to build a cooperative, integrative leadership culture – in effect, collective leadership at the system as well as organisational level.

> *"Collective leadership requires the development of shared leadership within teams and across teams based on open and supportive communication, candid and mutual feedback and agreed, shared and challenging goals. This builds communities of teams and creates a culture that values differences and enables decision-making at the closest point of contact with the users by teams rather than just individuals.*
>
> *Within teams there is a need to create a cohesive, optimistic and effective environment that stimulates and supports innovation, continuous learning and improvement."*

HSC Collective Leadership Strategy

2.1.3 Interdependent, collaborative leadership

Rapid innovation and adaptation to change require a collaborative, interdependent culture and solutions that cut across function, region, and profession. Leaders must learn to shift away from the 'individual expert' model so common in today's healthcare systems and move towards a model that works across boundary groups and teams and spans disciplines, levels, functions, generations, and professions.

> *"These new collaborations will be able to integrate knowledge throughout the system and to anticipate and solve unprecedented*

challenges — all while delivering efficient, high-quality, compassionate patient care across the continuum.“ [6]

Centre for Creative Leadership 2016

Interdependent, collaborative leadership means leaders must work effectively across boundaries. The HSC Collective Leadership Strategy sets out the key components for collaborative leadership:

- A compelling shared vision for transforming the health and well-being of the population across Northern Ireland;
- A shared commitment to work together for the medium and long term (not just the short term);
- Frequent contact between leaders who need to work together to build trust and make real progress to deliver a world class service;
- A shared agreement to identify and resolve conflicts quickly, fairly, transparently and without blame, and a commitment to collaborative problem solving;
- A commitment to establish shared learning for improvement rather than blaming for mistakes;
- A clear commitment to support and value each other’s organisations, mutually supporting system success in transforming health and well-being in our population;
- Equal partnerships between those who work in Health and Social Care and the people they serve, through a co-production approach.

Research consistently shows that HSC organisations need visionary leaders who can inspire and develop employees, build and mend relationships effectively, lead and motivate teams, and engage in participative/collaborative management.

In addition to these core competencies, new and different leadership skills will be required to see HSC organisations through periods of change. Transformation of

6 Collaborative Healthcare Leadership A Six-Part Model for Adapting and Thriving during A Time of Transformative Change Centre for Creative Leadership 2016.

services will see HSC systems leading such changes and managing a changing workforce.

An investment in leadership talent is one way to engage employees and prepare for future leadership needs. Clinical and social care staff who are promoted into leadership roles need support and development as they make the transition, enabling them to approach the role as effectively as possible. As in business, often the most technically proficient individuals are promoted to managerial positions without the self-awareness, emotional intelligence, and other leadership competencies required for success.

Throughout HSC organisations leadership talent can be grown and supported in multiple ways, including extensive use of feedback, coaching, and developmental assignments and challenges.

As part of a well-articulated business strategy, healthcare organisations need comprehensive strategies for identifying, hiring, developing, and retaining leadership talent. Building a culture rich with assessment, challenge, and support helps to grow the talent pipeline. Building and growing a pool of people capable of taking on larger and more complex leadership roles can both transform the organisation and maintain quality and safety standards.

For HSC Board Members collaborative leadership practices include:

- Re-defining a new leadership strategy in the face of the challenges of ensuring quality and safety of service users;
- Re-defining a new leadership strategy in the face of the new structures and models associated with reform;
- Identifying, developing, and retaining the leadership talent needed to create and implement solutions in the face of rapid and evolving change; and
- Creating a culture that encourages and values mutual respect and professional practice.

2.1.4 Compassionate leadership

It is recognised that an important starting point for those delivering health and social services is **compassion** – a core value of the HSC as a whole and its staff. Sustaining the HSC as a culture of high-quality compassionate care requires **compassionate leadership** at every level and in interactions between all parts of the system – from regional leaders to local teams.

Compassionate leadership in practice means leaders listening intently to those they lead, arriving at a shared (rather than imposed) understanding of the challenges they face, empathising with and caring for them, and then taking action to help or support them. Such leadership will begin to address the problems the service faces, because top-down solutions are not working. Meanwhile, patient care and staff health are being undermined.

> *"Virtually all NHS staff are committed to providing high-quality and compassionate care. They represent probably the most motivated and skilled workforce in the whole of industry. However, we impose on them a dominant command and control style that has the effect of silencing their voices, suppressing their ideas for new and better ways of delivering patient care and suffocating their intrinsic motivation and fundamental altruism. Released, their motivation and creativity will ensure commitment to purpose and performance. Their voices are needed to tell us how care can best be improved as the endless remote top-down plans often fail because they ignore the reality of day to day care."*

Kings Fund – 5 Myths of Compassionate Leadership 2019

The HSC Collective Leadership Strategy emphasises the need for a consistent approach to compassionate leadership in practice.

- **Attending:** paying attention to people – being present and listening with intent.

- **Understanding:** finding a shared understanding of the situation.
- **Empathising:** using emotional intelligence and engaging people.
- **Helping:** taking intelligent action to help.

It is well recognised that compassionate leadership relies heavily on emotional intelligence that would include:[7]

- Self-awareness – accurate self-assessment/self-confidence;
- Self-management – self-control, adaptability, initiative, achievement, orientation, integrity, value system;
- Social awareness – individual/organisational, empathy; and
- Social skill – influencing/communication.

In such a way, the leadership community is characterised by authenticity, honesty and openness, curiosity, decisiveness and appreciation.

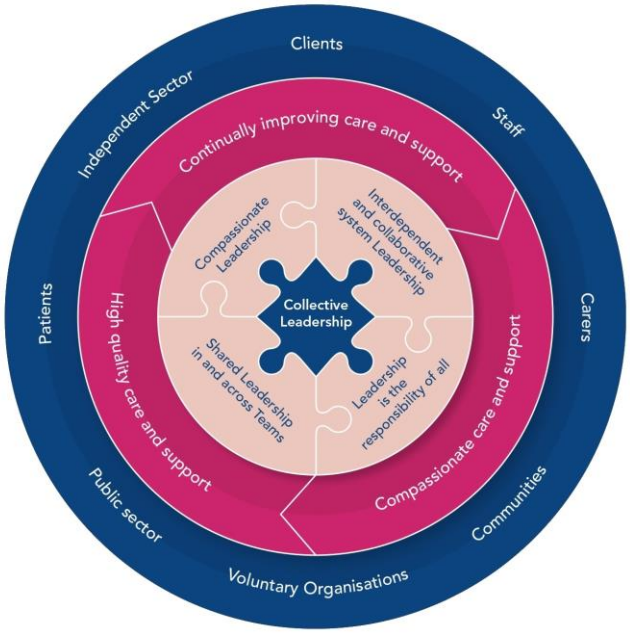


Figure 4: Additional HSC Collective Leadership Strategy components

7 Cavazotte, Flavia; Moreno, Valter; Hickmann, Mateus (2012). 'Effects of leader intelligence, personality and emotional intelligence on transformational leadership and managerial performance'. *The Leadership Quarterly*. **23** (3): 443–455. 2011.

Throughout the HSC Board Member Handbook the key **leadership role of Board Members** is stressed in setting the culture of the organisation, in working with others to set strategy, in ensuring accountability within and without the organisation, in the understanding and use of intelligence and in the development of a community of leaders.

2.2 Common values

The HSC has developed a core set of values for all staff and organisations that underpins the attitude and behaviours expected which align closely to the themes in the HSC Collective Leadership Strategy; these include:

- Working together;
- Compassion;
- Excellence; and
- Openness and honesty.

Table 1 sets out the meaning of each value and the expected behaviours.

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution. • I treat people with respect and dignity. • I work as part of a team looking for opportunities to support and help people in both my own and other teams. • I actively engage people on issues that affect them. • I look for feedback and examples of good practice, aiming to improve

		where possible.
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness. • I learn from others by listening carefully to them. • I look after my own health and well-being so that I can care for and support others.
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference. • I take responsibility for my decisions and actions. • I commit to best practice and sharing learning, while continually learning and developing. • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships. • I ask someone for help when needed. • I speak up if I have concerns. • I challenge inappropriate or unacceptable behaviour and practice.

Table 1: HSC Values, meaning and expected behaviours

2.3 A common vision

Research suggests that leaders in the best-performing health care organisations prioritised the development of a common vision and developed a strategic narrative focused on high-quality, compassionate care. In these organisations, all leaders (from the top to the front line) made it clear that high-quality compassionate care was the core purpose and priority of the organisation.[8] There is evidence that such alignment has an important influence on reducing the effects of 'fault lines'[9]/silos – a common problem in health care organisations.

A vision must also be translated into leadership actions because the messages that leaders send about their priorities are communicated more powerfully through their actions than their words. Leadership authenticity is revealed by what leaders monitor, attend to, measure, reward and reinforce and this in turn regulates and shapes the efforts of staff.[10]

2.4 Leadership culture

Why care about culture?

In its most basic form, culture is a mechanism for sustainability and survival. It also has the hidden power to derail strategic change initiatives. In fact, research shows the majority of strategic change initiatives ultimately fail because they don't address culture.

Leaders must understand and communicate a clear vision to **create** an environment that attracts people who share their same values. You lay the groundwork by being clear with your purpose, and by leading by example and modelling the behaviours you **would** like to see practiced.

- A culture is formed by beliefs that drive behaviours.

8 Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., McCarthy, I., McKee, L., Minion, J., Ozieranski, P., Willars, J., Wilkie, P., and West, M. (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. BMJ Quality and Safety, 23 (2), 106–115.

9 Defined as group and status differences that interfere with effective collaboration Bezrukova, Thatcher, Jehn, Spell 2012.

10 Avolio B.J. & Gardner W.L. (2005). Authentic leadership development: getting to the root of positive forms of leadership. The Leadership Quarterly, 16 (3), 315–338.

- New beliefs lead to new behaviours and new possibilities emerge.
- Change the leadership mind-set and you change the organisational culture.[11]

Organisational culture is defined as "the values and beliefs that characterise organisations as transmitted by the socialisation experiences newcomers have, the decisions made by management, and the stories and myths people tell and re-tell about their organisations".[12]

The key challenge facing HSC organisations is to nurture cultures that ensure the delivery of continuously improving high-quality, safe and compassionate healthcare.[13]

Leadership is the most influential factor in shaping organisational culture and so ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental.

2.5 Leadership activities specific to HSC Board Members

Board leadership is most effective when Boards:

- Enact the vision and values of their organisations through what they pay attention to and what they monitor, reprove or reward;
- Listen to service user and other stakeholder voices as the most important sources of feedback on organisational performance; and
- Listen to staff voices to discover how they can best support and enable staff to provide high-quality patient care.

Effective Boards ensure that:

- A strategy is implemented for nurturing a positive culture;

11 Collaborative Healthcare Leadership A Six-Part Model for Adapting and Thriving during A Time of Transformative Change. Centre for Creative Leadership 2016.
12 Schneider, B. & Barbera K.M. (eds.) (2014). The Oxford Handbook of Organisational Climate and Culture. Oxford, Oxford University Press.
13 Leadership & Leadership Development in Health Care: The Evidence Base – The King Fund 2015.

- Sense problems before they happen and improve organisational functioning;
- Promote staff participation and proactivity;
- Enable and encourage responsible innovation by staff; and
- Engage external stakeholders effectively to develop cooperative relationships across boundaries.

2.5.1 Leadership in shaping the culture

While leadership is the responsibility of all, HSC Board Members have a particular responsibility to ensure that the Board acts in the best interests of the public and is fully accountable to the Minister for the services provided by the HSC organisation and creates/ensures an organisational culture that supports this.

Figure 5: 'The Healthy Board': roles and building blocks[14]

'The Healthy Board' Principles for Good Governance NHS Leadership Academy 2013 sets out the responsibilities of Boards with a key element being **leadership for 'shaping culture'** in the organisation.

14 The Healthy Board' Principles for Good Governance NHS Leadership Academy 2013, www.leadershipacademy.nhs.uk

2.5.2 Shared leadership in and across teams

For HSC Board Members, shared leadership in and across teams is most clearly seen in the function of the Board alongside the Executive Director and Non-Executive Director roles, when they act together as well as act independently.

Acting together

Acting together is in the best interest for governing effectively and in doing so building patient, public and stakeholder confidence that their health and social care is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services;
- In ensuring that resources are invested in a way that delivers optimal health outcomes;
- In the accessibility and responsiveness of health services;
- That patients and the public can help to shape health services to meet their needs; and
- That public money is spent in a way that is fair, efficient, effective and economic.

Acting independently

Acting independently means to scrutinise and challenge through a system of integrated governance whereby systems and processes by which Trusts lead, direct and control their functions to achieve the organisational objectives of safety and quality, through which they relate to service users, wider community and partner organisations. This is set out in more detail in section 4.

HSC Board Member Handbook

SECTION 3: Roles and responsibilities

3.1 WHAT you do as an HSC Board

3.1.1 Strategy development

The overall purpose of a HSCB is to set the vision and strategy leading to the provision of safe and excellent health and care services for patients and people in the community, across the area of its responsibility. This is achieved through the efficient, effective and accountable governance of the organisation and by providing strategic leadership and direction that focuses on agreed outcomes.

Under the leadership of the Chair, the Board has corporate (collective) responsibility for four main functions:

- Ensuring that the organisation delivers its functions in accordance with statute, the Programme for Government and the Minister's policies and priorities;
- Providing strategic direction and leadership;
- Ensuring effective governance, especially financial stewardship; and
- Holding the Chief Executive and senior management team to account.

The Board fulfils its leadership role by developing a corporate strategy. The Board then agrees a corporate plan to turn this strategy into action over an agreed period of three years and promotes, then demonstrates, continuous improvements in corporate performance over this period.

Both the strategy and corporate plan must align with the Board's remit and indicate how it will contribute to enhancing the health and well-being of the population that it serves. The corporate plan should be approved by the Minister (or the Department on behalf of the Minister) and arrangements needs to be put in place for regular communication between the Board and the DoH to ensure effective monitoring and review.

At all times, the Board must ensure that it is focused on the design, implementation and delivery of safe and effective services and care to the community which will lead to the improvement of the health and well-being of the local population.

3.1.2 Accountability

In addition to the development of the organisation's strategy and direction, the Board has a clear and critical role in ensuring that there is effective and robust accountability for the three key areas of governance: **clinical and social care governance**, **staff governance** and **corporate governance**.

The Board should discharge this role by:

- Ensuring that there are effective clinical and social care governance arrangements in place through the development of a framework for continually improving the quality of the services and safeguarding high standards of care by the creation and maintenance of an environment in which excellence in clinical care will flourish.

- Ensuring that there is effective staff governance in place, demonstrating that staff are well informed, appropriately trained and developed, involved in decisions, treated fairly and consistently, with dignity and respect, in an environment where dignity is valued.

- Ensuring that staff are provided with a continuously improving and safe working environment, promoting the health and well-being of staff, patients and the wider community.[15]

- Putting person-centred care at the core of the delivery of high-quality services. Person-centred care is defined as "mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making".

15 The Sturrock Enquiry was a fully independent external review into allegations of a bullying culture at NHS Highland. The Scottish Government's response (2019) sets out a 65-point plan on what NHS organisations should do to develop a supportive culture.

- Promoting the safe, efficient, economic and effective use of staff and other resources including participation in shared services and collaborative service delivery arrangements.

- Ensuring that effective arrangements are in place to provide assurance on risk management, governance and internal control, the audit and risk assurance committee is a standing committee of the Board and should report to the Board on these areas.

- Receiving and reviewing regularly financial information on the management and performance of the organisation and being informed in a timely manner about any concerns.

- Taking into account relevant guidance issued by the Department and ensuring that systems are in place to notify the Department at an early stage about emerging issues which will impact on the operation or reputation of the organisation and/or the provision of health and care services to the population.

- Appointing (with the approval of the Minister) the Chief Executive and, in consultation with the Minister/Department, setting appropriate performance objectives and terms of remuneration (through the remuneration committee) linked to these objectives which give due weight to the proper management and use of resources within the stewardship of the organisation and the delivery of outcomes.

- Demonstrating high standards of corporate governance at all times, including openness and transparency in its decision-making.

- Ensuring that appropriate and effective mechanisms are in place for the Board and organisation to engage with service users, carers and the community in the planning and provision of HSC services and in addressing health inequalities.

3.1.3 The role of the Minister

Every ALB sponsored by the DoH is expected to be aware of, and work within, a strategic and operational framework determined by the Department. Every ALB falls within the portfolio of a specific Minister who will set its overall policy aims, define expected outcomes arising from implementation of that policy, and will review its progress against these actions.

The term **Arm's Length Body** does not mean that an organisation is beyond Ministerial control. The Minister will decide how much independence and flexibility each ALB should have, depending on its size and the nature of the functions it carries out.

Founding legislation gives the Minister the power to issue a formal direction requiring the ALB to take particular action. However, the use of these formal powers is rare.

The Minister is mainly responsible for:

- Considering and approving the ALB's strategic objectives and the policy and performance framework within which it operates;
- Securing and approving the allocation of public funds for the ALB;
- Approval of key documents such as the Management Statement and Financial Memorandum and the ALB's corporate plan;
- Making appointments to the Board;
- Approving the terms, conditions and remuneration of the Chair and Board Members, and in most cases the Chief Executive; and
- Issuing letters of strategic guidance.

The Minister may also seek to increase his/her understanding of the ALB through formal meetings with the Chair and Board and other more informal events. The Minister is responsible to the Northern Ireland Assembly and may be asked at any time to attend the Assembly or one of its committees to answer questions from Members of the Legislative Assembly (MLAs).

Representing the interests of the Minister

Board Members of an HSC ALB are appointed by the Minister in order to ensure the delivery of, or advise upon, his/her policies and priorities. The representation of an ALB's views to the Minister by the Board is of course perfectly legitimate and acceptable, but such action should be viewed within this wider context. Crucially, Board Members and the Board corporately should be clear about the Minister's policies and expectations for their ALB.

If they are in any doubt on this point at any time, they should seek clarification from the Chair.

As a 'fit and proper person', there is an expectation that Board Members should cause no embarrassment to Ministers during their time with the ALB.

3.2 HOW you do it as an HSC Board

3.2.1 Shaping a healthy community

The quality of care that patients and service users experience is affected by leaders and managers at all levels of an organisation. Effective leaders and managers have an impact on how organisations perform, how staff feel about their work and their motivation to deliver high-quality care, and how services are developed, delivered and improved.

Delivering high-quality services depends on an organisational culture and set of values that puts patients and service users first and encourages and celebrates innovation, improvement and learning. Non-Executive Board Members in particular have a key role in promoting and nurturing such a culture and values.

3.2.2 Governance and culture

A healthy organisational culture is not about what we do, but about how we do it. By developing and sustaining a healthy organisational culture, HSC Boards will create

the conditions for the delivery of high-quality health and care services. This should be through developing values and driving behaviours that support a healthy culture.

Good governance flows from a shared ethos or culture, as well as from systems and structures. Non-Executive Board Members play a lead role in establishing, modelling and promoting values and standards of conduct for the organisation and its staff.

Boards are responsible for ensuring that the organisation meets its statutory duties in relation to participation and equalities (Annex 2) and for promoting good practice by providing leadership as well as challenge.

The actions of all Boards are open to public scrutiny. Demonstrating a culture in which participation is encouraged, supported and valued can be a positive way of developing or reinforcing public confidence in the staff and services.

Non-Executive Board Members are expected to:

- Actively support and promote a healthy culture for the organisation and reflect this in their own behaviour; and
- Provide visible leadership in developing a health culture so that staff believe they are a safe point of access to the Board for raising concerns.

In practice this means:

- Promoting a positive culture which includes upholding and promoting the values of HSCNI;
- Being an ambassador of the HSC body, representing it honestly and positively, engaging with a wide range of organisations;
- Leading by example, including behaviour at Board meetings;
- Being visible to staff and patients; and
- Demonstrating a commitment to **openness, transparency and candour.**

Openness

Enabling concerns to be raised and disclosed freely without fear and for questions to be answered.

Transparency

Allowing true information about performance and outcomes to be shared with staff, patients and the public.

Candour

Ensuring that patients harmed by a healthcare service are informed of the fact, that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it. This includes providing sufficient information and not misleading by omission of information.

Board prompts

- These skills will develop with experience. Get out and about as much as possible; speak to other Board Members, staff, patients and members of the public.

What can Non-Executive Board Members do to help shape culture within the Board and the organisation?

- Ensure that Board business is conducted in an open and transparent manner;
- Think about whether Board Members encourage constructive debate and discussion;
- Ensure that the Board actively publishes information;
- Make sure that you know what the Board does to encourage staff to follow NHS Board principles;
- Consider how the Board monitors feedback from patients and what actions are then taken; and
- Make yourself visible and approachable to staff and members of the public.

3.2.3 Conduct and leading by example

The public has high expectations of those who serve on the Boards of public bodies and the way in which they conduct themselves in undertaking their duties. As a Board Member of an HSC body, it is your personal responsibility to meet these expectations by ensuring that your conduct is above reproach.

As follows, there are three fundamental principles of Board life to which all Board Members (including the Chair) must adhere.

Principle 1 – Corporate responsibility

While Board Members must be ready to offer constructive challenge, they must also share collective responsibility for decisions taken by the Board as a whole. If they fundamentally disagree with the decision taken by the Board, they have the option of recording their concerns in the minutes. However, ultimately, they must either accept and support the collective decision of the Board – or resign.

Board decisions should always comply with statute (in particular, the statute establishing the HSC body), Ministerial Directions as well as departmental guidance.

However, it is also important that Boards demonstrate a strong degree of independence in order to maintain credibility with the public and stakeholders.

Principle 2 – Confidentiality

All Board Members must respect the confidentiality of sensitive information held by the organisation. This includes commercially sensitive information, personal information and information received in confidence by the HSC body. It is also essential that debate of a confidential nature that takes place inside the boardroom is not reported outside it.

Principle 3 – Conduct

Board Members have a responsibility to set an example by demonstrating the highest standards of behaviour and complying fully with the Seven Nolan Principles of Public Life, summarised in Appendix 3:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership.

It is important that nothing a Board Member does or says when acting as a Board Member tarnishes in any way the reputation of the organisation or the Board.

If a Board Member has specific concerns about the manner in which the organisation is being run, these should be raised with the Chair in the first instance. If the Board Member fails to achieve resolution with the Chair, it is open to him or her to take their concerns to the relevant senior civil servant in the DoH – but Board Members should appreciate that this is a significant step and should not be taken lightly.

3.2.4 Being an effective Board Member

Effective Board Members (Executive and Non-Executive) are critical to achieving safe and excellent health and care services for patients and people in the community.

Effective Board Members are expected to constructively challenge and be a critical friend. However, it is not the role of the Chair and Non-Executive Board Members to have a detailed involvement in the day-to-day management of the organisation.

In order to be effective in their role, Board Members should:

- Actively participate in collective decision-making, and chair, or participate in, where required, one or more of the committees of the Board;

- Act in accordance with the principle of collective responsibility for decisions of the Board – no Board Member is appointed on a representative basis for any HSC body or group and Members are expected to bring an impartial judgement to bear on the business of the HSC Board;

- Question intelligently, challenge rigorously, debate constructively and decide dispassionately;

- Be sensitive to the views of others, inside and outside the boardroom;

- Be an ambassador for the organisation and support public involvement and engagement, demonstrating the ability to undertake a representational role across health services in Northern Ireland;

- Actively work with stakeholders in the local community, other Boards, regional support organisations and beyond to achieve the aims of the HSC body;

- Work with all other interested parties and fully represent the Board's activities, in an honest and positive way, whilst encouraging and maintaining good relationships;

- Put into action the Minister's policies and priorities in the context of the Board's area and remit;

- Develop an effective working relationship with other Board Members and staff within the health and care system;

- Gain the trust and respect of other Board Members;

- Support Executives and other senior staff in their leadership of the business while monitoring their performance and conduct;

- Commit to ongoing personal development activities in support of their Board role; and

- Uphold the highest ethical standards of integrity and probity and comply with the Board's code of conduct, derived from the Nolan Principles and the Code of Conduct and Code of Accountability for Board Members of HSC Bodies (July 2012).

3.2.5 Due diligence

Due diligence is often cited as a method to make sure that everything is the way it is supposed to be. It involves doing all the necessary homework, background checks, and analyses to identify problems, offer solutions, and document procedures. In terms of corporate governance, this may include asking the following questions:

- What is the strategic purpose and vision of the organisation?
- What are short, medium and long-term objectives for achievement to strive for?
- What are the key corporate risks?
- How are resources allocated to bring this about, in particular, the financial and human resources?
- How is the management structure geared to the achievement of the strategy?
- Financial controls – how do they work?
- Operational controls – how do they work?
- What are the management priorities in the near, intermediate and long term?
- Past and present performance – what progress has been made towards the achievement of the organisation's short, medium and long-term goals? How does our performance compare to that of other HSC organisations?
- What specific underlying factors or forces determined those results?

- Constituency protection – what mechanisms are in place to ensure that the interests of all stakeholders are addressed, and that the appropriate statutory or regulatory requirements are met?
- What arrangements are in place to identify and mitigate the risks in relation to litigation and disputes?
- How well is the organisation able to respond to crises, and what contingency plans and processes are in place?

3.2.6 Compassionate leadership

A compassionate leader, as well as being a compassionate person, encourages compassion and caring in the wider organisation. An effective Board Member, being a compassionate leader, encourages employees to talk about their problems and to provide support for one another. This is recognised in the HSC Collective Leadership Strategy, Department of Health 2018

Professor Michael West[16] and his work on leadership within the NHS provides a helpful perspective on a compassionate approach to leadership within the health service. Board Members may find the following video links useful in this regard.

Collaborative and compassionate leadership, Professor Michael West
Five myths of compassionate leadership
Leadership in today's NHS

Board Members also have a responsibility to ensure that staff have confidence in the fairness and impartiality of procedures for registering and dealing with their concerns and interests. The Public Interest Disclosure (Northern Ireland) Order 1998 gives legal protection to employees who raise certain matters or concerns, known as 'qualifying disclosures', without fear of reprisal.

As a Board Member, you should ensure that your organisation has a whistleblowing (or freedom to speak up) policy and appropriate procedures in place. This will allow

16 Visiting Fellow, Leadership and Organisational Development, The King's Fund and Professor of Work and Organisational Psychology at Lancaster University Management School.

staff to raise concerns on a range of issues such as fraud, patient safety, staff welfare/bullying etc. without having to go through the normal management structure.

In May 2018, NHS Improvement issued Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts.

3.2.7 An effective Chair

As follows, the Chair has additional responsibilities over and above those of the other Non-Executive Board Members, particularly in relation to leadership of the Board and the conduct of Board business.

Board leadership

Providing leadership to the Board, the other Non-Executives, the Chief Executive and Executive Board Members and ensuring the effectiveness of the Board in all aspects of its role, including directing the organisation towards achieving its own and the Minister's objectives. This includes:

a. Leading the Board's approach to strategic planning

Ensuring that the HSC body's policies and actions support the Minister's strategic priorities.

b. Monitoring

Ensuring the provision of accurate, timely and clear information to the Board and Board Members to enable them to monitor progress effectively and hold the Executive to account;

Overseeing the implementation of Board decisions; and

In consultation with the Board as a whole, undertaking an annual appraisal of the performance of the Chief Executive.

c. Board and Board Member recruitment and development

Ensuring that Executive and Non-Executive Board Members work together effectively as a team;

Ensuring that the Board, in accordance with recognised good practice in corporate governance, is diverse in terms of relevant skills, experience and knowledge appropriate to directing the Board's business;

Ensuring that the Minister and Department are advised of the Board's needs when vacancies arise;

Ensuring that the Chair and all Board Members receive appropriate induction training on appointment and are fully briefed on the terms of their appointment, duties, rights and responsibilities;

Assessing the performance of individual Board Members – Non-Executive and Executive – on a continuous basis and undertaking a formal appraisal at least annually; and

Sharing and using the relevant skills and expertise of all Board Members.

d. Representation

Representing the Board and organisation in links with the Minister (to whom the Chair is personally accountable), the Northern Ireland Executive, the Assembly and the public;

Ensuring effective communication with the Board, staff, service users and the public;

Ensuring good communication and feedback from Board Members representing the Board on internal and external committees; and

Promoting positive relationships with key partners and stakeholders.

e. Board business

Planning and chairing Board meetings;

Facilitating the effective contribution of Non-Executive Board Members;

Ensuring that the Board, in reaching decisions, takes proper account of guidance issued by the Department and other departmentally designated authorities;

Obtaining professional advice for the Board when needed, in particular when the Board is taking a decision on matters that pose a significant operational or reputational risk;

Leading the Board's approach to the establishment of committees and ensuring that the Board effectively considers substantive reports from committees; and

Ensuring that the work of the Board and any committees is subject to regular self-assessment and that the Board is operating strategically and effectively.

3.2.8 Board papers – what a Board Member should expect

Good quality Board papers are an essential pre-requisite to effective decision-making at Board meetings.

A major failing in many public bodies (and HSC ALBs) is the sheer volume and excessive length of papers that come to the Board. Very often, Board papers contain too much detail, much of which is irrelevant and/or of little use to Board Members in making decisions. Such papers are often not focused on the key issues and impacts/challenges.

Board papers containing excessive and superfluous detail can lead Board Members into focusing on operational issues, rather than strategic and governance issues and the reason for the paper coming to the meeting can often get lost in the process.

If a lengthy paper has to come to the Board, the author should provide a short summary at the beginning of the paper. Alternatively, the key points can be highlighted in a short paper with the lengthy document included as an appendix. In all cases, the key issues and points should be highlighted in a cover paper which should be attached to the front of each paper. Some suggestions for the format of such a cover paper are included in Appendix 4.

The Chair of the Board should sign off the agenda in sufficient time to allow papers to be developed for the meeting. The Chair should also review the papers coming to the meeting to ensure that they are pertinent to the discussion and remit of the Board, and that they are concise, focused and clear about what is being asked of the meeting. The Chair should ensure that there are few if any papers which are 'only for noting', or 'below the line' (not to be discussed at the meeting and only for information).

Papers should be sent to Board Members no later than a week in advance of the Board meeting. Only in exceptional circumstances should papers arrive later than this and only with the agreement of the Chair.

Effective governance is only possible if the right information is being presented for review, discussion and decision-making. Papers that progress through a series of stages before being considered by the Board should become progressively shorter in length.

Non-Executive Board Members should not be considering documents which have been developed specifically for other purposes/groups. Generally speaking, a paper being considered by the Board should be shorter and more condensed than a paper previously considered by a committee or an individual directorate/team.

One of the challenges for officers preparing reports that may be considered at different levels (for example manager, executive team, committee and Board) is to be able to develop and re-work papers that are not just duplicate reports but which provide appropriate information for each meeting.

Too much information presented too close to the date of a Board meeting does not allow Board Members to assimilate the details, prepare adequately or identify the key issues for reflection, dialogue and constructive challenge.

'Recycled' reports – which may not contain the most up-to-date information or which have not been revised to consider the purpose of presenting the report to different audiences (Board, committee etc.) – are generally unhelpful. Effective governance ensures that all reports describe clearly and succinctly the specific aim in presenting the report content to different audiences, as appropriate.

Governance is at its most effective when there is a balance of information presented in relation to the past and to the future, thus enabling an effective decision-making process.

A good Board paper will contain sufficient information to enable a Board Member to interpret and understand the issue under consideration. The paper should also contain enough detail on context to support informed discussion and decision-making.

The information presented to the Board should focus whenever possible on both process and outcome, if this is appropriate to the issue, and the implications and proposed actions.

Information reports should be brief and present information using a combination of text as well as graphs and diagrams when possible.

Non-Executive Board Members need to ensure that they have sufficient information to understand the performance of the whole organisation. It is important to ensure that there is sufficient information provided on services and processes that are working/performing well in addition to identifying the opportunities for learning and improvement from any system defects/failures.

3.2.9 Cover papers

Within your organisation, there should be guidance issued to all staff and a standard format agreed for the drafting of Board papers and reports, including the requirements for financial assessment and risk assessment of the impact of options presented to the Board.

A cover paper should be prepared for and attached to all Board papers.

The template for the cover paper should be tailored to each organisation's individual requirement, and a sample of this is set out in Appendix 4.

Non-Executive Board Members can ensure that the right information is collected and presented by:

Supporting and encouraging the presentation of **timely information** which should also clearly outline why this is being presented and what decisions are required;

When reviewing Board papers, consider **processes, outcomes and experiences** and if you do not have enough information ask for anything that you think is missing;

Communicating expectations that information is presented **succinctly,** with background information and in a way that reflects priorities for services, decision-making and assurance; and

Discouraging the use of '**for noting'** or 'for information' items and encourage more detail on what is to be noted and how the information being tabled relates to the requirement for any actions.

Once the minutes of the Board meeting are drafted, they should be reviewed by the Chair first, then the Chief Executive and then circulated (as amended) to Board Members within a short time of the Board meeting (normally 14 days). They should

then be amended (if required), agreed and signed off at the following Board meeting and published on the website.

Although this section specifically refers to Board papers, all of the principles and practices referred to are equally applicable to Board-level **committee papers**.

3.2.10 Board Secretary

The development of Board papers, etc. in accordance with the organisation's procedures and best practice should be facilitated and supported by a Board Secretary who is personally responsible to the Chair and the Board for:

- Ensuring that Board papers are produced to the appropriate standard and that, following each Board meeting, actions are taken within required timescales;

- Ensuring the full provision of information to Board Members so that they can maximise their ability to contribute to Board meetings, discussions etc.;

- Leading the continuous development and implementation of the Board's corporate governance system, providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance matters as required;

- Providing advice and guidance to ensure that the Board acts within its legal authority and statutory powers and that Board Members comply with the Nolan Principles and the code of conduct;

- Ensuring that Board business is conducted in a spirit of openness and transparency;

- Managing the administrative and secretarial support to the Board and appropriate committees to deliver effective administration support to Board business; and

- Providing personal support and guidance to the Chair and Chief Executive and managing the business of their private office, including the handling of Assembly Questions and enquiries from the Minister and other elected representatives.

Other areas where the Board Secretary should take a key role include the development of a strategic planning cycle that clearly indicates where the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans.

The Board Secretary should develop an integrated annual work programme and co-ordinated timetable for Board meetings, Board seminars/workshops and committee meetings. This programme should not only ensure that strategic planning is co-ordinated and the appropriate level of scrutiny is delivered, but also that decisions are taken in a logical sequence.

In some organisations, there will not be a specific post of 'Board Secretary'. In such instances, these duties and responsibilities are often discharged by a senior officer such as a Deputy Chief Executive, Director of Finance or Director of Corporate Services with the appropriate knowledge and expertise.

3.2.11 Personal development and how the Board supports its Members in their own learning

The following list of induction guidance and training is not prescriptive, but is designed to give an idea of the type of support that may be provided by HSC organisations. Further information is set out in section 6.

Meetings

A one-to-one meeting should take place with the Chair immediately following appointment to discuss in broad terms what is expected of a Board Member in the first year and any individual role he or she is expected to play. (The Chair and Board Member should meet on a regular basis as part of the appraisal process.) A new Board Member should attend an induction session within one month of appointment that should cover a range of relevant topics (see section 6.1.1)

Ideally, this session should be attended by all new Board Members and by some existing Board Members to allow the latter to pass on experience. Some other members of the senior management team may also attend, as may the Board Secretary.

New Board Members may require support in certain areas. The induction process should explore development needs for all new Board Members and agree a development plan.

It may also be appropriate for a Board Member to meet with other key staff in the organisation – for example, with the Chief Executive who will be able to advise on his/her role as the Accounting Officer, and, where the Board Member is to sit on a committee, with key staff.

Obtaining feedback from new Board Members on the induction they received will provide a useful source of information to those developing the induction programmes and will help ensure the process remains effective.

Publications

A list of publications and other documentation that Board Members should expect to receive as part of their induction is set out in section 6.1. Other useful publications include The Healthy NHS Board 2013 – NHS Leadership Academy 2013 and The Healthy NHS Board Principles for Good Governance 2011.

First Board meeting

Time should be allocated so that a new Board Member can be formally introduced to all present. In advance of this meeting, the new Member should be made aware of any protocols, for example in relation to making points at meetings, presenting information and overall expectations as to behaviour (being inclusive, respecting others etc.).

At the end of the Board meeting, the Chair should spend a few minutes with the new Board Member to allow them an opportunity to ask any questions or raise concerns that they may have.

Training and development[17]

It is important that all newly appointed Board Members attend the 'On Board' or other departmentally approved training programme within six months of their appointment; further information is set out in section 6.

The HSC body should also consider providing any further training deemed necessary to assist the Board, individually or collectively, to carry out its duties, particularly covering areas such as their roles and responsibilities, the financial management and reporting requirements of public bodies, ethical standards and any other differences which may exist between private and public sector practice.

There should also be an opportunity for Board Members to attend training and other networking events organised on a cross-HSC basis.

Induction for Board Chair

The induction of a new Chair is the responsibility of the Department and the Chief Executive of the HSC body in question.

When a new Chair is appointed, the Department should ensure that an early meeting is arranged with the Permanent Secretary to ensure that there is mutual

17 This is expanded further in section 6 Training and development.

understanding about what is expected of the HSC body. It may also be appropriate for an early meeting to be arranged between the Chair and the Minister.

The induction of the new Chair should cover all the topics already mentioned. In addition, there are some topics that are specific to new Chairs, including the following.

Appraisal[18]

The Minister (or as delegated) is responsible for setting objectives for the Chair and conducting his/her appraisal. The appraisal process encourages critical reflection and provides an evidence base upon which Non-Executives can build for future development. It takes place annually and is the basis on which personal development plans are formed.

Formal performance appraisal is a compulsory requirement of the Code of Practice[19] issued by the Commissioner for Public Appointments Northern Ireland.

Leadership

An important part of the induction process will be to explore with the Chair the experience he/she has, any training that is required and any development opportunities that may be appropriate for the new Chair.

Recruitment and selection

The Chair should be involved in the selection of other Board Members. Non-Executive Board Members should be involved in the selection and appointment of Executive and senior team members. It is important to ensure that he/she has undertaken appropriate training in conducting interviews, including equality awareness training.

18 The requirements for performance appraisal are set out in detail in section 6.2 in this handbook.
19 CPANI, Code of Practice JL2 December 2016 and Appendix A – Statement of Compliance Summary of Codes of Practice in Public Life set out in Appendix 7.

Further reading

The publications Challenges to Effective Board Reporting and Effective Board Reporting produced by the Chartered Governance Institute and Board Intelligence provide some useful insights into developing Board reporting.

3.2.12 Scrutiny and challenge

Processes, without intelligent and rigorous scrutiny, are not enough!

In order to ensure that all key functions are delivered effectively, Board Members need to hold the organisation to account for its performance by offering purposeful and robust scrutiny and challenge.

The key prerequisites for effective scrutiny

There are four things that need to be in place before effective scrutiny and challenge can happen:

1. Effective scrutiny is dependent on having **clarity in structures, roles and responsibilities.**

- A clear structure that clarifies responsibility for delivering performance from the Board to the point of care and back to the Board is needed. In particular, ensure that responsibility for functions related to patient safety and quality (improvement) are vested clearly and simply.

- A joint understanding is required between Board and Executive as to what should be scrutinised, by whom and how often. For example, what level of performance information should come to the Board, what should be considered at committee level, what matters are delegated to the Executive (and when should delegated matters be escalated to Board level)?[20]

20 The Board must also keep a track of delegated matters to ensure that these are being discharged effectively.

2. Effective scrutiny relies on Board Members having a **clear understanding of what is important.**

- The core purpose of an HSC body is to deliver safe, effective and excellent services to patients and people in the community, across the area of its responsibility – the focus of the Board has to be on 'quality and safety' as much if not more than on financial stewardship.

- Use quantitative targets with caution – although some quantitative targets do have an important role, they should never displace the primary goal of better healthcare. The most important performance indicators should be qualitative around the achievement of positive outcomes for patients and service users.

- Quality has to be a core part of all Board meetings both as a standing agenda item and as an integrated element of all major discussions and decisions.

- Quality performance cannot be adequately covered at a Board meeting but will need to be considered in more detail by a 'quality' committee with membership that has the in-depth knowledge and expertise to add value.

- The focus of the Board should be on driving continuous quality improvement across the full range of its services – creating and sustaining a learning organisation and constantly evaluating what works and what doesn't and how we can do things better (including learning from experience elsewhere).

3. Effective scrutiny relies on the provision of **clear, timely, comprehensible summary (written) information** to the Board.

- The Board needs to set out its expectations to management about the nature, format, length and frequency of reports to the Board. The length of Board papers should be appropriate and proportionate to the issues to

be addressed with a presumption against unnecessarily long papers – important and key issues should not be 'buried' in a lengthy paper.

- Board Members should receive performance information in a clear, easily digestible format, using graphic overviews, trend analysis and brief commentary. High-quality Board papers are not purely descriptive – they include analyses that will actively direct the attention of Board Members to the key issues, implications and consequences.

- The Board should develop its intelligence through a range of sources and should review the sources and quality of intelligence as part of a periodic review of its decision-making processes.

- The Board (and each committee) should review its information requirements with the Executive on an annual basis.

A Board that is drowned in paperwork and a myriad of performance information cannot scrutinise effectively.

4. Effective scrutiny thrives within an organisational **culture that welcomes and encourages scrutiny and constructive challenge**; where no subject is considered to be off limits for Board discussion; and where disagreements are regarded as a normal feature of Board meetings.

- There should also be a rule of 'no surprises' between the Board and executive team – both ways.

The characteristics of effective scrutiny

So, what does effective scrutiny look like? Here are some of the tell-tale signs.

Effective scrutiny focuses on the most **important measures of performance and highlights exceptions** – it does not focus on minor issues or the merely interesting. Remember, scrutiny should always be linked to risk!

Effective scrutiny avails of every opportunity to **offer appreciation and encouragement** to staff etc., where there is excellent performance.

Effective **scrutiny seeks (and gets) assurance where remedial action** has been required to address performance weaknesses or concerns.

Effective scrutiny **looks beyond the written information** provided to Board Members and develops an understanding of the daily reality for patients and staff, to make data more meaningful.

- Research suggests that the governance of quality can be improved if Board Members **periodically step outside of the boardroom** to gain first-hand knowledge of the staff and patient experience.

Effective scrutiny does not mistake **reassurance** for **assurance** (particularly in relation to service quality and patient safety) but is demonstrated through robust and constructive challenge from all Board Members (Executive and Non-Executive).

- Vagueness is never good – papers and answers need to be evidence-based and credible.

- Always allow sufficient time for complex issues and never be rushed into a major decision.

- If the Board lacks knowledge or expertise, buy it in/access it internally or externally and make use of it before making any major decision.

- Good results still need scrutiny and challenge.

While having due regard to the **views of stakeholders** (for example from a regulator or the local community), this does not absolve you of your responsibility for robust scrutiny.

Effective scrutiny takes account of **different sources of information** and assurance and places a high value on independent scrutiny of performance (including from regulators), patient experience surveys etc.

- Always ask yourself the question 'how does this information compare with our own experience, any other sources of assurance etc'?

- Where there are differing messages emerging from different sources, commission, or otherwise obtain another independent source of assurance.

- Where possible, obtain comparative data on the performance of similar organisations through benchmarking.

- Draw upon credible examples of good practice against which to compare and contrast local performance.

- Invite (and record) views/assurances on major issues from the Chief Executive and senior managers – and take advice from clinical leaders.

Effective scrutiny **welcomes any question** however relevant it might seem at first – when Board Members are unclear, unconvinced or have serious reservations in relation to a Board discussion or decision on a complex or specialist matter, they are not afraid to ask that question or seek additional assurance even if they might look foolish in so doing.

Effective scrutiny (with robust challenge) is 'how we do business'.

- Scrutiny involves everyone on the Board and it is not just the Non-Executives challenging the Executives. Executive Board Members

challenge the Non-Executives and challenge each other – they do not restrict their contribution to their areas of executive responsibility.

- There are no ‘show’ Board meetings – Board Members do not feel obliged to put on a united front at public meetings because challenge and robust scrutiny might reflect badly on the organisation – challenge and scrutiny, that is just how we do business around here!

HSC Board Member Handbook

SECTION 4: Assurance and scrutiny

Ensuring the quality and safety of services through scrutiny and challenge.

The Good Governance Institute defines assurance as a "positive declaration that a thing is true. Assurances are therefore the information and evidence provided or presented which are intended to induce confidence that a thing is true amongst those who have not witnessed it for themselves. For an individual to 'be assured', they must trust the assurance(s) they have been provided with and therefore be confident themselves that the thing is true".[21]

HSC organisations operate on the principle of reasonable rather than absolute assurance. In determining reasonable assurance it is necessary for HSC Boards to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

Assurance draws attention to the aspects of risk management, integrated governance and control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. An effective integrated risk management framework and a risk-based approach to assurance helps an Accounting Officer and Board to judge whether or not its agenda is focusing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources. The Trust Board committees, and in particular the audit and governance committees, can help the Accounting Officer and Board to formulate their assurance needs, and then consider how well assurance received actually meets these needs by gauging the extent to which assurance on the management of risk is comprehensive and reliable.

Assurance cannot be absolute so the committees (and Trust Board sub-committees) will need to know that the organisation is making effective use of the finite assurance mechanisms at its disposal, targeting these at areas of greatest risk. The Board assurance framework and corporate risk registers and their

21 Good Governance Institute 2013.

functions in supporting a risk-based approach are considered in section 4 (b) of the handbook.

Central to being an effective Board is the ability of members to scrutinise information put in front of them, consider what other information is needed with an overarching responsibility to assure themselves of the quality and safety of services. Such information is presented through an integrated governance framework.

The following sections summarise these areas and suggest prompts that may be used by Board Members.

SECTION 4: (a) Quality

4.1 Duty of quality

4.2 Health inequalities

4.3 Quality improvement and measurement

4.1 Duty of quality

The statutory duty of quality (found in The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003) sets out a requirement that each HSC Trust puts arrangements in place to monitor and improve the quality of the health and social care which it provides and the environment in which it provides them. This means that all Board Members are accountable for quality and it should feature highly on the Board's agenda as a standing item. The Board may wish to establish a quality and safety standing committee to regularly discuss quality performance in more detail.

In 2006 the Quality Standards for Health and Social Care were published. They have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

4.1.1 Role of RQIA

In addition to introducing statutory duty of quality the Order of 2003 introduced a statutory duty of quality. The 2003 Order also requires the Regulation and Quality Improvement Authority to conduct reviews of, and make reports on, arrangements by statutory bodies for the purposes of monitoring and improving the quality of the HSC services for which they have responsibility.

RQIA reviews provide assurances about the quality, safety and availability of HSC services in Northern Ireland and they aim to encourage continuous improvements in HSC services. They offer an important opportunity for the Board to receive independent assurance about their organisation with regard to:

- Governance;
- The quality of HSC services provided;

- The effectiveness with which services are commissioned, planned and delivered; and
- Levels of compliance with statutory requirements as well as standards and guidelines endorsed by the Department of Health; and the extent to which departmental policy has been implemented/adhered to.

RQIA use a range of approaches to each review, including self-assessment, validation visits by panels of independent experts, involvement of lay people and service user feedback. They will produce a report for each review which highlights areas of good practice and makes recommendations for improvement. The findings are reported to the Minister for Health and to the relevant HSC organisations who will be expected to provide updates in relation to each recommendation. Lessons learned are shared across the wider HSC sector.

Reports from each review are publicly available on the RQIA website.

4.1.2 Role of the Board in quality

The Board should be the driving force for continuous quality improvement and the clinical and social care governance framework should provide a co-ordinated approach to, and focus on, these quality standards.

Boards must ensure that there are clear lines of responsibility and accountability for the overall quality of treatment and care. There should be proactive systems in place to identify and report poor performance, near misses and adverse incidents so that they can be dealt with appropriately and lessons can be learned and shared. There should also be effective systems to identify, value and share good practice.

There are a number of areas Boards should consider when assessing the effectiveness of governance systems.

Communication

- Are there clear channels of communication between staff?

- Do staff know when to escalate issues to senior staff?
- Are staff encouraged to raise concerns?
- Are senior staff proactive about seeking views from front line staff on the quality of services and how they can be improved?
- Are there clear systems in place to support the above points?

Data collection and analysis

- Is the right information collected?
- Is the information analysed?
- Is information collated in an accessible and easily retrievable manner?

Qualitative information

- What other qualitative information is routinely gathered (complaints, staff/user surveys, patient/client records, adverse incidents, staff observations)?
- Is this qualitative information collated and assessed in a way that informs quality assurance and improvement?

Board prompts

- Are there appropriate staff tasked with the correct levels of quality assurance?
- Are staff members aware of the responsibilities they and others have in terms of assurance?
- Do staff members carry out these duties routinely and robustly?
- Do they use appropriate types and levels of information to make reasonable and proportionate judgements?
- Are robust risk thresholds used to determine assurance levels, including when action is required and what represents reasonable and proportionate action?

4.2 Health inequalities

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

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

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

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

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

The framework intends to create the conditions for individuals and communities to take control of their own lives, and move towards a vision for Northern Ireland

where all people are enabled and supported in achieving their full health and well-being potential.

4.2.1 Health inequalities in Northern Ireland[22]

Regional health inequalities refer to the difference in health outcomes between the 20% most deprived and 20% least deprived areas of Northern Ireland according to the Northern Ireland Multiple Deprivation Measure.

4.2.2 A social gradient of health

Health inequalities are often considered in terms of the gap between the most and least deprived quintiles of the population. However this does not account for those areas of intermediate levels of deprivation in the socioeconomic spectrum that may also be relatively disadvantaged, meaning that health inequalities affect everyone. There is consistent evidence from throughout the world that people at a socioeconomic disadvantage suffer a heavier burden of illness and have higher mortality rates than their better off counterparts.

Different inequality measures can give information about different aspects of inequalities. Some measures concentrate on the extremes of deprivation such as the most/least deprived (or absolute) gap analysis presented in the main body of this report, whilst others include relative inequality gaps across the socioeconomic scale – taking into account the whole population – and can give quite different interpretations of inequalities.

4.2.3 Life expectancy and general health

In 2016–18 the life expectancy gender gap between males and females in Northern Ireland was 3.7 years. There was no change in the deprivation gap for male life expectancy at birth, although it improved across all areas. There was no change in female life expectancy at birth across all areas and therefore no change in the inequality gap. There was also no change in the male or female healthy life

22 Source: Northern Ireland Statistics and Research Agency (NISRA)

expectancy gaps, although male healthy life expectancy did improve for Northern Ireland overall.

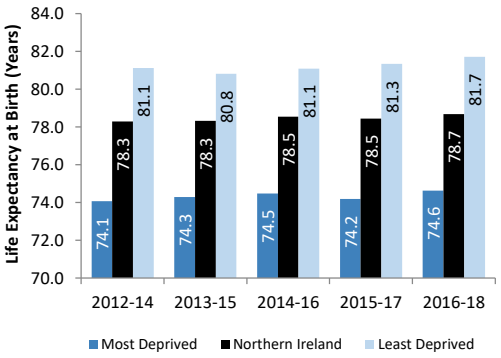


Figure 6: Male life expectancy at birth (Health Inequalities Annual Report 2020)

4.2.4 Premature mortality

Rates of premature mortality generally decreased over the period in Northern Ireland and its most and least deprived areas. The inequality gaps narrowed or remained broadly similar except for death rates among under 75s due to respiratory diseases, where the deprivation gap widened due to increased mortality in the most deprived areas. The inequality gaps for premature mortality remained large with the most deprived areas continuing to experience higher mortality rates than the least deprived areas. For respiratory mortality among under 75s, the rate in the most deprived areas was almost three and a half times that seen in the least deprived.

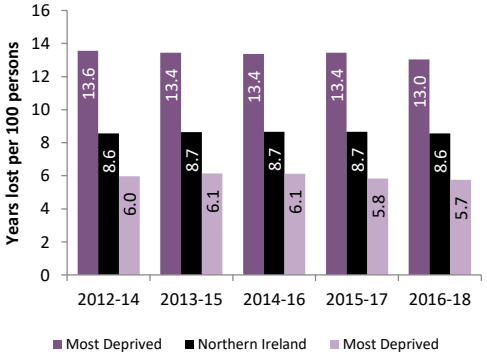


Figure 7: Potential years of life lost (Health Inequalities Annual Report 2020)

4.2.5 Major diseases

Inequality gaps for all indicators remained constant over the period. There were improvements in all indicators at a regional level, with the exception of admissions for respiratory conditions where there was no change, and cancer incidence where there was a negative change. There was also negative change in the most and least deprived areas for cancer incidence. The largest inequality gap was observed for admissions due to respiratory diseases, with the admission rate in the most deprived areas around double that of the least deprived areas, for all ages and for those aged under 75 years.

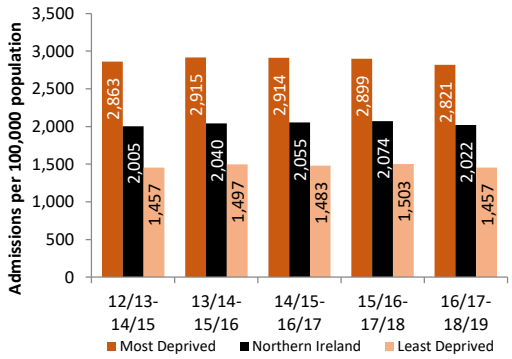


Figure 8: Standardised admission rate – respiratory (Health Inequalities Annual Report 2020)

4.2.6 Hospital activity

Inequality gaps for all indicators narrowed over the period, with the exception of emergency care attendances and elective inpatient admissions which remained constant. All admissions indicators improved across Northern Ireland and in its most and least deprived areas, with the exception of day case, which remained constant in the most deprived areas and increased in the least deprived areas. Emergency admissions continued to show the largest inequality gap of the four indicators analysed. Despite a narrowing of the gap, the rate among those living in the most deprived areas remained more than three-fifths higher than that in the least deprived areas.

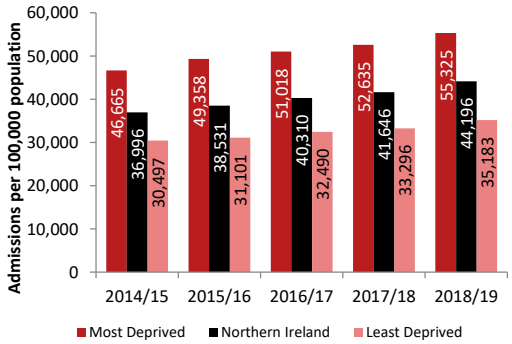


Figure 9: Standardised attendance rate – emergency care (Health Inequalities Annual Report 2020)

4.2.7 Mental health

Large inequality gaps continue to exist for mental health indicators, with the latest position showing that the rate of suicide in the most deprived areas was nearly three and a half times that in the least deprived areas, with the gap widening. There was positive change regionally and in the most and least deprived areas for admissions due to self-harm, with the inequality gap narrowing. Prescription rates for mood and anxiety disorders increased in Northern Ireland and its most and least deprived areas.

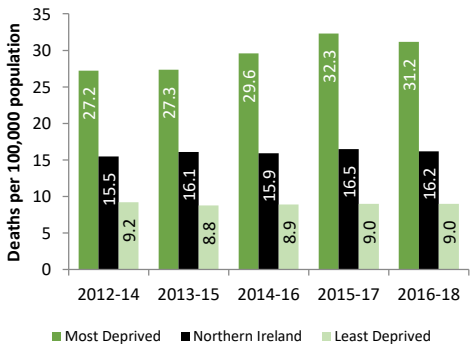


Figure 10: Crude suicide rate (Health Inequalities Annual Report 2020)

4.2.8 Alcohol, smoking and drugs

Alcohol, smoking and drug related indicators continued to show some of the largest health inequalities monitored in Northern Ireland. For alcohol, specific mortality and alcohol-related admissions, the rate in the most deprived areas is approximately four times that seen in the least deprived areas. Although there has been no change

in the inequality gap for lung cancer incidence, the rate has increased in Northern Ireland and its most deprived areas. While the admission rate for drug related causes decreased across all areas, the opposite was true for the death rates for drug related causes and drug misuse which rose with a widening of the inequality gaps.

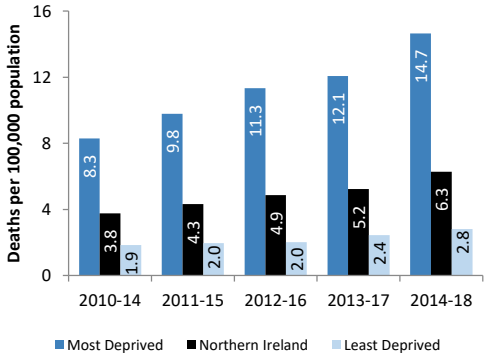


Figure 11: Standardised death rate – drug misuse (Health Inequalities Annual Report 2020)

4.2.9 Pregnancy and early years

Changes over the period in inequality gaps related to pregnancy and early years tended to vary across the indicators analysed. The low birth weight inequality gap narrowed, due to negative changes in the least deprived areas. The gap between the most and least deprived areas for smoking during pregnancy widened due to positive changes in least deprived areas. The inequality gaps for the under 20 teenage birth rate and the proportion of mothers smoking during pregnancy still remain very large. For both, the rate in the most deprived areas was five times the rate in the least deprived areas.

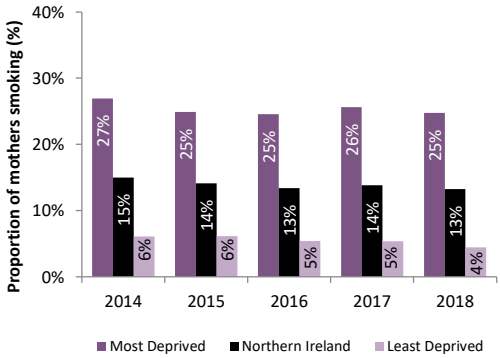


Figure 12: Smoking during pregnancy (Health Inequalities Annual Report 2020)

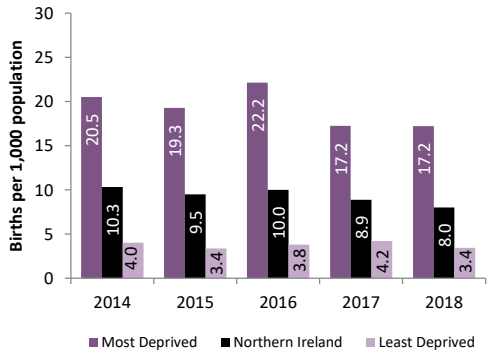


Figure 13: Teenage birth rate U20 (Health Inequalities Annual Report 2020)

4.2.10 Childhood obesity

Over the period analysed there was no notable change in the proportion of Primary 1 children reported as overweight or obese. It should be noted that as the underlying figures are somewhat low, small annual changes can have a large impact on the observed inequality gap. However, rates of obesity are continually higher in the most deprived areas.

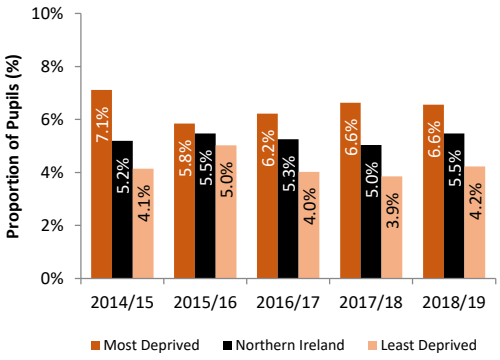


Figure 14: Obesity – Primary 1 BMI (Health Inequalities Annual Report 2020)

4.2.11 Summary of changes in sub-regional equality gaps over the past five years[23]

Changes in deprivation-related inequality gaps

Over the period analysed, with the exception of the Belfast Trust, there were more inequality gaps that widened than narrowed in each HSC Trust. This was also true for the majority of Local Government Districts, with the exception of Ards and North Down; Armagh City, Banbridge and Craigavon; Belfast; and Newry, Mourne and Down.

Comparison of an area's health outcomes against the regional average

The following areas had a majority of health outcomes that were better than the Northern Ireland average:

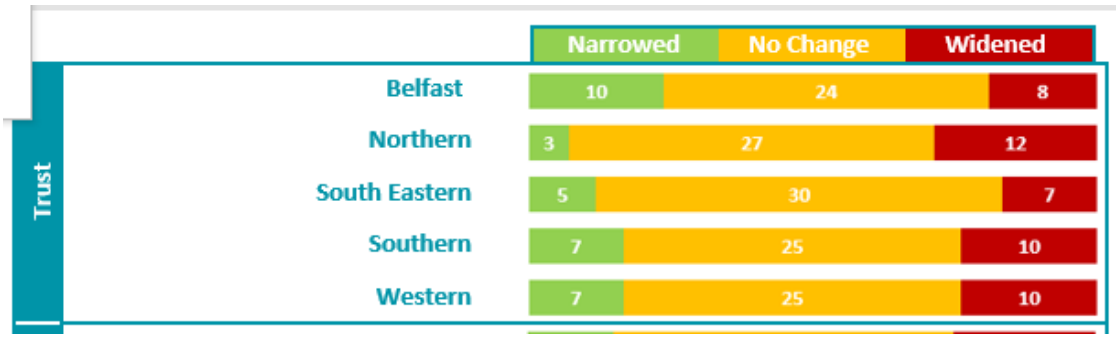
- South Eastern HSC Trust
- Ards and North Down
- Causeway Coast and Glens
- Lisburn and Castlereagh

The following areas had a majority of health outcomes that were worse than the Northern Ireland average:

- Belfast HSC Trust
- Belfast Local Government District
- Derry City and Strabane

For each area analysed, the following chart shows the number of indicators that widened, narrowed or did not show a notable change across the period.

23 NISRA Report on Health Inequalities 2020



* For the purposes of this graphic, gaps which reversed direction, but remained similar in magnitude have been included in the 'no change' category.

Figure 15: Health Inequalities Annual Report 2020

4.2.12 Urban-rural analysis

Compared with the regional average, rural areas experienced better outcomes across the majority of indicators analysed, however fire and ambulance response times continue to remain higher in rural areas. There were no notable changes in rural Northern Ireland gaps over the analysed period, with the exception of ambulance response times where the gap decreased from 61% in 2015 to 32% in 2019.

Board prompts

- Do we know where an improvement is needed?
- What do we need to do as a Board to identify and encourage the spread of this improvement to these areas?
- Is there anything the Board needs to do to unblock a barrier to spread? Or, what can we learn from this failure?
- Am I generous in acknowledging success?
- How do I support the Chief Executive and other leaders?
- How do I approach the challenges in improving health inequalities?
- How do I go about challenging or criticising? Am I supportive or do I only discourage?

4.3 Quality improvement and measurement

What is quality improvement and why is it important?

Quality improvement (QI) is a systematic approach to improving health services and the quality of care and outcomes for patients based on iterative change, continuous testing and measurement, and empowerment of front line teams.

Quality improvement tools can play a key role in improving health care, including improvements in time-savings, timeliness of service provision, cost reductions and a decrease in the number of errors or mistakes. At a time of severe financial restraint, rising demand for services and significant workforce pressure, quality improvement approaches offer opportunities to improve the quality of care and increase productivity.[24]

4.3.1 What are the key lessons for senior leaders in adopting a quality improvement approach?

Adopting a quality improvement (QI) approach involves significant and sustained cultural change within organisations, which will require time and resource. Before starting on a quality improvement journey, organisations – and particularly leadership teams – should establish a clear rationale for pursuing a QI approach and accept that it is neither a 'quick fix' in the face of huge operational pressures nor a form of 'turnaround' strategy.

QI methods require a fundamental change to how organisations work, and leaders need to ensure that staff are engaged with and actively involved in developing a shared vision of the quality improvement strategy. QI approaches require a very different leadership style from the one many organisations have: leaders need to commit to a shift from 'problem-solving' to being enablers of change.

It is vital to build Board-level commitment to the principles of QI and support for the shift in emphasis from assurance to improvement.

24 https://www.kingsfund.org.uk

4.3.2 What are the key enablers for embedding a culture of QI?

In order to successfully embed quality improvement approaches, organisations need to develop a new approach to leadership that moves away from imposing top-down solutions to recognising that front line teams, service users and carers are often best placed to develop solutions.

Patient involvement and co-production is a key enabler for a successful QI strategy. Staff engagement – through developing a shared vision, sharing progress and allowing staff the time and space to make changes and innovate – is also vital for success. In addition, leaders should recognise the need to allocate sufficient time and resources to quality improvement – including time for staff away from their 'day jobs' to undertake training or participate in quality improvement activities.

Resources are also required to invest in an educational infrastructure that means staff can be trained in the tools and techniques of the chosen approach. At its core, QI is about change and commitment to continuous improvement.

There are various approaches that include Lean, Six Sigma and Plan-Do-Study-Act (PDSA) cycles. Studies have noted the importance of fidelity to one improvement methodology as it may be more straightforward to build an infrastructure around one approach, and train and build capacity in one methodology. There is a counter argument, however, that, with the complexity of health and social care, we need the flexibility to fit one method to the particular context to get the best possible outcomes.

4.3.3 How can we judge the impact of QI initiatives?

Evaluating and communicating the impact of quality improvement is not straightforward. Individual QI initiatives often take considerable time to demonstrate impact, and even the most successful efforts will face obstacles and setbacks along the way. Although more work is needed to understand how quality QI can be robustly and meaningfully evaluated, those engaged in quality improvement have already begun to use a series of informal indicators as a guide. These included

qualitative comments from staff on the quality improvement approach in staff surveys, and the demand for places on QI training courses and subsequent attendance.

4.3.4 What is the role of the Non-Executive Director in ensuring their organisation prioritises quality improvement?

The Non-Executive Director plays an essential role in ensuring that their organisation priorities QI, including the measurement of quality and achievement of quality-related outcomes.

Board prompts

- Lead by example.
- Be aware that QI is everyone's business.
- Be aware that data is used differently for improvement and for the management of performance and be clear what type of problem the data presented to the Board addresses.
- Ask the right questions to ensure your support and provide oversight of quality improvement in your Board and understand the answers to these questions.
- Make the connections at strategic level that ensure QI activity is held together by an infrastructure and intent for QI across the Board area.

Further information can be accessed here.

4.3.5 What is the aim of the improvement initiative?

Non-Executive Directors can ask how a particular improvement aim was formulated. If it was developed by a group having looked at a problem and who used data to identify and define it, and the problem is understood, then the chances of producing a successful approach to addressing the problem are high.

The 'data' might be survey results from patients, or complaints from staff or patients; it does not have to be quantitative. An aim is most easily formulated where there is

a clear evidence base to inform the actions that will achieve it; sometimes a judgement is necessary where the evidence base is not so clear. A Non-Executive Director can help question if in fact energy is being invested in making the right changes. They will need to be clear that the organisation has the right aims that address what those who receive care most need.

It is important to remember that improvement aims are intended to generate unease with the status quo and to support a sense of urgency that a change is necessary. The change usually involves a redesign of a system or process. It does not involve exhorting people to work harder in the same way. An improvement aim is aspirational and not a target which tempts people to ‘game’ the system or which is used for judgement.

Organisations will have different starting points. Often, a ‘best in class’ organisation will find it harder to reduce a poor practice, for example, by 50%, than an organisation that is an outlier where the poor practice is more evident.

It is important to understand the importance of having an aim that is locally challenging and causes interest.

Examples of the questions that a good aim provokes are:

- How did ward 10 achieve 366 ‘days between’ a patient developing a preventable pressure ulcer?
- How did the GP surgery achieve a reduction of wasted appointments (do not attends) of 45%?

Board prompts

- What is the problem this aim seeks to address?
- Is there data that describes the problem?
- What is the vision behind this aim?
- Is there a clear approach to how those concerned will know the aim is achieved? How has the aim been forged?
- Are unintended consequences likely?
- Do I believe in the aim?
- Does my experience suggest that this is an unrealistic aim?
- Is it appropriate to challenge this aim – or do I need to think and understand more about this?
- Is it the correct change?

4.3.6 Enthusing, involving and engaging staff

It is vital not to undervalue the importance of involving all relevant staff. Breaking down traditional hierarchies for a multidisciplinary approach is essential to ensure that all perspectives and ideas are considered, and all staff are engaged in all levels of improvement. Without involvement, the organisation cannot expect commitment, ownership or further innovation through testing changes. The Non-Executive Director can ask how staff are being engaged in the improvements reported on to the Board.

4.3.7 Involving patients and co-production

Patients, carers and the wider public are the only people who experience the whole healthcare journey from start to finish. They therefore have a significant role to play, both in designing improvements, and also monitoring whether these changes have delivered the anticipated impact.

Patients and their families frequently define quality differently from clinicians and managers (King's Fund, 2011). What they view as a problem or value within a service may be unexpected. They have a role to play not only in person-centred care improvements but in safety and effectiveness too. Therefore, leaders must

ensure patients and their families are able to contribute meaningfully to their organisation's quality improvement programmes.

Board prompts

- Are we improving the right things for maximum impact?
- Is there evidence that there is a problem and something really needs to be improved?
- Does our data about patient and staff experience suggest this would be a good change?
- Do I believe this change is a good use of attention and resource?
- Will fulfilling the aim make a difference to care in this HSC Board area?
- When I walk in the area where this work is taking place and talk to staff, do they know about it?

4.3.8 Is there a clear change method?

When working to improve a situation, it is important to be clear on the change method being used and to consider whether it is appropriate to the issue being addressed. When working to address system level challenges, improvement often requires a combination of approaches. The approach must be appropriate for the 'problem'.

Quality improvement methodologies

There are various quality improvement techniques or methodologies that include PDSA cycles, Lean and Six Sigma.

Models of change – when do we use QI methodology in healthcare?

In some cases, wider systems changes will be necessary to bring about improvement. These could include a change of legislation, or professional regulations. Similarly, the introduction of training to existing staff or introducing a new component to pre-registration courses so that new staff entering a system will bring a new skill will bring about change.

QI methodologies work within the current legislative, professional and regulatory frameworks and challenging these is beyond the scope of these techniques. Parallel activity may of course work to make these changes.

Skill is required to discern which method is most applicable to the issue being addressed. For example, repeated actions that follow a particular sequence, such as the insertion of catheters, or the issuing of repeat prescriptions, are well suited to being improved through the model for improvement that requires rapid hypothesis building, testing and retesting. Redesigning pathways of care that are inefficient and unreliable may lend themselves to lean techniques. An example would be making the distribution of medicines throughout a series of hospitals more efficient.

It is important to recognise that QI usually takes time; the more people who are involved and more complex the environment the longer it will take to make and then embed improvements.

Crucially, Board Members are in a strong position to support the wider cultural changes that will be necessary if these QI methodologies and the 'habit' of QI are to become part of the local culture.

PDSA cycles

PDSA cycles are used to test an idea by trialling a change on a small scale and assessing its impact, building upon the learning from precious cycles in a structured way before wholesale implementation. To learn more about PDSA cycles click here.

Process mapping

Although technically not an improvement methodology, since a map is simply a description, process mapping has been included here, since developing a process map is often the first step in any improvement initiative. The sequence of steps in a process are identified and drawn. Quite often this act of investigating and describing a process will immediately show areas where there are inefficiencies or blockages. This can then lead to improvement action to 'unblock' and streamline the process.

To find out more about process mapping, click here.

Lean

To read about how lean thinking is being applied in NHS Scotland, click here.

Six Sigma

To read about Six Sigma click here.

As healthcare is an extremely complex system, involving many human factors, it is important to consider which methodology will suit the intended improvement and the local context. It is also important to remember that improvement has a 'result' and is not only an activity. An understanding of why a particular improvement was identified and why a particular method was selected suggests fluency with the methodologies. If a Board is to lead by example this is a requirement. Changes may also have unintended consequences and the role of a Non-Executive Director is to be alert for the impact on the whole system.

In a large organisation, the narrative draw of one approach may engage staff powerfully and support culture change. Whether one approach or a variety of approaches is adopted, strategic support, integration, intent and planning for QI are important.

Board prompts

- How was the change method decided?
- Were other methodologies considered?
- Is the degree of attention to the problem proportionate and risk based?
- If the change happens, will the result matter? (So what?)
- Do I need to know more before I can properly understand this?
- Am I leading by example in introducing and/or supporting improvements at Board level?
- Do I have a preferred change methodology that blinkers me to others?

4.3.9 Can we measure and report progress on our improvement aim?

Non-Executive Board Members need to be aware that measurement can be used for different purposes. Measurement for improvement differs from measurement for judgement and measurement for research. In one Board meeting, Non-Executive Board Members will often be required to understand data for these three different purposes. It is important to know the different expectations on Board Members for each type of measurement.

Data is commonly gathered from services so that managers and quality assurance and scrutiny organisations can judge the performance of those services against agreed quality thresholds and targets. Data is also commonly collected by research projects that seek to develop knowledge of better ways of delivering services. An example would be data on different medicines to manage blood pressure in patients in the community.

Data for improvement cannot usually be used for comparisons between sites and against thresholds, and more commonly involves tracking processes and outcomes for the same site(s) over time. A typical example is a run chart for a ward showing the number of admissions where a care plan is in place within a particular timescale.

Measurement for improvement informs staff learning as the improvement process develops; data is therefore ‘good enough.’

Rather than waiting for the results of an audit, an improvement approach might use a small sample of case notes used in one morning to see if an action has been taken, and quickly establish if not, then why not. This intelligence is fed into the picture of trying to make the improvement work later that day. For example, if case notes suggest an action did not take place and it is then identified that a new member of staff who did not know about the action was on the rota, then in future the induction for new staff can include reference to this.

At Board level, data for improvement at the local level is usually reported once it has been collected at scale or over a period of time, where there is a cohesive story. A typical point in reporting to the Board is when an improvement has been demonstrated and it then becomes a strategic responsibility to consider how to spread that improvement elsewhere.

Data can be used to understand how well the system is working in meeting the needs of those receiving care and can help the organisation focus energy on the right things. For example, staff might be concerned at the delays in movement of patients through an outpatient clinic; quantitative measures of time and qualitative measures through patient satisfaction surveys would confirm this needs improvement.

Data can be used to prioritise improvements so that those that will bring the biggest change are made first; for example, falls prevention, pressure ulcers and sepsis.

Measurement for improvement should include a small set of measures to test the hypothesis that a particular intervention will bring about an improvement from a variety of angles.

Interpreting data

Board Members will be required to understand data that are reported to them, rather than know about how data might be collected, analysed and presented. Whilst a series of quarterly reports might be enough to establish a trend for some measures, data for improvement needs to show points plotted over units of time that allow for interpretation if a change introduced at one point has had an impact. This is typically shown in a run chart that can be annotated.

Non-Executive Board Members also need to be aware that variation in a process may cause a ‘point in time’ data return to fluctuate between ‘green’ one month and ‘red’ the next if the variation is around the set target level. It is important to understand the variation over time rather than responding to the one data point, and support the Board to minimise these variations.

It is not enough for a Board to simply approve QI data. It is a Board responsibility to see if there are links to other improvements elsewhere in the Board area, ensure the QI work is integrated into a Board-wide intent for QI and an infrastructure to ensure improvements can be sustained.

Board Members are in a position to encourage and support improvement by example, by making links through knowledge of what is going on elsewhere, and by supporting wider changes that could bring about parallel improvements. A Board needs to clear on the purpose of and be alert to the impact on staff if asking for measures.

Board prompts

- What is the data for?
- Is it up to date?
- What does it say?
- Do I know how to look at this presentation of data?
- Do I understand it?
- Do I need to have a short session with someone who can interpret this?
- Do I know how this presentation differs from other data presented in Board papers?

Resources and improvement

Capacity is related to time and ability to spot opportunities

There also needs to be the mental ‘headspace’ to formulate improvements and follow them through. Studies from national QI programmes have shown that middle managers are so busy doing the work that even if they know about QI and are committed to it (are capable of leading QI work), they often don’t have the capacity to support QI in their areas. Often they are responsible for much of the measurement for performance on which the Board is judged and it takes skill and application in order for them to flex and encourage improvement.

A Non-Executive Director can ask what plans there are:

- For developing staff in improvement skills across the NHS Board area;
- For supporting staff to actually use the skills they have learned, including creating the 'headspace' for proactive improvement work; and
- To retain those staff once they have learned the skills.

A lot of disconnected projects, each with their different measures and reporting mechanisms can be very demanding on staff and the system. QI is most likely to be effective if improvement projects are linked and supported at a system-wide level and all are focused on a few key aims for the whole Board area. This ensures good governance and avoids a 'scattergun' approach. There is a tension, of course, between wanting to encourage staff to think of and develop improvements, and ensuring that this enthusiasm and energy is focused on priority areas for the Board and where it will make most difference.

It is a Non-Executive Director's privilege to have an overview of the system and to support the integration of changes so there is intent for, and a consistent approach to QI, and that activity is held together and sustained with an infrastructure. This helps ensure QI becomes part of the culture and is not only activity that is person or situation dependent.

Board prompts

- Do staff in the relevant area have the capacity to take on this improvement?
- Are they capable (i.e. do they have the skills)?
- What is the Board plan for improvement?
- How can I support the development of capacity and capability in my Board area?
- Does my Board have a philosophy or consistent approach to QI?
- Does my Board have a commitment to building up capability and capacity in QI?

4.3.10 Have we set our plans for innovating, testing, implementing and sharing new learning to spread the improvement everywhere it is needed (spread plan)?

Approximately two-thirds of healthcare improvements go on to result in sustainable change that achieves the planned objective (Health Foundation, 2011).

Local improvements, however, need to be acknowledged, celebrated and spread. Spread is “when best practice is disseminated consistently and reliably across a whole system’ and involves the implementation of proven interventions in each applicable care setting”.

Understanding barriers to quality improvement

Non-Executive Directors need to understand that QI involves change and change is often resisted. An understanding of what may hold back change will help in developing QI in the first place and then supporting the spread of that change. Some barriers relate directly to the potential of the Board to support or inhibit improvements, most notably the role of leadership and organisational context and culture. Non-Executive Directors have a powerful role in leading by example.

There are barriers to spreading improvements. In healthcare a third of improvements are never spread beyond the unit where the improvement originated, a further third are embedded in their unit and spread to the organisation and the final third are spread beyond the organisation (UK NHS Institute for Innovation and Improvement, 2010). A common mistake in attempting to spread a success is to task those who have first introduced the change with the responsibility for spreading it. It is not their responsibility; it is a strategic responsibility.

Spread is not as simple as identifying an improvement in an area and telling others to go and do the same. A plan for spreading the change that is supported by Board leadership will be required. The plan needs to make sure that the conditions are created so that those in the next area in the spread plan wish to adopt the change.

The relevant people need to be identified, starting with those who are most likely to adopt the change and the ground prepared. Supporting others to make the change may require a combination of persuasion, marketing and communication skills and change management. On an encouraging note, the history of the NHS is the history of adopting innovations and positive changes. Antibiotics, anaesthetics and the concept of an outpatient department were once innovations. The current challenge is to ensure that innovations and changes that bring an improvement to the way healthcare is delivered are adopted.

Sustainable change

Sustainability is when new ways of working and improved outcomes become the norm. There is evidence that sustainable change is more likely in certain contexts (Health Foundation, 2014). A model that involves patients and staff in co-developing, co-designing and implementing changes is more likely to secure a change than one driven by a 'command and control' or hierarchy model where a change is enforced.

A successful and sustainable spread of change requires understanding of the organisational culture, and knowledge of different units, areas and staff groups. The plan for spread must align with the vision and values of the organisation to ensure the work to spread the improvement is undertaken with conviction in each area. The role of senior leadership is to support alignment of improvements and provide the overview of the system to ensure that improvements are reliably implemented, spread and sustained.

Board prompts

- How can we celebrate this success?
- Do we know where else this improvement is needed?
- What do we need to do as a Board to encourage the spread of this improvement to these areas?
- Is there anything the Board needs to do to unblock a barrier to spread? Or, what can we learn from this failure?
- Am I generous in acknowledging success?
- How do I support the Chief Executive and other leaders?
- How do I approach the failure of an improvement?
- How do I go about challenging or criticising? Am I supportive or do I only discourage?

SECTION 4: (b) Integrated governance

4.4 An overview of integrated governance

4.5 Clinical governance

4.6 Social care governance

4.7 Risk management and effective controls

4.8 Financial stewardship

4.9 Information governance

4.10 Professional regulation and standards

4.4 An overview of integrated governance

Corporate governance was first defined in the Cadbury Report[25, 26] as the "*system by which organisations are directed and controlled"*. This direction and control is essentially concerned with the most senior levels of an organisation and how they seek to achieve their objectives and meet the necessary standards of accountability and probity. For the NHS, corporate governance was defined by the Audit Commission as "*the framework of accountability to users, stakeholders, and the wider community, within which organisations take decisions and lead and control their functions to achieve their objectives".*

In the mid-1990s it was recognised that the NHS saw corporate governance as a series of strands covering clinical, social care, financial and other aspects rather than on more fundamental areas such as the quality of health care and the need for greater emphasis on clinical and social care governance. In 2006 the concept of **integrated governance** emerged and was defined as the "*systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations".*

Key to delivering this is the Trust/ALB integrated governance strategy, accountability and assurance framework.

Clinical governance (see section 4.5) is defined as "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellent care will flourish".

Social care governance (see section 4.6) is defined as "the process by which organisations ensure good service delivery and promote good outcomes for people who uses services".

25 The Report of the Committee on the Financial Aspects of Corporate Governance. December 1992.
26 Human 'Corporate Governance in the NHS', November 2003.

The following parts of the HSC Board Member Handbook form the key elements of clinical and social care governance quality and safety arrangements:

- Serious adverse incidents (SAIs) (section 4.5.1)
- Never event (section 4.5.5)
- Management of HSC complaints (section 4.5.7)
- Early alert (section 4.5.9)
- Clinical standards and guidelines (section 4.5.10)

4.4.1 The need for transition to integrated governance systems

In 2007, the Social Care Institute for Excellence defined social care governance as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[27]

The context for integrated governance in healthcare has its origins in 2004[28] when NHS organisations were urged to: move governance out of individual silos into a coherent and complementary set of challenges, requiring Boards to focus on strategic objectives, but also to know when and how to drill down to critical areas of delivery, require the development of robust assurance and reporting of delegated clinical and operational decision-making in line with well-developed controls and to be supported by Board assurance products, which provide Board Members with a series of prompts with which to challenge their objectives and focus.

The Good Governance Institute's Integrated Governance Handbook recognised that in simple terms there is only one governance and that this is primarily the business of the Board. Apart from clinical practice at the point of care the Board is the key place where all the aspects of governance (clinical, social care, quality, cost, staffing, information etc.), come into play at the same time.[29] Effective governance requires that organisations do not dissipate the composite whole into fragments that never realign.

27 Social Care Institute for Excellence 2007.
28 NHS Confederation Conference Paper by Professor Michael Deighan (and others): 'The development of integrated governance, NHS Confederation', May 2004 as summarised by John Bullivant.
29 Ibid.

In 2006, integrated governance was defined as the "systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations".[30] Key to delivering these systems, processes and behaviours are the Trust's integrated governance arrangements clearly articulated in a strategy or framework which also encapsulates the organisation's accountability and assurance arrangements.

Governance is 'the discussion'

Governance is a way of thinking. It takes account of feelings, intuition, data, information, experience, knowledge, leadership, decision-making, management, risk, risk appetite, risk management.

Information is sometimes based on analysis and interpretation of data, it can come from other sources, for example an announcement about a change in policy or service reconfiguration, new guidance.

It is informed by

Personal knowledge and experience.

Knowledge and experience of the organisation

Knowledge and experience from the wider world within health and social care and beyond, such as the airline industry.

Governance is about

Management – managing people and managing services.

Leadership – setting the tone and the culture and making decisions

Risk – identification and assessment of risk; risk appetite and risk mitigation/management.

It exists at every level of an organisation.

4.5 Clinical governance

Clinical governance is defined as a "system through which NHS organisations are accountable for continuously improving the quality of their services and

30 DoH Integrated Governance Handbook 2006.

safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".[31]

Social care governance is defined as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[32]

The following sub sections are key elements of the clinical and social care governance quality and safety arrangements of HSC Trusts:

- SAIs
- Complaints
- Early alerts
- Never events
- Clinical guidelines
- Lookback review processes and patient recall.

4.5.1 Adverse incidents, including serious adverse incidents

Effective Boards will recognise that HSC organisations that report more adverse events SAIs usually have a better safety culture. The HSC system can't learn and improve if it does not know what the problems are. It is important to know what happened and why it happened. Effective Boards will also want to know about the things that nearly happened (near misses) as well as those that did.

This section should be read in conjunction with the case studies in section 5.

In line with IHRD Recommendation 69 (iii): Trusts should appoint and train Executive Directors with specific responsibility for learning from SAI-related patient deaths.[33] In practice, the six HSC Trusts have an Executive Director/Director lead for SAIs.

31 Scally & Donaldson, BMJ 1998, 317, 61–65.
32 Social Care Institute for Excellence 2007.
33 IHRD Report, Op. Cit. Volume 3 Page 94.

The Board has collective responsibility for promoting effective patient safety and should actively encourage the reporting of adverse incidents (see also section 4.11 Openness and candour). Board Members should check their organisation against the following criteria of what 'good' looks like in relation to the reporting of adverse incidents.

- We understand that high reporting indicates an open and fair culture.
- We encourage and support staff to report things that go wrong.
- We make it easy to do so and we ensure we feedback themes and lessons learned across the organisation and nationally.
- We understand that effective, honest communication and team working supports situational awareness across teams and the organisation, and allows all team members to have a voice, be listened to and responded to.

Various Board prompts have been provided in the case studies in section 5, however the following are frequently asked questions in relation to the management of adverse incidents and in particular the management of SAIs.

What is an adverse incident?

An adverse incident is defined as any "event or circumstances that could have or did lead to harm, loss or damage to people property, environment or reputation"[34] arising during the course of the business of a HSC organisation, Special Agency or commissioned service.

When the potential for harm/loss/damage is detected and the incident is prevented this is considered a 'near miss'[35] and can be used for organisational learning.

Organisations have to create an open and fair culture which facilitates the reporting of incidents (including near misses[30]) and the sharing of learning which results in change and improvements being made. This avoids making similar mistakes repeatedly.

34 DHSSPS, How to Classify Adverse Incidents and Risk 2006. Adverse incidents are reported by staff using electronic incident reporting forms at local level.
35 A near miss is defined as "… an event that might have resulted in harm but the problem did not reach the patient because of timely intervention by **healthcare** providers or the patient or family, or due to good fortune" CMPA Good Practice Guide.

Adverse incidents are reported by staff using electronic incident reporting forms at local level. The HSCB, PHA and HSC Trusts use a commercial software company, Datix Limited (Datix). Datix is a patient safety organisation that produces web-based incident reporting and risk management software for HSC organisations. Incidents are coded in Northern Ireland using **Datix Common Classification System (CCS)** codes. Datix can be used to interrogate adverse incident information at a systems level and can produce incident reports ranging from local directorate reports to Board reports based on a range of variables including patient type (for example inpatient/outpatient), classification code (type of incident, for example medication error or delay in diagnosis) severity, category and location.

The requirement on HSC organisations to routinely report SAIs to the DoH ceased on 1 May 2010 and transferred to the HSCB, working both jointly with the Public Health Agency and collaboratively with the Regulation and Quality Improvement Authority. The regional guidance can be accessed here.

What is a SAI?

The Board should seek assurance that adverse incidents that meet the threshold of being reported as an SAI are being appropriately notified to the relevant agency, for example HSCB/PHA and RQIA where applicable (See also Memorandum of Understanding at section 4.5.4).

The regional guidance provides a list of criteria that will determine whether or not an adverse incident constitutes an SAI. The criteria include the following.

- Serious injury to, or the unexpected/unexplained death of:
    - A service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit);
    - A staff member in the course of their work; or
    - A member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and/or member of the public.

- Unexpected or significant threat to provide service and/or maintain business continuity.
- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.
- Serious self-harm or serious assault (including homicide and sexual assaults), on other service users, on staff or on members of the public.
- Incidents involving a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.
- Serious incidents of public interest or concern relating to:
    - Any of the criteria above; and
    - Theft, fraud, information breaches or data losses by member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT THAT MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

What is the aim of the SAI process?

The SAI process aims to:

- Provide a mechanism to effectively share learning in a meaningful way, with a focus on safety and quality, ultimately leading to service improvement for service users;
- Provide a coherent approach to what constitutes an SAI and to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation, Special Agency or commissioned/funded service;
- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;
- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;
- Recognise the responsibilities of individual organisations and support them in ensuring compliance by providing a culture of openness and transparency that encourages the reporting of SAIs;
- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence; and
- Maintain a high quality of information and documentation within a time bound process.

Learning from SAIs

Trust Boards should be aware that the key aim of the regional procedure for reporting SAIs is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following an SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided. Board Members should therefore seek assurance that learning is being shared internally and across the system thorough regular reports to the risk and assurance committee of the Board (or equivalent).

Board prompts

- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How we know if improvement in practice has been embedded?

See sections 4.3 Quality improvement, and 4.7.6 Clinical and social care audit.

When should the HSC organisation report the SAI?

The HSC organisation is required to report the SAI within **72 hours** of the incident being discovered.

Board prompts

- Are we meeting timescales for the notification of SAIs? If not, what is the rationale?

How does the HSC organisation review an SAI and are there timescales for reports to be submitted?

There are three levels of review that may be applied depending on the complexity of the serious adverse incident. The Board should seek an assurance that SAIs are being investigated at the appropriate level and review panels/teams are commissioned in accordance with the procedure and that the timescales for submitting reports is monitored.

4.5.2 Levels of SAI review

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. Most will be subject to a Level 1 review. For some more complex SAIs, reporting organisations may instigate a Level 2 or Level 3 review immediately following the incident occurring.

Level 1 review – significant event audit

Most SAI notifications will enter the review process at this level and a significant event audit or SEA will immediately be undertaken to assess what has happened, why it happened, what went wrong and what went well. The review will assess what has been changed or what change has been agreed and will identify local and regional learning.

The possible outcomes from the review may include:

- Closed – no new learning; or closed – with learning; and
- Requires Level 2 or Level 3 review.

The Trust is required to submit a learning summary to the HSCB within eight weeks of the SAI being notified.

Level 2 review – root cause analysis

Some SAIs will enter at Level 2 review following an SEA. When a Level 2 or 3 review is instigated immediately following notification of an SAI, the reporting organisation is required to inform the HSCB, within four weeks, of the terms of reference and membership of the review team for consideration by the HSCB/PHA designated review officer.

A Level 2 review must be conducted to a high level of detail and should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. Level 2 root case analysis or RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report.

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 review – independent reviews

Level 3 reviews will be considered for SAIs that are particularly complex, involving multiple organisations, having a degree of technical complexity that requires independent expert advice or which are very high profile and attracting a high level of both public and media attention. In some instances the whole team may be independent to the organisation/s where the incident/s occurred.

The HSCB/PHA Designated Review Officer sets timescales for the Trust to report the proposed Chair and membership of the review team at the onset for approval.

The timescale for the completion of the Level 3 review and comprehensive action plan will also be agreed between the Trust and the HSCB/PHA as soon as it is determined that a Level 3 review is required.

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident. Appendix 14 of the Protocol for Responding to SAIs in the Event of a Homicide should be followed and can be found here.

4.5.3 Involvement of service users/family/carers in reviews

Board Members should seek assurance that the organisation has fully engaged with service users/family and carers in SAI reviews. The level of engagement will depend on the wishes of the service user/family or carer and can change over time.

This section should be read in conjunction with 'Being Open' and the Department of Health policy directive on a Statement of What You Should Expect If You are Involved in a Serious Adverse Incident for service users, carers and families which sets out the arrangements for families to respond to the findings/conclusions of a serious adverse incident review report and to receive written answers from the healthcare organisation.

Following an SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user/family engagement across the region. The Trust is required to complete a pro forma: Checklist for Engagement/Communication with the Service User/Family/Carers following an SAI. This must be completed for each SAI to ensure appropriate engagement regardless of the review level which is submitted to the HSCB/PHA. The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroner's office and that this is also communicated to the family/carer.

Detailed guidance for Trusts on engaging with service users/family/carers following an SAI is provided in A Guide for Health and Social Care Staff – Engagement/Communication with Service User/Family/Cares.

Board prompts

- Are we actively encouraging the reporting of adverse incidents?
- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How do we know if improvement in practice has been embedded?
- Do we (ALB Boards) get the right information in relation to adverse incident trends and themes?
- Do we get the right information in relation to SAIs?
- Are we engaging with service users? And how do we know the engagement with service users is effective?
- Are we always open when things go wrong?
- Are the teams reviewing Level 2 and Level 3 SAIs independent enough?
- Are we meeting timescales for reporting and follow-up?

4.5.4 Memorandum of Understanding

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding (MOU) − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU on investigating patient or client safety incidents. It can be found on the Department's website here.

The MOU has been agreed between the DoH, on behalf of the HSC, the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for Northern Ireland) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided, for example it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSC.

It sets out the general principles for the HSC, PSNI, Coroners Service for Northern Ireland and the HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for Northern Ireland or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body;
- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these;
- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high-level decisions are taken; and

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC organisations should note that the MOU does not preclude simultaneous investigations or reviews by the HSC and other organisations, for example root cause analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, a strategic communication and decision group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede an SAI review and subsequently delay the dissemination of regional learning.

4.5.5 What is a 'never event'?

Never events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

It is important, in the spirit of honesty and openness, that when staff are engaging with service users, families or carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a never event. However it will be for HSC organisations to determine when to communicate this information to service users, families and carers.

All categories included in the current NHS never events list (see associated DoH link below) should be identified to the HSCB when notifying an SAI. HSC

organisations are required to complete a separate section within the SAI notification form. The SAI will continue to be reviewed in line with the current SAI procedure.

4.5.6 What is a 'near miss' event?

A near miss: an unsafe situation that is indistinguishable from a preventable adverse incident except for the outcome. A near miss in healthcare is an incident that might have resulted in harm but the problem did not reach the patient/client because of timely intervention by healthcare providers or the patient/client or family, or due to good fortune. Near misses may also be referred to as 'close calls' or 'good catches.'

In a culture of safety, near misses are seen as 'free lessons'.

Near misses may occur many times before an actual harmful incident. Many avoidable deaths have a history of related near misses preceding them.

'High reliability' organisations view near misses as learning and improvement opportunities. Such organisations ask: 'How will the next patient/client be put at risk or harmed?' They value and acknowledge input, and make appropriate improvements.

Conversely, '**low reliability**' organisations are falsely reassured because no harm occurs and they mistakenly conclude the system of care is safe. They wait for harm to occur.

System failures or provider performance issues including provider error, or both, may lead to a near miss.

Why are near misses important?

- They represent 'error prone situations' and 'error traps' waiting to catch other patients and providers.

- There is less anxiety about blame as there are no liability concerns (because no one has been harmed).

Why should near misses be reported?

Reporting near misses helps to:

- Reduce risks for all patients by not waiting for harm to occur;
- Trigger improvements in weak spots in the processes of care;
- Alert other providers to possible vulnerabilities and gaps in training; and
- Contribute to planning, recovery testing, and harm mitigation strategies following events that do result in harm.

Examples of near misses

Sometimes a medication is prescribed without considering the patient's allergies or potential for significant drug interactions. In many, but not all, situations the patient or pharmacist recognises the risk in time.

4.5.7 Management of HSC complaints

Complaints within the HSC are managed in line with regional guidance. 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning', was published by the DoH on 1 April 2009 (and updated **in October 2013).**

What is a complaint?

The regional guidance defines a complaint as 'an expression of dissatisfaction that requires a response'. Complainants may not always use the word 'complaint'. They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are really complaints and need to be handled as such.

Who can complain?

Any person can complain about care or treatment, or issues relating to the provision of health and social care.

Complaints may be made by:

- A patient or client;
- Former patients, clients or visitors using HSC services and facilities;
- Someone acting on behalf of existing or former patients or clients. As long as they have obtained the patient's or client's consent;
- Parents (or persons with parental responsibility on behalf of a child); and
- Any appropriate person, for example the next of kin, in respect of a patient or client unable by any reason of physical or mental capacity to make the complaint themselves or who has died.

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

What happens if a complaint is made by a third party?

Confidentiality must be respected at all times and complaints made by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complainant the HSC organisations will seek consent from the patient/client concerned or their next of kin where necessary.

There will be occasions where it is not possible to obtain consent, such as:

- Where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- Where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by a disability, mental illness, brain injury or serious communication problems); and
- Where the subject of the complaint is deceased.

Is there support for complainants?

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are available in Northern Ireland and are an important way to enable people to make informed choices. These services help

people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

What issues does the regional complaints guidance not cover?

The regional guidance does not deal with complaints about private care and treatment or services including dental care or privately supplied spectacles, or services not provided or funded by the HSC Trusts (for example, provision of private medical reports).

The guidance does not cover complaints raised within the HSC organisation, for example issues of staff grievances, investigations under disciplinary procedures or issues raised under speaking out or whistleblowing procedures.

There are separate procedures in place for issues that occur under the following that are also not covered by the complaints procedure:

- A request for information under freedom of information;
- Access to records under the Data Protection Act 1998;
- An independent inquiry;
- A criminal investigation;
- The Children Order representatives and complaints procedures;
- Protection of vulnerable adults;
- Child protection procedures;
- Coroner's cases; and
- Legal action.

Complaints received by the Trusts in relation to GP practices and services will be passed onto the HSCB.

Does the Trust deal with complaints about regulated establishments/agencies and/or independent service providers?

HSC Trusts may make use of regulated establishments/agencies and independent service providers, for example residential homes and domiciliary care providers, to

provide services for patients and clients. This form of treatment and/or care is subcontracted to the relevant organisation and funded by the HSC Trust.

These organisations are contractually obliged to have in place governance arrangements for the effective handling of, management and monitoring of complaints. On commissioning of the service it is accepted good practice for the commissioner, i.e. Trust staff, to inform the patient/client and relatives/carers that the regulated establishment/agency or independent service provider will have a complaints procedure in place.

If a patient/client or relative/carer has a complaint relating to the contracted services they should raise the complaint with the provider of care in the first place. However, if the complaint is raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the independent service provider for investigation or it may decide to investigate the complaint itself where the complaint raises serious concerns or where it is in the best interests of the public to do so.

How can complaints be made?

Complaints can be made to a member of a HSC organisation staff at the point of service delivery.

HSC organisations should work closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation. Trust staff should be trained and supported to respond sensitively to the comments and concerns raised by service users.

Formal letters of complaint received at point of service delivery

If a formal letter of complaint is received at the point of service delivery it will be forwarded to the HSC organisation's complaints officer/Department.

Formal complaints made to the corporate complaints officer/team

Complaints may be made verbally, in writing, via telephone (including voicemail) or electronically (via e-mail).

What information should be included in a complaint?

Complaints officers will require relevant contact details, who or what is being complained about, when the events of the complaint happened and where possible what remedy is being sought.

What are the timescales for making a complaint?

The regional guidance indicates that a complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within six months of their becoming aware of the cause for complaint, or within 12 months of the date of the event, whichever is earlier.

In any case, where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request that the Northern Ireland Public Services Ombudsman (NIPSO) consider it.[36]

HSC organisations will normally consider the content of the complaints that fall outside of the time limit in order to identify any potential risk to public or patient safety and, where appropriate investigate the matter.

What is the process for formal complaints?

An acknowledgement of receipt of the complaint should be made within two working days and the acknowledgement will normally express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the organisation. The acknowledgement should contain a copy of the regional HSC '*What happens next'* leaflet.

Complaints should be graded for severity.[37] The issues raised by the complainant may be of a serious nature and may constitute an SAI and the patient/client or

36 Northern Ireland Public Services Ombudsman at www.nipso.org.uk

family/carer advised. If that is the case, then the SAI process outlined in section 4.5.1will apply.

The complaint will be investigated within the service area that the complaint arose. In the case of a complaint across two or more service areas/or directorates the HSC organisation will normally nominate a lead directorate who will seek input from the other service areas. Within HSC organisations the Chief Executive may delegate the signing of the final response to the lead service director. The complainant should receive a full response within 20 working days of the receipt of the formal complaint. If the complaint has been notified as an SAI then the SAI timescales will apply. Engagement with the client/service user in these circumstances is crucial (section 4.5.3).

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the organisation will be unable to meet the 20 working days timescale.

What happens if the complainant is dissatisfied with the response?

The complainant will be advised in the first response that they should contact the organisation within three months of the Trust's response if they are dissatisfied with the response or require further clarity. Discretion for extension of this timescales rests with the HSC organisation.

The first step of local resolution should then be that of an offer of further response to the complainant. This may be in the form of a further written response signed off by the lead director(s). This response should be issued **within 20 days** of the complaint being re-opened.

37 Regional Risk Matrix, Appendix 16 HSCB Regional SAI Reporting Procedure. Available at: www.hscboard.hscni.net

Does the HSC organisation meet with the complainant?

An offer of facilitation of a meeting with the relevant staff will be offered. This will normally be taken forward by the existing investigation team and chaired by someone at head of service level or above. The notes of the meeting should be agreed by all that were present.

What happens if the complainant remains dissatisfied with the response?

Complainants may wish to include the involvement of the Patient and Client Council.

Other options should be considered:

- Local resolution by a second investigation team;
- Conciliation;
- Involvement of lay persons;
- Involvement of independent experts; and
- Review by an independent panel.

4.5.8 What is the role of the Ombudsman?

The role of NIPSO is to provide a free, independent, and impartial service for handling complaints about public services in Northern Ireland. NIPSO will make a decision on each case by taking into account all the available facts and evidence. Its role is to carefully consider the views and opinions of both the person making the complaint and whoever is being complained about. Their aim is to help public services improve through investigations and reports.

NIPSO is not an advocacy agency (an agency that acts in favour of a particular cause, idea or policy), but their role is to sure that the rights of people who complain are respected.

The Ombudsman's legal authority to investigate complaints and make recommendations, as appropriate, is set out in the Public Services Ombudsman Act (Northern Ireland) 2016.

The Act provides the Ombudsman with significant powers to obtain information from public service providers and their employees.

Investigations are conducted in private, though the Ombudsman has the power to publish reports considered to be in the public interest. Before publishing reports NIPSO will take appropriate steps to protect the identity of the complainant.

Section 1: Ombudsman Principles

Principles of Good Administration

Principles of Good Complaint Handling

Principles for Remedy

Section 2: Guidance

Good Administration and Good Records Management

Guidance on Issuing an Apology

Information promise

Human Rights Manual

Section 3: Leaflets

NIPSO Information Leaflet

Signposting to the Ombudsman

Board prompts

- What are we doing to resolve complaints at the point of service?
- Are we always open when dealing with complaints?
- Are we engaging with service users? How we know that service users are satisfied with the responses they receive to their complaints?
- How many complaints are re-opened? How many are referred to NIPSO?
- How is learning from complaints fed into local programmes of care?
- How do we know if improvement in practice is embedded?
- Does the HSC organisation get the right information in respect of themes and trends emerging from the management of complaints? What does it tell us about the quality of our services?
- Are we meeting timescales for acknowledging and responding to complaints?

4.5.9 Early alert system

Notification of emerging issues by HSC Trusts – early alert notifications

The early alert system is the established communications protocol between the DoH and HSC organisations. It is based on the principles of 'no surprises' and an integrated approach to communications. Accordingly, HSC organisations should notify the Department (copied to the HSCB) promptly, and within 48 hours of the event in question, of any emerging issues (events) that have occurred within the services provided or commissioned by their organisation, or relating to family practitioner services.

Events should meet one or more of the following criteria:

- Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;
- The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

- The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client; and
- The event may attract media attention.

The early alert system guidance states “that it is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at director level or higher) communicates with a senior member of the staff in the Department (i.e. the Permanent Secretary, Deputy Permanent Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event”.

The guidance states “that the next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties”. In all cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the appropriate pro forma and forwarded, within 24 hours of notification of the event, to the Department and the HSCB.

Board prompts

- Are we actively encouraging the reporting of early alerts?
- Are we meeting the timescales for reporting and follow-up?
- How can we be assured that the information provided in the early alert is accurate, or as accurate as possible given that facts about the even may still be emerging?

4.5.10 Clinical standards and guidelines

Since the introduction of clinical and social care governance, clinical guidelines have increasingly become a familiar part of clinical practice. Every day, clinical decisions at the bedside, rules of operation at hospitals and clinics, and health spending by governments are being influenced by guidelines. As defined by the Institute of Medicine, clinical guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific

clinical circumstances".[38] They may offer concise instructions on which diagnostic or screening tests to order, how to provide medical or surgical services, how long patients should stay in hospital, or other details of clinical practice.

The principal benefit of guidelines is to improve the quality of care received by patients. For service users the greatest benefit that could be achieved by guidelines is to **improve health outcomes**. Guidelines that promote interventions of proved benefit and discourage ineffective ones have the potential to reduce morbidity and mortality and improve quality of life, at least for some conditions.

Guidelines can also **improve the consistency of care**; studies around the world show that the frequency with which procedures are performed varies dramatically among doctors, specialties, and geographical regions, even after case mix is controlled for.[9] There is a potential that patients/clients with identical clinical problems may receive different care depending on their clinician, hospital, or location. Clinical guidelines offer a remedy, making it more likely that patients will be cared for in the same manner regardless of where or by whom they are treated.

Clinical guidelines are published by a professional body or national organisation with acknowledged expertise in the relevant clinical field. Sources of professional guidance include organisations or reports that are specific to Northern Ireland (for example safety and quality alerts), wider UK bodies (for example NICE, the National Institute for Health and Care Excellence), European societies and international societies. Typically, guidance produced by such organisations is published and freely available on the internet.

Social care guidance is included in the current NICE service level agreement, however, the DoH (NI) Social Care Group undertook to develop a pilot process for the endorsement of these guidelines but have yet to implement NICE social care guidance.

38 Steven H Woolf, Professor of Family Medicine; Richard Grol, Director; Allen Hutchinson, Professor of Public Health; Martin Eccles, Professor of Clinical Effectiveness; and Jeremy Grimshaw, Professor of Public Health. 'Potential benefits, limitations, and harms of clinical guidelines', 1999.

NICE was established in an attempt to end variation in healthcare standards (the so-called ‘postcode lottery’ of healthcare) in England and Wales, where treatments that were available depended upon the NHS health authority area in which the patient happened to live, but it has since acquired a high reputation internationally as a role model for the development of clinical guidelines. NICE is a Non-Departmental Public Body tasked with producing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance to promote clinical excellence and the effective use of resources for people using the NHS is designed for use in England and, as such, does not automatically apply in Northern Ireland.

The Department established formal links with NICE on 1 July 2006, whereby guidance published by the Institute from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in the HSC. This link has ensured that Northern Ireland has access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions. NICE provides national guidance and advice to improve health and social care and publishes guidelines in the following areas.

- **Technology appraisals,** where NICE determines whether or not a drug, medical device or surgical procedure should be funded by the NHS, based on its evaluations of efficacy and its cost-effectiveness.

- Clinical guidelines on the **management of specific diseases** and groups of patients.

- Public health guidance, covering the **promotion of good health** and the prevention of ill health.

- Interventional procedures programme, assessing **the safety and efficacy of new interventional procedures**. England, Wales, Scotland and Northern Ireland are full participants in this programme and fund NICE accordingly.

- **Social care guidance** – NICE works with the adult and children's care sectors to develop independent recommendations for social care.

- **Antimicrobial prescribing guidance** – evidence-based guidelines for managing common infections in the context of tackling antimicrobial resistance, specifically in relation to bacterial infection and antibiotic use.

- **Highly specialised technologies** – the NICE HST programme only considers drugs in development for very rare conditions which by virtue of the small patient population can be significantly more expensive than routinely commissioned medicines.

In the DoH (NI) service level agreement with NICE it was agreed that the Department may add caveats to guidelines to cover legal or policy differences applicable to Northern Ireland, the Department is not permitted to make material changes to the content of the guidelines. The **guidance must be endorsed as a whole** – particular recommendations may not be 'cherry picked' for inclusion or exclusion. NICE guidance is developed for the English HSC system and caveats might include references, for example, in respect of mental capacity legislation or circumstances surrounding the legal circumstances for termination of pregnancy. Whilst there is a process to check the guidance for legal and policy applicability here, there is no reassessment of the clinical or cost evidence used by NICE in coming to its decisions and forming its advice.

The guidance from NICE does not override or replace the individual responsibility of health professionals.

Whilst NICE guidelines are the only source of guidelines with a departmental policy for implementation, they are not the only clinical standards and guidelines which inform clinical practice. Clinical teams typically keep abreast of a full spectrum of clinical guidance. This can be extremely challenging. For example, in 2018/19 a BSO Internal Audit identified approximately 350 guidelines, confidential inquiries

and safety alerts that had been issued to be actioned by HSC Trusts over an 18-month period.

Assurance and monitoring arrangements

It is the responsibility of HSC organisations, under the statutory duty of quality as specified in Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003, to put in place the necessary systems, which should include adequate and comprehensive dissemination, as part of their clinical and social care governance arrangements, for implementing NICE guidance.

The HSC Board is responsible for monitoring implementation of NICE guidance within the HSC system.

The HSC Board holds director-level meetings with the HSC Trusts where the implementation of NICE guidelines is a standing item on the agenda. **All HSC Trusts are required to provide positive assurance that the initial required actions of targeted dissemination, identification of a clinical/management lead and implementation planning have taken place.** This is in addition to the positive assurance that will be sought on implementation.

Clinical audit is a very widely used technique across the HSC, whereby existing practice is compared against an existing quality standard.

Board prompts

- What are our policies and procedures for the management of clinical and social care standards and guidelines?
- What assurances do we have that clinical and social care standards and guidelines are effectively received and disseminated throughout the organisation?
- What assurances do we have that clinical and social care standards and guidelines are implemented (see also section 4.7.6 Clinical and social care audit)?
- How are we using the internal audit function to obtain assurance on internal controls on the management of clinical and social care standards and guidelines? Is the scope and level of investment in internal audit appropriate? How are we maximising the assurances we can gain from internal audit and do internal audit staff have the right skills and experience? Are we making best use of other independent forms of assurance?
- Do we need to establish or increase investment in a separate compliance function to ensure operations comply with clinical and social care guidelines and our policies?
- To what extent do we use the clinical audit function appropriately? Is it systematic and focused on our own risks as well as on nationally identified issues? Are the results regularly reported to the Board through the assurance framework? Does it give us a comprehensive view of the quality of clinical services across the Trust's portfolio?
- What are our potential sources of assurance? Do we use these appropriately, balancing them across the risk profile of the Trust? How have we satisfied ourselves that they are not skewed towards big and topical projects and that we keep our eye on the ball more widely? How do we systematically test and evaluate the sources of assurance?

4.5.11 Lookback review processes including patient recall

A lookback review process is implemented as a matter of urgency where a number of people have potentially been exposed to a specific hazard, in order to identify if

any of those exposed have been harmed and to identify the necessary steps to ameliorate the harm as well as to prevent further potential occurrences of harm.[39]

A lookback review is a process consisting of the following four stages.

1. Immediate action including a **preliminary investigation** and **risk assessment** to establish the extent, nature and complexity of the issue(s).
2. Identification of the **service user cohort** to identify those potentially affected.
3. **Recall** of affected service users.
4. Closing and **evaluating** the lookback review process and the provision of a **report** including any recommendations for improvement.

The decision that a lookback review is required often occurs after a service user, staff member or third party such as a supplier has reported concerns about the death or harm to a service user, or the potential for death or harm, the performance or health of healthcare staff, the systems and processes applied, or the equipment used. The triggers for consideration of a lookback review may include, but are not limited to the following:

- Equipment found to be faulty or contaminated and there is the potential that people may have been placed at risk of harm;
- Concern about missed, delayed or incorrect diagnoses related to diagnostic services such as screening, radiology or pathology services;
- Concerns about incorrect procedures being followed or evidence of non-compliance with extant guidance;
- Concerns raised regarding the competence of practitioner(s) or out-dated practices;
- A service review or audit of practice shows that the results delivered by either a service or an individual were not in line with best practice standards and there is a concern that there was potential harm caused to a cohort of service users as a result;

39 Health Service Executive (HSE) 'Guideline for the Implementation of a Look-back Review Process in the HSE', HSE National Incident Management and Learning Team, 2015. Section 1 page 4.

- Identification of a staff member who carries a transmissible infection such as Hepatitis B and who has been involved in exposure-prone procedures which have placed service users at risk; or as a
- Result of the findings from a preceding SAI or a thematic review by the HSCB/ PHA or RQIA.

HSC organisations are required to implement The Regional Guidance for the Implementation of a Lookback Review Process. A draft policy to replace HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer on 8 March 2007 is currently out for consultation and it is envisaged that this will be issued in Spring 2021. The draft policy details the roles and responsibilities of all stakeholders including HSC Boards, Chief Executives, the PHA/HSCB and the DoH. It documents the steps, including the service user and staff support and communication plans that are to be undertaken by HSC organisations when a lookback review process is initiated. HSC organisations should develop their own local policies and procedures, consistent with the policy and regional guidance when issued during 2021, to address any potential lookback review process.

The purpose of the draft policy and regional guidance is to ensure a consistent, co-ordinated and timely approach for the notification and management of potentially/affected service users carried out in line with the principles of 'Being Open'[40] whilst taking account of the requirements of patient confidentiality and data protection.[41, 42]

The objectives of the policy are to:

1. Assist HSC organisations in adopting a risk-based approach and ensure the timely management of appropriate and relevant care for affected groups of service users.

40 National Patient Safety Agency, 'Being open – communicating patient safety incidents with patients and their carers'. September 2005. Archived on 18 February 2009 at webarchive.nationalarchives.gov.uk.
41 European Union, 'General Data Protection Regulations (GDPR)'. 25 May 2018 at https://eugdpr.org.
42 Data Protection Act 2018, www.legislation.gov.uk

2. Establish a standard approach to notification of service users, families/carers, healthcare managers and the public of clinical incidents involving potential injury, loss or other harm to groups of service users.

3. Ensure that communication with, and support for, all affected and potentially affected service users, their families and/or carers and also staff occurs as soon as reasonably practicable, and in as open a manner as possible..

4. Ensure that the HSC organisation adopts appropriate support mechanisms for the health and well-being of staff involved.

5. Ensure that communication with the DoH, HSCB, PHA and the public occurs in a consistent and timely manner.

6. Ensure that HSC organisations' services have established and consistent processes in place when a lookback review is undertaken, and that they also maintain the business continuity of existing services and public confidence.[43]

7. Ensure that HSC organisations appropriately reflect upon the issues which prompted the review and any learning from the outcomes of a lookback review within their systems of governance.

43 South Australia Health, Lookback Review Policy Directive, Safety & Quality, System Performance & Service Delivery, July 2016. Section 1 page 4.

Board prompts

- Can we be assured that immediate steps have been taken to prevent any further harm?
- Has a risk assessment of the situation been carried out?
- What is the level of harm to service users?
- How many service users could this potentially impact?
- Does this affect any other Trust or healthcare provider?
- Has an early alert been submitted?
- Does this constitute an SAI?
- Have we informed the potentially affected service users?
- What is our communication plan including service users, general public and the media?
- How can we reassure service users and the public that the services provided by the Trust are safe?

4.6 Social care governance

HSC Trusts as corporate entities are responsible in law for the discharge of statutory functions delegated by the HSCB. The scheme for the delegation of statutory functions specifies the control and assurance processes informing the organisation's discharge of its statutory functions. The nature and scope of these functions and related services give rise to enhanced levels of public scrutiny. These include:

- Interventions in respect of personal liberty;
- The protection of children and vulnerable adults;
- Corporate parenting responsibilities;
- Provision of vital services; and
- Exercise of regulatory functions.

Their effective discharge is central to organisation integrity. As a consequence, they have heightened organisation and corporate significance and assurance profile. The Trust is required to have in place systems that are capable of balancing appropriately the complex issues of protection and care.

Statutory responsibilities of HSC Trusts

The Health & Personal Social Services (NI) Order 1994 permits the Regional Health & Social Services Board to delegate responsibility for the discharge of relevant personal social services statutory functions to HSC Trusts. Specific duties and powers have been delegated to each Trust under the following legislation:

- The Children (Northern Ireland) Order 1995;
- The Adoption (Northern Ireland) Order 1987;
- The Children (Leaving Care) Act (Northern Ireland) 2002;
- The Mental Health (Northern Ireland) Order 1986;
- The Disabled Persons (Northern Ireland) Act 1989;
- The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978;
- The Carers and Direct Payments (Northern Ireland) Act 2002; and
- The Health and Personal Social Services (Northern Ireland) Order 1972.

The Executive Director of Social Work

The Executive Director of Social Work must be a registered social worker and holds delegated responsibility for personal social services delegated functions. The Executive Director of Social Work is a member of the Trust Board and is accountable to the Chief Executive for compliance with legislative requirements and for ensuring that systems, processes and procedures are in place to effectively discharge statutory functions in respect of child care, mental health, disability and community care and in relation to the social work and social care workforce. The Executive Director of Social Work has a dual responsibility – operational responsibility for the delivery of children's services and executive responsibility for social work in adult services – and provides a direct line of professional accountability from social work practitioners in all programmes of care to the Chief Social Worker, Department of Health.

The HSC Trust as a corporate parent

When a child comes into care ('looked after'), the HSC Trust becomes the corporate parent. The term 'corporate parent' means the collective responsibility of the Trust Board, employees, and partner agencies, for providing the best possible care and safeguarding for the children who are 'looked after'.

A child in the care of the Trust depends on the Trust Board to be the best parent it can be. Every Trust Board Member and employee of the Trust has the statutory responsibility to act for that child in the same way that a good parent would act for their own child.

Corporate parenting principles

- To act in the best interests, and promote the physical and mental health and well-being, of children and young people who are 'looked after';
- To encourage those children and young people to express their views, wishes and feelings;
- To take into account the views, wishes and feelings of those children and young people;
- To help those children and young people gain access to, and make the best use of, services provided by the HSC Trust and its relevant partners;
- To promote high aspirations, and seek to secure the best outcomes, for those children and young people.;
- For those children and young people to be safe, and for stability in their home lives, relationships and education or work; and
- To prepare those children and young people for adulthood and independent living.

Child protection

Those who work with children, young people or families, in whatever capacity, have a particular responsibility to promote their welfare and ensure they are safe. All organisations and agencies working with children and young people must discharge their functions with regard to the need to safeguard children and young people, must have procedures in place for safeguarding, and ensure these are adhered to.

There will unfortunately be occasions where early intervention and support is not sufficient and a child is identified as being 'at risk of significant harm'. In such cases statutory intervention to protect the child or young person will be required. This may include the child being the subject of a child protection plan, the child's name being

placed on the child protection register, and/or the child becoming 'looked after' by the HSC Trust.

Adult safeguarding

Adult Safeguarding: Protection and Prevention in Partnership (DHSS&PS and DoJ, 2015) is the Government's adult safeguarding policy developed by the Department of Health and the Department of Justice on behalf of the Northern Ireland Executive.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect.

The policy states that adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe.

Adult safeguarding extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

The following definitions are intended to provide guidance as to when an adult may be at risk of harm and in need of protection.

1. An **'adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal circumstances – which may for example include but may not be limited to age, disability, special educational needs, mental or physical frailty, or life circumstances such as isolation, socioeconomic factors and living conditions.

2. An '**adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased if unable to protect

for example their own well-being, property, assets and where the action or inaction of another is causing or likely to cause harm.

The rights of vulnerable adults to live a life free from neglect, exploitation and abuse are protected by the Human Rights Act 1998.

Social care governance framework

The Social Care Institute for Excellence publication, Social Care Governance: A Practice Workbook (NI) (2nd edition) (2013) defines social care governance is defined as the process by which organisations ensure good service delivery and promote good outcomes for people who use services.

The publication sets out many of the key factors that are associated with organisations which are well managed, high-performing and successful.

This publication provides a social care governance framework which supports Trust Boards to review the quality, safety and effectiveness of current practice, and to identify the actions necessary to improve and develop. Non-Executive Directors are encouraged to review this comprehensive framework and use it as an aid to supporting them in the discharge of their corporate social care governance responsibilities.

The framework includes four key areas of social care governance:

- Leadership and accountability;
- Safe and effective practice;
- Accessible and flexible service responses; and
- Effective communication and information.

Board prompts

Leadership and accountability

- Are the systems in place to support the discharge, monitoring and reporting of statutory functions sufficiently robust and offer you the necessary assurance?
- Do you receive a corporate parenting report every six months with sufficient information to provide you with assurance about your corporate parenting responsibilities? (DHSS-PSNI Corporate Parenting Circular CC3/02)
- What social care governance structures and arrangements are in place and do they support you in discharging your corporate responsibilities? Are the social care governance strategic audit plans aligned to the risk and assurance framework to drive quality and safety?
- Does the culture of the organisation support and contribute to organisational learning and improvement; effective partnerships with other organisations; and meaningful collaboration with people who use social services and carers?
- How are resources planned and invested in social services functions to ensure optimal outcomes are being delivered? What gaps exist in human and financial resources within social services and how are these being addressed?
- How is unmet need identified and what system is in place to record and use the information?

Safe and effective practice

- How is risk assessed and managed? Is there evidence of service user and carer involvement in risk management and decision-making?
- What system is in place for the notification, management and reporting of adverse incidents in social care and near misses in the organisation and are they sufficiently robust?
- Does the organisation have effective commissioning arrangements in place which deliver safe, quality social services through third parties?

- Is quality improvement methodology proactively used in social services to improve quality and safety?
- Does the organisation proactively support research activities and evidence-based practice in social work and social care to shape service development?

Accessible and flexible service responses

- What systems are in place to gain direct feedback about the quality of services provided?
- Does the organisation have appropriate systems in place to promote and support the involvement of people who use social services, and carers, in all aspects of service planning, delivery, evaluation and review?
- How does the organisation support integrated and partnership working with other key and related organisations to deliver quality social care services to adults and children?
- How is the equality and human rights duty upheld in the discharge of social services?

Effective communications and engagement

- How is social care governance information shared across your organisation at team, directorate and corporate level to support service improvement? How is learning and service improvement evidenced?
- How does the organisation promote and support the use of quality standards across all programmes of social care and how are they reported on?
- How effective are the data systems for statutory duty reporting?
- How is information and data captured, including emerging trends, analysed and communicated to support future planning, commissioning, and unmet need?

4.7 Risk management and effective controls

4.7.1 Corporate governance

The Board should ensure that there are effective arrangements for governance, risk management and internal controls in place throughout the organisation and be able to assess and demonstrate those arrangements through a number of key documents, including the **assurance framework** and the **governance statement.**

Traditionally, responsibility for governance has been discharged through a number of separate controls or disciplines such as finance or clinical and social care governance. But risk crosses boundaries and the systems and controls put in place to manage it must be comprehensive and flexible. The **assurance framework** is designed to help Boards address this by providing a clear, concise structure for reporting key information to Boards.

The assurance framework identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls, or where the organisation has insufficient assurance about them. It should also provide structured assurance about how risks are managed effectively to deliver agreed objectives. As well as establishing a basis for the spread of good practice, it allows the Board to determine where to make the most efficient and effective use of their resources. A robust assurance framework provides a strong basis for effective challenge and better-informed decision-making in the boardroom. It will also be of direct relevance to senior Executives, risk and governance managers, and clinical and social care professionals.

The **governance statement** sets out an organisation's system of internal controls and is signed by the Chief Executive, for inclusion in the annual report and annual accounts. The statement will cover the organisation's capacity to handle risk, its risk and control framework, as well as a review of the effectiveness of its internal control. These areas are examined in more detail below.

4.7.2 Risk management

Organisations face a wide range of uncertainties and factors that may affect the achievement of their objectives. This can create a positive risk (opportunities) or a negative risk (threats).

Risk management focuses on identifying threats and opportunities, while **internal control** helps counter threats and take advantage of opportunities.

Proper risk management should help organisations make informed decisions about the level of risk that they want to take and implement appropriate internal controls that allow them to pursue their objectives.

Risk management is not the same as minimising risk. It is important to remember that being excessively cautious can be as damaging as taking unnecessary risks. Risk taking is the basis of progress. Without it, you cannot have innovation and the benefits that come from developing new procedures and interventions or changing business practices. Boards have to carefully consider whether or not potential long-term rewards will be greater than short-term losses.

It is the role of the Board to decide which risks they need to reduce, which they are prepared to accept and what their tolerances are for those risks they are willing to accept. This is known as **risk appetite.**

The Board must make a considered choice about its risk appetite, taking account of its legal obligations, business objectives, and public expectations. This means that different organisations will have different approaches to the same risks and these may change over time, depending on the circumstances. Figure 16 sets out these concepts in more detail.

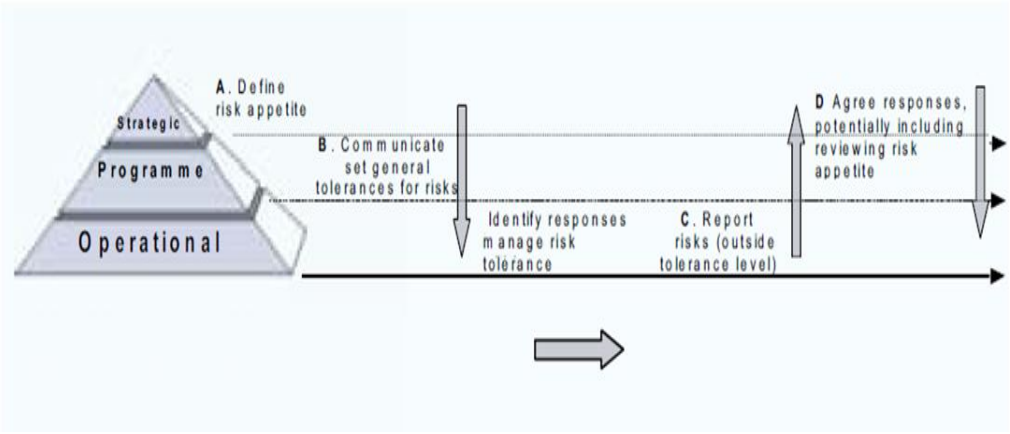


Figure 16: Risk management (HM Treasury, Thinking About Your Risk: Managing Your Risk Appetite, A Practitioner's Guide, November 2006)

A key part of determining risk appetite is the analysis and assessment of each risk. This needs to be done against a common set of metrics. More detail on this can be found here.

Once risk appetite has been established the Board can make decisions about how to respond to different risks. Examples of risk response and when they might be used are set out in Table 2.

Response	When to use
Take opportunities	For circumstances where the potential gain seems likely to outweigh the potential downside.
Tolerate	For unavoidable risks, or those so mild or remote as to make avoidance action disproportionate or unattractive.
Treat	For risks that can be reduced or eliminated by prevention or other control action.
Transfer	Where another party can take on some or all of the risk more economically or more effectively, for example through insurance, sharing risk with a contractor, or management techniques such as public-private partnership.
Terminate	For intolerable risks, but only where it is possible for the organisation to exit (note that some risks can only be assumed by the public sector).

Table 2: Risk responses (Managing Public Money NI)

The Board should make its position on risk clear to both employees and the public through formal annual risk appetite statements so that everyone understands why and how decisions have been taken and as an assurance that the organisation is taking a proportionate response to a risk.

While it is the executive team who will manage the risk, the Board's primary function centres around the organisation's overall control and direction, supported by an audit and risk assurance committee (chaired by a suitably experienced Non-Executive Board Member) and internal audit. More information on this is available in sections 4.7.3 and 4.7.4.

The Board itself should not expect to have more than a dozen or so risks before it and, of those, there should be two or three which pose an immediate threat to organisational stability. Instead, managers will be dealing with the other ongoing corporate and lower-level risks. The assurance framework is designed to allow the

Board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to principal objectives.

It is essential, therefore, that Boards assure themselves that organisations have robust systems in place to deal with a wide range of risks and these systems should be reviewed routinely. As risks (and the appropriate response) can change over time and depending on circumstances, the systems should include the routine monitoring of risks and procedures to raise concerns with the Board as quickly as possible and in line with their risk tolerances. Regular risk assessments should be carried out and information provided on 'close calls' and 'near misses' to enable the Board to evaluate the strength of the risk management procedures.

Figure 17 sets out the process of risk assessment, treatment and review.

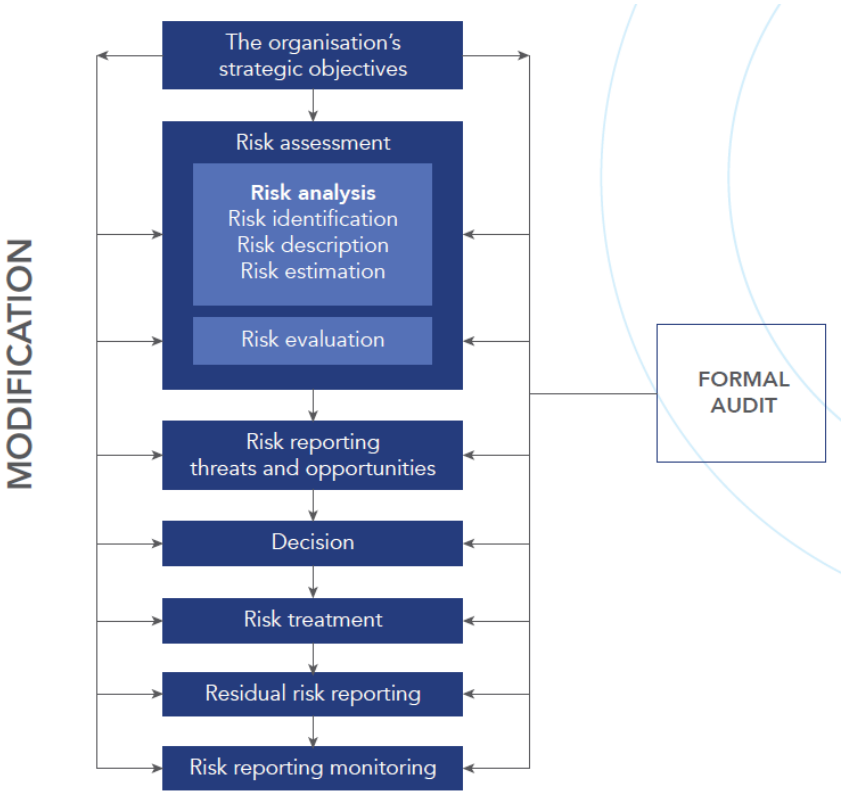


Figure 17: A simple guide to risk for members of Boards and governing bodies (The Good Governance Institute)

Effective governance structures and processes should integrate performance-focused risk management and internal control across all aspects of organisations. The Board should take the lead on, and oversee the preparation of, the organisation's governance statement for publication with its resource accounts each year.

Board prompts

- What level of risk taking we view to be acceptable?
- Have we considered the risk in the context of other risks?
- Have we communicated our risk appetite?
- Have we identified the limits of our risk appetite so that we know when decisions need to be escalated?
- Are risks and opportunities being managed so that the right balance is struck between the organisation's aims and its risk appetite?
- Are risks appraised frequently and systematically?
- Are changes to risks tracked?
- Are adjustments made in response?
- Have the costs been considered?
- How likely is the risk?
- What is the potential impact?
- Have we taken the risk appetite of our partners and suppliers into account?

4.7.3 The remit and membership of the audit committee

The audit committee is responsible for **audit, risk and internal control**, and will report to the Board as appropriate. The Board may decide to have a separate risk committee if it has feels the audit committee has sufficient time or suitable membership to deal with both issues.

The Board should establish an audit committee of independent Non-Executive Directors, with a minimum membership of three (or in the case of smaller organisations, two). The Chair of the Board should not be a member. At least one member should have recent and relevant financial experience.

The main roles and responsibilities of the audit committee include:

- Monitoring the integrity of the organisation's financial statements and publications, including reviewing any significant financial reporting judgements contained in them;
- Providing advice to the Board on the annual report and accounts, particularly whether they are fair, balanced and understandable and if they provide sufficient information to assess the organisation's position and performance;
- Reviewing the organisation's internal financial controls and internal control and risk management systems;
- Annually assessing the need for an internal audit function, monitoring and reviewing the effectiveness of any existing internal audit function and making recommendations to the Board;
- Conducting the tender process for external audit and approving the remuneration and terms of engagement. Making recommendations to the Board about the appointment, reappointment and removal of the external auditor;
- Reviewing and monitoring the external auditor's independence, objectivity and the effectiveness of the external audit process, in line with relevant UK professional and regulatory requirements; and
- Reporting to the Board on how it has discharged its responsibilities.

It is important to note that the audit committee should not limit its focus to internal financial control matters. It has a central role in providing the Board with assurances about all of the organisation's activities and how it is delivering against its objectives, and, the audit committee should review the governance statement before submitting it to the Board for approval and sign-off. More information on clinical (and non-clinical) and social care governance can be found at sections 4.5 and 4.6.

DoH ALBs are required to complete the National Audit Office Audit Committee Checklist, on an annual basis as recommended as best practice by the National Audit Office. Audit committees can assess their performance against best practice using the checklist.

4.7.4 Internal and external audit

Regular internal audits are carried out by auditors to provide an independent, objective assurance about an organisation's risk management, controls, reporting and governance processes. The main purpose of an internal audit is to provide accounting officers with an evaluation of the overall adequacy and effectiveness of these processes. The Accounting Officer will use the Head of Internal Audit's opinion as a key assurance element when completing the annual governance statement. It is one of the key elements of good governance and should add value and improve an organisation's operations.

BSO Internal Audit Unit provides internal audit services to all 16 HSC organisations in Northern Ireland and the NI Fire and Rescue Service.

There should be direct interaction between the Board and internal audit. The Chief Audit Executive must report to the Board and have free access to the Chief Executive and the Chair of the audit committee.

While internal auditors can be used to provide advice and other consulting assistance to employees, external audit do not typically providing close support to the organisations they are examining. This is because external audit are not responsible to management or the organisation; their primary responsibility lies with providing assurances to the public that public resources have been safeguarded appropriately.

Boards should consider evidence from internal and external audit when making decisions about how to manage and control opportunity and risk.

4.7.5 Internal controls

Internal controls are a key part of corporate governance, providing **clear lines of accountability** throughout the organisation. Examples of internal controls include:

- Monitoring by the Board (corporate strategies, action plans, risk policies, annual budgets and business plans, corporate performance, and governance structures and procedures);
- Internal audits and robust policies;
- Proper balance of power (including selection and succession planning of Executives);
- Performance based remuneration; and
- Monitoring by other stakeholders.

In addition to the governance statement, organisations must complete a mid-year assurance statement, to be signed by the Chief Executive and submitted to the Department of Health by the end of October each year. The mid-year assurance statement enables the Accounting Officer to attest to the continuing robustness of their organisation's system of internal control at the mid-year position and, therefore, covers the same areas as the governance statement at the end of the year. Organisations must also develop an assurance framework to strengthen Board-level control and assurance in general, a statement on internal control and the mid-year assurance statement. More information on these documents can be found at Appendix 5 (ii).

Board prompts

- What safeguards are in place to ensure that performance targets are met, to prevent misuse of resources and counter fraud?
- What records are used to track performance and the use of resources?
- What audit arrangements are in place?
- What information does the organisation publish about its resource and activities?
- How often is this information reviewed?
- How and when are policies and projects evaluated?

4.7.6 Clinical and social care audit

Clinical and social care audits have been endorsed by the Department of Health in successive strategic documents as a significant way in which the quality of clinical care can be measured and improved. Originally, clinical and social care audits were developed as a process by which professionals reviewed their own practice. However, clinical and social care audits are now recognised as an effective mechanism for improving the quality of care that patients and clients receive as a whole. It offers a crucial component of the drive to improve quality.

Boards have not always done enough in the past to measure quality; now they must do so, and a clinical and social care audit provides a mechanism for this. There are a variety of related processes which also have a role in measuring and improving quality, such as confidential, serious adverse incident reviews, patient surveys, research, peer review, internal audit and so on. None of these replace clinical and social care audits and a systematic clinical and social care audit is the main way of assessing compliance of ongoing clinical and social care against evidence-based standards.

A clinical and social care audit needs to be a strategic priority for Boards as part of their clinical and social care governance function. A clinical and social care audit is effectively the review of professional performance against agreed standards, and the refining of professional practice as a result. It is one of the key compliance tools at a Board's disposal and has an important role within the assurance framework.

The clinical and social care audit needs to be carefully compared with, and is complementary to, an internal audit; however they are different processes. It is rare for internal audit providers to have access to specialist clinical knowledge, whereas, for example, an insurance company's internal audit function would almost certainly employ, or have access to, an actuary. Trusts need to consider how they can best gain assurance over clinical and social care risk management and their Boards have a role in driving quality assurance, compliance, internal audits and 'closing the loop.' They need to ensure that the recommendations of reviews and clinical and social care audits are actioned by seeking assurance that improvements in care

have been made. Ideally this should be part of an overall quality framework and should be reported in the Trust's publicly reported annual quality improvement report, or equivalent.

Boards will want assurance that there is a clinical and social care audit strategy in place that meets their strategic priorities, and that:

Meets national commitments and expectations;

Prioritises local concerns;

Integrates financial and clinical and social care audits;

Delivers a return on investment; and

Ensures improvements are implemented and sustained.

Boards should use clinical and social care audits to confirm that current practice compares favourably with evidence of good practice and to ensure that where this is not the case that changes are made that improve the delivery of care. Clinical and social care audits can:

- Provide evidence of current practice against national guidelines or HSC standards;
- Provide information about the structures and processes of a healthcare service and patient outcomes;
- Assess how closely local practice resembles recommended practice;
- Check 'Are we actually doing what we think we are doing?'; and
- Provide evidence about the quality of care in a service to establish confidence amongst all of its stakeholders – staff, patients, carers, managers and the public.

Boards will want to be assured that clinical and social care audits are:

- **Material** – i.e. that they are prioritised to focus on key issues and that the value outweighs the cost;
- **Professionally undertaken and completed** – i.e. clinical and social care audits are undertaken and completed to professional standards including the quality of data being analysed;

- **Producing results** that are shared and acted upon; and
- **Followed by improvements** that are made and sustained.

Boards have clear questions they should ask about any clinical and social care audit programme in their Trust. To advance clinical and social care audits, roles and responsibilities need to be clearly established. The Board's role is to ensure that a clinical and social care audit is strategic, happens regularly, is clinically and cost effective and is linked to the safety and quality agenda.

10 simple rules for HSC Boards

1 Use clinical and social care audits as a **tool in strategic management**; ensure the clinical and social care audit strategy is allied to broader interests and targets that the Board needs to address.

2 Develop a **programme of work which gives direction and focus** on how and which clinical and social care audit activity will be supported in the organisation.

3 Develop **appropriate processes** for instigating a clinical and social care audit as a direct result of adverse clinical events, critical incidents and breaches in patient safety.

4 Check the clinical and social care audit programme for **relevance to Board strategic interests** and concerns. Ensure that results are turned into action plans, followed through and re-audit completed.

5 Ensure there is a **lead clinician who manages** the clinical and social care audit within the Trust, with partners/suppliers outside, and who is clearly accountable at Board level.

6 Ensure **service user and carer involvement** is considered in all elements of a clinical and social care audit, including priority setting, means of engagement, sharing of results and plans for sustainable improvement.

7 Build clinical and social care audits into **planning, performance management and reporting.**

8 Ensure with others that clinical and social care audits cross care boundaries and encompasses the **whole service user pathway.**

9 Agree the **criteria of prioritisation** of clinical and social care audits, balancing national and local interests, and the need to address specific local risks, strategic interests and concerns.

10 Check if the clinical and social care audit **results in evidence of complaints** and if so, develop a system whereby complaints act as a stimulus to review and improvement.

Key points

- The aim of a clinical and social care audit has always been quality improvement.
- A clinical and social care audit is a team endeavour.
- The Department of Health has consistently supported clinical and social care audits.
- Clinical and social care audits are now also a mainstream accountability and not solely clinician owned. They are a quality management and governance activity alongside being a professional development activity.
- Board involvement in clinical and social care audits is very recent and has been minimal to date.
- A requirement to demonstrate active engagement in local and national clinical and social care audits is now becoming more clearly a statutory requirement for HSC Trusts.

HSC Boards are the first line of regulation. While they have accountability for strategic decision-taking for the Trust, they must also represent their stakeholders; the public, patients and funders. This is a difficult balancing act and requires great skill and expertise to reflect national and local priorities, and to ensure safe, cost effective and integrated care that is constantly striving for improvement, whatever the financial climate.

There is scope to maximise the assurance provided by the clinical and social care audit function through considering how programmes can be better aligned to the Trust's individual risks as well as taking account of national priorities. For example, if local serious adverse incident reviews, complaints or surveys illustrate specific,

persistent and/or local concerns, then the clinical and social care audit programme can be designed to include the monitoring of standards related to those concerns.

Board prompts

- Is the approach systematic and focused on locally identified risks as well as on national issues?
- Are the results regularly reported to the Board and used as evidence in the assurance framework?
- Does the clinical and social care audit give a comprehensive view of the quality of clinical services across the Trust's portfolio?

Roles and responsibilities in a clinical and social care audit

There is no prescriptive structure for an effective clinical and social care audit but it is likely that your organisation will have a set of governance roles and committees and a set of management/clinical functions and groupings. The role of the Board is in gaining assurance that strategic objectives are achieved and that services commissioned or provided are safe and cost effective. In respect of the clinical and social care audit (as above), Boards will want to be assured that clinical and social care audits are: material, professionally undertaken and completed, produce results that are shared and acted upon and followed by improvement.

HSC Trusts make a substantial, but often unquantified, commitment to clinical and social care audits. Over and above the costs of any central clinical and social care audit team, there is also a significant hidden cost to Trusts arising from the 'supporting professional activity sessions' within the (medical) consultant contract. These comprise a significant part of the contract and are typically used for clinical and social care audit work, continuing professional development, and additional managerial responsibilities.

The issue of cost-effectiveness is crucial in the current financial climate and the importance of the patient/client quality and safety. Clinical and social care audits do have costs, particularly in staff time. The recommendations they make may require

changes in the organisation or delivery of clinical services, training and additional capacity that will require additional costs. However this needs to be balanced against the finding that efficient and effective care can be cheaper. A clinical and social care audit can be useful in identifying processes that are inefficient or ineffective. They can lead to changes in practice that are not only cheaper but are also preventative. Boards will need to consider these factors.

A clinical and social care audit should be able to demonstrate its value in having a **direct impact on care,** rather than simply measuring care standards, if it is to be justifiable in the quality and safety agenda. Boards will need to be assured that:

- Clinical and social care audits are not just measurement activities but have a quality improvement element;
- Those conducting clinical and social care audits and making recommendations for actions do these with a view to efficiency, productivity and demonstrable impact;
- Clinical and social care audits are not simply conducted for the requirements of professional purposes (such as revalidation, professional membership etc.) but also have an equal secondary purpose of improving services;
- Clinical and social care audits involve patients and the public wherever possible and all results and recommendations are made publicly available;
- Clinical and social care audit recommendations are realistic and practical;
- There are clear timescales and plans for when the clinical and social care audit will be conducted and results acted upon – Boards can ensure action does not 'slide'; and
- Clinical and social care audit actions have led to sustained improvements and clinical practice or service delivery has not 'reverted'.

Selection of clinical and social care audit topics

The Board should have a key role in selecting clinical and social care audit topics. Many of these will be dictated by national clinical and social care audit programmes required by the Department of Health and regulators, but there should be room for the Board to determine topics that reflect the Trust's strategic priorities, concerns or gaps in independent assurance.

The Trust's audit committee (not the clinical and social care audit committee) should ensure the processes are robust to ensure the governance structures are fit for purpose. The focus is one of process rather than content but audit committees should also be looking to ensure that audits are integrated across quality, finance and resources. The line of accountability and responsibility to the Board needs to be clear. These groups do not usually have routine responsibility for clinical and social care audit committees but will focus attention on clinical and social care audit work for specific reasons.

Board prompts

- Do we have a clinical and social care audit strategy based on national and local priorities?
- Do we have a relevance test to approve commitment of resources?
- Does our focus on national clinical and social care audits mean we have no resource to advise on local priorities?
- What proportion of approved clinical and social care audits has been completed to time and budget?
- Has the Board agreed what constitutes materiality, unacceptable variation in clinical and social care audit results a) standards and b) comparisons with others?
- For all clinical and social care audits that identify unacceptable variation is there an action plan?
- Is our Board assurance framework supported by clinical and social care audit as assurance?
- Have we assurance that clinical and social care audits have led to improved service delivery?
- Do we share our clinical and social care audit results with others?
- Do our contracts with suppliers/providers require co-operation in clinical and social care audits, for example in the CQUIN regime?
- Are we using clinical and social care audits for quality assurance usage, and do they fit with our Trust's agreed quality process?
- Are areas such as mental health, primary care neglected in local clinical and social care audit programmes?

4.8 Financial stewardship

Organisations must operate with propriety and regulatory compliance in all that they do under a **statutory duty of financial control and requirement to break even.**

They must use resources efficiently, economically and effectively, ensuring value for money and quality of delivery. Achieving value for money is a core principle when using public funds and organisations must find the right balance of quality,

effectiveness and cost. This means ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed. They must have robust internal controls to safeguard public resources and be able to give timely, transparent and realistic accounts of their business to provide assurances to the public

4.8.1 Roles in HSC organisations

The Board, Chief Executive and senior management team all have a role to play in demonstrating effective financial stewardship of public funds through scrutiny and challenge. Board Members should be provided with copies of the organisation's annual report and accounts.

Board prompts

- Is procurement carried out objectively and fairly to achieve value for money?
- Are projects appraised and approved in line with guidance?
- Budget profiles and adjustments
- Do partnerships with other organisations have agreed documented arrangements in place?
- Has expenditure outside the normal delegated limits been approved by the appropriate person/body?
- Has expenditure outside the normal delegated limits been disclosed on the resource accounts?
- Do the accounts give an accurate picture of the organisation's financial position and transactions?
- Is the organisation's published financial information transparent and up to date?
- Does the organisation publish information about its plans and performance?
- Does the organisation have appropriate internal delegations?
- Is the Board provided with regular and meaningful information on costs, efficiency, quality and performance?
- Is there periodic assessment of whether decisions taken remain appropriate, including feedback from internal and external audit and elsewhere
- Are projects and policies evaluated during and after, to inform decisions about whether to continue, adjust or end the activity?
- How will lessons be learned?
- How will proposals be financed?
- Is there budget and estimate cover?

4.8.2 The role of the Chief Executive as Accounting Officer

Each NDPB or ALB must have an Accounting Officer and this is usually the most senior official in the organisation. They are accountable for the use of resources within the organisation and should ensure that the organisation operates effectively

and to a high standard of probity. They are supported in this role by the Board. The Accounting Officer must personally sign the organisation's accounts, the annual report and the governance statement.

Board Members should familiarise themselves with the obligations under managing public money – a helpful resource can be found here.

Board prompts

- Are resources being used in line with legislation and procedures?
- What are the delegated limits for the organisation?
- Are resources being used to deliver value for money?
- Are resources being used in line with the organisation's strategic aims and objectives?
- Do the governance arrangements enable decisions to be shared, delegated and implemented?
- What internal controls are in place to ensure that resources are used as intended?
- Does the organisation give timely, transparent and realistic accounts of its business, underpinning public confidence?

4.9 Information governance

The storage and use of large amounts of clinical and other sensitive data needed for effective health and care services brings a significant level of risk. The provision of effective management and good quality education and training in information governance is an important method of managing this risk. It also assists HSC organisations in meeting their statutory responsibilities and policy obligations in the areas of data protection, confidentiality, freedom of information and IT security.

Information governance is a key issue for all HSC organisations and contracting organisations and is fundamental to the effective delivery of HSC services, particularly as services move towards the introduction of an electronic health record. Without effective and trusted arrangements for handling service user-identifying

information and other sensitive data, the ability of HSC organisations in Northern Ireland to provide high-quality services could be severely compromised. An information management assurance checklist is set out in Appendix 6.

The fundamental objectives of information governance are to:

- Support high-quality care by promoting the safe, effective and appropriate use of information in Northern Ireland;
- Encourage closer working within HSC services and contracting organisations to prevent duplication of effort and enable a more efficient use of resources;
- Allow staff to discharge their responsibilities to consistently high standards, and
- Comply with legislation and professional codes of ethics by developing support arrangements and providing appropriate tools.

4.9.1 Information governance and regulation

Information governance should include the following.

General Data Protection Regulation (2016) (GDPR): EU law on data protection and privacy for all individuals within the European Union and the European Economic Area.

UK Data Protection (2018): Introduces four distinct data protection regimes into UK Data Protection Law.

GDPR and UK Data Protection 2018 relate to personal information (data). Personal data is information relating to a natural person who can be identified or who are identifiable, directly from the information, or who can be indirectly identified from that information in combination with other information.

Personal data could be something as simple as a name, address or a staff/customer number, or could be other types of identifiers such as an IP address.

It may also include special categories of personal data such as race, ethnicity, political opinions, health data, or sexual orientation.

4.9.2 Freedom of Information Act 2000

The Freedom of Information Act provides public access to information held by public authorities. It does this in two ways:

- Public authorities are obliged to publish certain information about their activities; and
- Members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland. This includes HSC ALBs and other ALBs in Northern Ireland.

Recorded information includes printed documents, computer files, letters, emails, photographs and sound or video recordings (this will include communications with and by Non-Executives on personal platforms – email, social media, written form, etc).

4.9.3 Cyber security

Cyber resilience is being able to prepare for, withstand, rapidly recover and learn from deliberate attacks or accidental events in the online world. Cyber security is a key element of being resilient, but cyber resilient people and organisations recognise that being safe online goes far beyond just technical measures.

By building an understanding of cyber risks and threats, individuals and organisations are able to take the appropriate measures to stay safe. This should include IT security, more generally. Depending on the organisation, this is likely to be a key component in the corporate risk register of a HSC ALB.

4.9.4 Principles (in relation to service user information)

The Caldicott Principles were developed in 1997 following a review of how service user information was handled across public HSC services. The review panel was chaired by Dame Fiona Caldicott and it set out six principles that organisations should follow to ensure that information that can identify a service user is protected and only used when it is appropriate to do so.

Since then, when deciding whether it needs to use information that would identify an individual, an organisation should use the principles as a test. The principles were extended to adult social care records in 2000.

The Caldicott Principles (as revised in 2013)

Principle 1. Justify the purpose(s) for using confidential information
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2 . Don't use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

In April 2013, Dame Fiona Caldicott reported on her second review of information governance. Her report Information: To Share Or Not To Share? The Information Governance Review, informally known as the Caldicott2 Review, introduced a new seventh Caldicott Principle.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality

HSC professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

4.9.5 Information sharing

Information sharing is a complex, but necessary element in the provision of safe, secure and effective health and care services, but this brings with it risks and challenges.

The Department developed a protocol for sharing service user information in 2011 that should be used to support the safe management of personal information between the health and care services.

In addition, the Scottish Government recently produced a toolkit, the Information Sharing Toolkit, which may aid Board Members further in this regard and in light of the requirements of GDPR.

4.9.6 What does this mean for Board Members?

Boards have a role to play in the oversight of information governance within the ALB. Board Members must be assured that the organisation:

- Complies with the legislation; and
- Has appropriate technical and organisational measures to meet the requirements of accountability, including the annual statement of compliance.

From 2018–19 the Department has sought an annual assurance from individual chief executives in relation to their organisation's compliance with information management requirements. HSC organisations are required to maintain the best practice standards set out in this guidance document in order to be able to both provide assurance to the Department and for BSO Internal Audit purposes. BSO Internal Audit will continue to audit HSC organisations' information management compliance on a periodic basis, as is currently the case.

The DoH guidance should be used as a reference document to aid completion of the information management assurance checklist document (set out in Appendix 6) which the Chief Executive in collaboration with the organisation's senior information risk owner (SIRO) and its personal data guardian will be required to complete annually.

The organisation exercising ongoing diligence must review, and where necessary update the measures the ALB has put in place.

It is not for Board Members to do the work or manage information, but to ensure that things are done in respect of all of the above areas and that the policies, procedures and effective management are in place. Consequently, Board Members should be aware of the requirements in respect of all of these areas, without needing to have a detailed understanding.

It is expected that each ALB will have an (operational) information governance committee, together with robust policies and procedures covering all of the areas in respect of information governance. The information governance policy should have been agreed at Board level and should be regularly updated. An information governance report should be brought to the Board annually by a designated member of the executive team.

An overview of all areas of information governance will be included in the induction of all new Board Members and it is good practice to make Board Members aware of changes in legislation and strategy through development sessions and discussions at Board meetings.

The Information Commissioner's Office provides access to the legislation in respect of data protection and freedom of information and this can be used by Board Members as a helpful resource, with guides and toolkits, which will provide gain a wider understanding.

The NHS in England provides a useful Data Security and Protection Toolkit which Board Members may wish to access to assist in their understanding of the issued in respect of information governance.

The Department of Health has issued amended guidance[44] which sets out the expectations for organisation in assuring the Department that:

- They have an information governance management framework in place which is supported by policies, strategies and improvement plans;

44 Appendix 7.

- Mandatory information governance awareness and training procedures are in place and staff are appropriately trained;
- Information governance is supported by adequate information quality and records management skills, knowledge and experience;
- The SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy; and
- Documented and agreed procedures are in place to ensure compliance with the requirements of GDPR.

4.10 Professional regulation and standards

4.10.1 Professional regulation

Staff in specific clinical and social care posts should be registered with a relevant professional regulatory body, as a requirement of their appointment to HSC organisations, as set out in section 4.10.3 below.

Under current statutory healthcare regulation, there are 32 regulated occupations ranging from doctors, dentists and nurses to pharmacists, opticians and osteopaths. To work in any of these 32 professions, professionals must be registered with the appropriate regulator both at the time of appointment and on a continuous basis throughout their time of employment in HSC organisations. The Government is responsible for deciding which occupations are regulated. It is recognised that there are other posts for which registration is voluntary or where the professions are working towards statutory registration, as set out in section 4.10.4 below.

Regulatory bodies have three principle aims:

- Protecting the public;
- Maintaining public confidence in the profession; and/or
- Declaring and upholding professional standards.

Regulation is simply a way to make sure that healthcare professionals are safe to practise and remain so throughout their career, but it is far from simple itself. Regulation is designed to protect the population by limiting the risks that may be

faced when receiving treatment. In UK healthcare, regulation does not just apply to people but also touches many areas, from hospitals to equipment to medicines.

Individual registrants must meet minimum training requirements, pay a registration fee, submit evidence of continuous professional development and subscribe to a defined code of conduct. Individual registrants can be referred to their relevant professional registrant body where issues of professional standards or behaviour are at issue.

The individual regulators have four main functions to ensure that those they register are fit to treat us. They do this by:

- Setting standards of competence and conduct which health and care professionals must meet in order to register and practise, this includes updating and/or producing new guidance (for example, 10 years ago professional behaviour on social media would not have been something regulators would need to cover);
- Checking the quality of education and training courses to make sure they give students the skills and knowledge to practise safely and competently;
- Maintaining a register of professionals which everyone (including the public) can search, but also making sure that the professionals on their registers remain fit to practise. After all a doctor or dentist could pass their exams, start practising and never look at another textbook again. However, regulators are there to make sure that this does not happen. They have various systems in place to gather evidence that their registrants continue to develop professionally and keep up-to-date with developments in their chosen field; and
- Investigate complaints about people on their register and decide if they should be:
    - Allowed to continue to practise (also known as being fit to practise);
    - Allowed to continue to practise but with conditions on how they should work (for example, attending a training course);
    - Suspended from practising; or

- Struck off the register (also known as ‘erasure’), either because of problems with their conduct or their competence.

This process is commonly known as fitness to practise.

In addition to these functions, some regulators will have other responsibilities. For example, the General Pharmaceutical Council also registers and inspects pharmacies.

4.10.2 The Professional Standards Authority

The **Professional Standards Authority for Health and Social Care** (**PSA**) oversees the nine statutory bodies that regulate health professionals in the United Kingdom and social care in England. Where occupations are not subject to statutory regulation, it sets standards for those organisations that hold voluntary registers and accredits those that meet them.

Until 30 November 2012 it was known as the Council for Healthcare Regulatory Excellence. It is an independent body, which is accountable to the Parliament of the United Kingdom. It assesses the performance of each regulator, conducts audits, scrutinises their decisions and reports to Parliament. It seeks to achieve balance in the oversight of regulation through the application of the concept of right-touch regulation.

4.10.3 Oversight of statutory regulators

The PSA covers the nine statutory bodies that regulate health professionals in the UK and social workers in England:

General Chiropractic Council

General Dental Council

General Medical Council

General Optical Council

General Osteopathic Council

Health and Care Professions Council

Nursing and Midwifery Council
Pharmaceutical Society of Northern Ireland
General Pharmaceutical Council

There are similarities and differences but all have the same basic core functions and they are all directly accountable to the Parliaments and Assemblies that hold their legislation. However, the number of registrants each regulator is responsible for varies greatly. For example, the Nursing and Midwifery Council has the largest register with over 690,000 nurses and midwives, whilst the Pharmaceutical Society of Northern Ireland registers 2,470 pharmacists and 548 pharmacies.

Some regulators like the General Chiropractic Council regulate one profession each, whilst the Health and Care Professions Council registers 16 different professions. There are also differences between regulators in their registration fees and fitness to practise processes. Meanwhile, the General Optical Council is the only regulator to register students. These are just a few of the differences. Many differences between regulators are caused by their disjointed legislation, whilst others may be rooted in the different environments in which the professionals work.

4.10.4 Voluntarily accredited associations

In addition several organisations offer a voluntary accredited scheme for practitioners:

Alliance of Private Sector Practitioners (foot health)
Association of Child Psychotherapists
British Acupuncture Council
British Association for Counselling and Psychotherapy
British Association of Sport Rehabilitators and Trainers
British Psychoanalytic Council
Complementary and Natural Healthcare Council
COSCA (Counselling & Psychotherapy in Scotland)
Federation of Holistic Therapists
National Counselling Society
National Hypnotherapy Society

Play Therapy UK

Society of Homeopaths

UK Public Health Register

United Kingdom Council for Psychotherapy

JCCP Practitioner Register

SECTION 4: (c) Culture

4.11 Openness and candour

4.12 Raising concerns

4.13 Internal and external engagement

4.11 Openness and candour

In his Inquiry into Hyponatraemia Related Deaths (IHRD), alongside recommendations focusing on specific clinical practices, Judge O'Hara made recommendations concerning openness and candour. This included a recommendation for legal duty of candour, for HSC organisations and staff, as well as support and protections to enable staff to fulfil that duty. In addition, Justice O'Hara recommended that HSC Trusts should appoint and train Executive Directors with specific responsibility for issues of candour.

Work is underway to introduce the necessary legislation and policies to implement these recommendations. Once they have been implemented, this section of the HSC Board Member Handbook will be updated to provide specific guidance about the legal duty of candour for HSC Boards and Executive Directors.

In the interim, HSC Trusts have put in place policies for openness so that service users, carers, families and staff can have a clear understanding of the standards expected; examples of these are given in Appendix 12.

4.12 Raising concerns

The safety of service users is the concern of everyone working in HSC services and accordingly it must be the duty of everyone to raise patient safety concerns.

However, because it has been found necessary to encourage whistleblowers, the Department has directed that HSC Trusts develop policies enabling staff to raise concerns about questionable practice.

The RQIA issued guidance for whistleblowers and published its Review of the Operation of Health and Social Care Whistleblowing Arrangements in September 2016.

It made 11 recommendations, seven of which the Department maintains "are either fully implemented or on target to be implemented" as at November 2017. This

impetus should be maintained. In every hospital there should be real or virtual individuals to whom concerns can be taken easily and without formality. There should be training and the system should be as responsive as possible.

4.13 Internal and external engagement

4.13.1 Building strong partnerships and engagement

An effective Board will have direct interactions with the organisation's staff, service users and carers as well as with the wider public and key stakeholders such as community and patient representatives, 3rd sector, regulators and the media etc.

Engagement should be routine and the feedback gathered systematically collected and analysed to actively inform the Board's priorities. The Board must demonstrate how it has used this feedback in its decision-making and resource allocation.

HSC organisations have a legislative requirement, as set out in the Health and Social Services (Reform) Northern Ireland Act 2009, to actively and effectively involve service users, carers and the public in HSC services. This is known as personal and public involvement, or PPI (see section 4.14).

Like the engagement itself, the benefits should go both ways. Engaging effectively allows the Board to demonstrate that it is being open, transparent and accountable. Listening to the voices and opinions of others ensures that the Board is putting the user experience at centre stage. Effective engagement should also provide a sense of empowerment and can help shape organisational change as well as drive cultural change. Staff and service professionals are a key element of this and they should be involved in the development of the organisation's strategy that they will be asked to deliver on.

4.13.2 Engagement strategy

The Board should develop an engagement strategy that sets out how and why the organisation intends to engage with staff, service users and carers, community, patient reps, regulators, academics, media, 3rd sector, faith sector etc. The Board

will need to consider how effective the engagement strategy has been and actively seek both qualitative and quantitative feedback.

The Public Health Agency has developed the Engage website as a central resource for involvement in HSC in Northern Ireland. It has a range of resources and tools to support HSC in involving service users, carers and the public. Check out Engage here. Whilst Engage focuses primarily on HSC organisations' responsibilities under the PPI legislation, the resources are useful in developing all forms of engagement.

4.13.3 Effective partnership working

The public sector is a complicated landscape with boundaries that are occasionally blurred and often a source of tension. The system works most effectively when all stakeholders have a shared vision including outcomes and agreement on how they will work together within the system while respecting individual organisational interests and constraints. This can only happen when organisations develop good relationships with regular and ongoing communication.

The basis of any good working relationship is information sharing and a shared sense of purpose but organisations may want to co-ordinate activities through a more formal partnership agreement. Issues to consider include:

- Formulating strategy;
- Ensuring accountability;
- Shaping culture;
- Transparency, particularly around decision-making;
- Outcomes and performance indicators; and
- Service user perspectives.

SECTION 4: (d) Involvement, co-production and partnership

4.14 Duty to involve and consult

4.14.1 Statutory duty to involve and consult

HSC organisations have a statutory duty to involve the public and consult them in relation to their health and social care. PPI is the term used to describe the concept of involving ordinary people and local communities in the planning, commissioning, delivery and evaluation of the HSC services they receive. PPI was first introduced as a concept by the Department in 2007 and it is a central component of the quality agenda.

More recently, there has been an increased focus on embedding a co-production approach to support transformational change and promote the opportunity for all service users and carers to partner with HSC staff in improving health and social care outcomes.

The statutory duty to involve and consult (Sections 19–20 of the Health and Social Care (Reform) Act (2009)) set out a requirement for health and social care to involve and consult service users and their carer's on matters relating to:

- The planning of the provision care;
- The development and consideration of proposals for changes in the way that care is provided; and
- Decisions to be made by that body affecting the provision of that care.

This means that all Board Members are accountable in relation to ensuring that the necessary steps have been taken to involve and consult service users and carers in all major decisions regarding the planning, development and delivery of HSC services.

4.14.2 What is involvement and why is it important?

People have a right to be involved in and consulted on decisions that affect their health and social care. We know that when people are meaningfully involved in decision-making about their health and social well-being, this leads to improved quality, safety, effectiveness and efficiency. Involvement can:

- Ensure responsive and appropriate services;
- Reduce perceived power imbalances;
- Contributes to tackling health inequalities;
- Reduce complaints;
- Reduce adverse incidents;
- Acknowledge rights;
- Increase levels of accountability; and
- Improve dignity and self-worth.

4.14.3 What are the key roles and responsibilities of HSC organisations?

The 2012 DoH policy circular sets out further 'Guidance for HSC organisations on arrangements for implementing effective personal and public involvement in the HSC'. The key roles and responsibilities for each HSC organisation are set out in within the guidance.

All relevant HSC organisations must also have a consultation scheme in place to make it clear how the organisation will involve and consult the Patient Client Council, service users and carers.

4.14.4 Role of the Board in involvement

In 2015, a set of standards for HSC organisations and staff in relation to personal and public involvement were developed and endorsed by the DoH. The five standards set out what is expected from HSC organisations, staff and Boards in relation to involvement:

1. Leadership – HSC organisations will have in place clear leadership arrangements to provide assurances that PPI is embedded into policy and practice.
2. Governance – HSC organisations will have in place clear corporate governance arrangements to provide assurances that PPI is embedded into policy and practice.

3. Opportunities and support for involvement – HSC organisations will provide clear and accessible opportunities for involvement at all levels, facilitating and supporting the involvement of service users, carers and the public in the planning, delivery and evaluation of services.
4. Knowledge and skills – HSC organisations will provide PPI awareness-raising and training opportunities as appropriate to need, to enable all staff to deliver on their statutory PPI obligations.
5. Measuring outcomes – HSC organisations will measure the impact and evaluate outcomes.

The Board is required to ensure that all major decisions relating to the planning, development and delivery of HSC services is undertaken with service users and carers. Boards must ensure there is evidence to demonstrate that service users and carers have been meaningfully involved before any major decision is taken.

Alongside organisational governance arrangements, Boards should specifically consider their responsibility in line with the standards for involvement:

Board prompts

- Have in place a named Executive and Non-Executive PPI at Board level with clear role descriptions and objectives in place.
- Ensure that there are appropriate governance and corporate reporting structures in place for involvement.
- Consider how the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Evidence awareness of targets in place for staff training and ensure a mechanism is in place to capture the uptake of PPI training.
- Consider what evidence is available to determine how service users and carers have been involved in all major decisions in relation to planning, developing and implementing services. Approve involvement monitoring reports for submission to PHA for assessment.

Involvement information and guides

The Engage website is the central resource for involvement in HSC and provides further information in relation to guides for involvement, involvement tools and training.

Board prompts

- How does the Board ensure that the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Is there evidence that service users and carers have been involved in all major decisions in relation to planning, implementation and evaluation of services?

4.15 Co-production and partnership working

The Bengoa Report, Systems not Structures[45] and Health and Well-being 2026: Delivering Together[46] placed an increased focus on partnership working and co-production. Delivering Together states:

> *"We must work in partnership – patients, service users, families, staff and politicians – in doing so we can coproduce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system."*

There has been an increased focus on advancing and building on PPI to encourage a move towards co-production and partnership working. Co-production is a highly person-centred approach which enables partnership working between people in order to achieve positive and agreed change in the design, delivery, and experience of health and social care. Co-production is a genuine partnership approach which brings people together to find shared solutions. It is regarded as the pinnacle of involvement.

45 DoH, Systems not Structures: Changing Health and Social Care, 2016.
46 DoH, Health and Well-being 2026: Delivering Together, 2017.

What are the key enablers for embedding co-production?

In order to progress the vision set out by Bengoa and within Delivering Together, the DoH published the Co-Production Guide for Northern Ireland – Connecting and Realising Value Through People. Adopting a co-productive approach is at the heart of improving people's experience of care. Co-production, done well can improve care outcomes, it can enable systems to become more effective, efficient, and is rewarding for the staff who provide care.

Six principles have been developed to enable the implementation of co-production across all HSC organisations. By working to embed a co-production approach, people will be active participants in co-design and co-delivery of services with measurable and objective improvement in people and staff experience, care outcomes and evidence of increased productivity across all services.

For co-production to be successful it requires Boards to lead and have co-production embedded in the organisation's core business and its culture. Roles and responsibilities for Boards and Executives have been set out against the six principles which are found in the Co-production Guide.

Board prompts

- How does the Board **value people** in creating the strategic and organisational conditions to enhance the role and contribution of people in the planning, development, delivery and evaluation of all the organisations activities and services? This involves leading from the front and valuing people's contribution by progressively sharing decision-making and promoting co-design and co-delivery.
- How is the Board **building representative networks** across all programmes of care? This includes investing time and resources in building relationships with local communities and groups of people who use services. It also involves investing in peer support, expert patient services and progressively creating self-managing teams who are empowered to co-produce with those who use services.

- Does the Board ensure **reciprocal recognition** by ring-fencing funding to enable the development of co-production across the organisation? This includes establishing systems that reward and recognise the contributions people make. It also involves learning from the experience of people who use services and staff who provide care by formally recognising how their contribution has changed the delivery of services.
- Is the Board working to strengthen **cross boundary working** to reach out and invest in multi-agency and community sector partnership to deliver better outcomes?
- Is the Board **enabling and facilitating** change in organisational culture which embeds co-production at the heart of the organisation's strategic planning processes. This involves leaders providing oversight and enabling all those involved in service planning, development and improvement to reflect the principles of co-production in their practice.
- How does the Board ensure that the voice of service users and carers is integrated into the decision-making process across the organisation, including at Board level?
- Is there evidence that service users and carers have been involved in all major decisions in relation to planning, implementation and evaluation of services?
- Consider if the appropriate mechanisms are in place in the organisation, to oversee the development of involvement, co-production and partnership approaches in the organisation.

4.16 Independent advocacy and the role of the Patient and Client Council

The **Patient and Client Council (PCC)** is responsible for delivering and/or providing access to advocacy and support services as specified by the Department of Health directive and HSCB guidance in supporting families to engage with the revised serious adverse incident processes through a 'hub and spoke' model of service delivery working with other providers of advocacy services. Other independent services will be identified and accessed as required through the PCC,

including the development of a network of available advisory services. Such advocacy services must meet the principles of:

- Independence;
- Confidentiality;
- Person and family led;
- Empowerment;
- Equality and diversity;
- Accessibility;
- Accountability;
- Safeguarding; and
- Supporting advocates.

HSC Trusts are responsible for ensuring that individuals and families are informed at the earliest practicable point of serious adverse events having taken place and for ensuring that they are engaged in setting out the terms of reference for subsequent reviews. As well as the allocation of a Trust liaison office, Trusts must ensure that families are directed to the PCC for independent sources of support and advocacy, including when expert advice is required in complex cases.

4.17 Shared decision-making

What is shared decision-making?

Shared decision-making is a practice in which a person receiving care and a person providing care work jointly to make decisions.

It brings together the expertise and experience of both, enabling each to understand what is important when choosing a course of action. By working together, we make the best treatment and care decisions for each individual.

There are a number of enablers for shared decision-making which include:

- A supportive organisational culture;
- Sharing examples of good practice;
- Communication in plain English and in different formats;
- Professional humility;

- Patient advocacy;
- A culture of learning; and
- Training programmes for professionals, patients and service users and their carers.

Fundamentally, shared decision-making begins and continues as a conversation between two people – a health or social care professional and a patient or service user.

HSC Board Member Handbook

SECTION 5: Case studies

This section is intended to assist HSC Board Members to undertake their role with confidence and rigour. Following on from the information in previous sections, where aspects of governance and assurance have been set out in detail, the case examples given are a useful means of testing and rehearsing the skills of scrutiny and challenge. Each case is based on real experience, changed only sufficiently to ensure anonymity.

Consider each case from the perspective of the timeframes and prioritisation to ensure you are focusing on the right issues at the right time, whether immediate, short term, medium term or long term.

For the information that you have been briefed on, ask:

- What information is relevant?
- What is unnecessary detail and extraneous to your understanding of the issues?
- What information is missing?

Consider perspectives such as:

- Patients/**service users**/carers/families (immediate impact and quality and safety and aftermath of any incidents);
- **Staff**/trade union (including agency/locum staff and staff employed by organisations commissioned to provide services by the Trust – issues may be welfare of staff but also whether or not staff or trained and adhere to standards and regulatory registration issues);
- **Notification** requirements (DoH – early alert, Coroner – death, professional regulators, PSNI, HSE, other regulatory/oversight bodies, for example nuclear);
- Implications for **governance** (internal oversight and accountability and external oversight and accountability of HSC body);
- Financial/**resources;**
- Service **continuity** risk (capacity, viability, waiting lists and waiting times);
- **Reputation** of the organisation; and

- **Openness** and candour.

There are some issues which should be considered when **serious harm** has been suspected or caused.

- What **support** has been put in place for the patient/service user/carer/family including advice and counselling?
- What **support** has been put in place for staff?
- Have service user and families been **engaged** and being given a full and **honest information** about the incident?
- If external agencies are involved – have they been **notified** with **a full and honest explanation of what has happened**? The Board should ask to see copies of notifications to other agencies and also detail of what family has been told – this could be routine as part of the evidence they ask for in Board papers.
- Who in the executive team is the point person (below the Chief Executive) for **overseeing Trusts response** and **updating the Board?**
- For a **serious adverse incident** – has this been properly scoped out and is resourced?

A series of questions is posed after each short case scenario, in most cases asking for what further information is required and the type of questions that could be asked to fulfil the individual responsibilities of HSC Board Members. A number of cases have been included which do not include these questions or prompts. These may be used to further test the skills of scrutiny and challenge.

5.1 Case studies for HSC Board Members

Case study 1. Ensuring an effective clinical and social care governance system – triangulating information

You sit on the Board of a busy HSC Trust responsible for providing a wide range of HSC services. On a regular basis you are provided with a range of performance and governance reports that are presented at the public Board meetings. All reports indicate that things are going well and the executive team is content that all principal risks are being managed. Recently however you/your family member attended for services at the Trust where you were surprised to find that the service was understaffed, morale was low, the service was chaotic and leaderless and you/your relative was dissatisfied with the services you received and observed. Since then you have asked other service users and staff of their experience and hear a similar story. You do not know how to reconcile your direct experience from the assurances on safety and performance that you receive on the Board.

You are wondering how to reconcile your direct experiences with the reports from the Board.

Case study links with:

Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.3 Quality improvement and measurement

What questions do you need to ask?

- How robust are the control measures identified in the Board assurance framework/corporate risk register? Do we have adequate independent assurance that the controls are effective? Is the assurance proportionate to the level of risk?
- How are our risk registers populated? Is there a bottom-up/top-down approach?

- What are our leadership walk-rounds telling us? Can we improve the process?
- Are we engaging with service users? And how do we know the engagement with service users is effective?
- Are we always open when things go wrong?
- Do we have a culture that enables our service users and staff to raise concerns?
- How is learning from adverse incidents and serious adverse incidents fed into local programmes of care?
- How do we know if improvement in practice has been embedded?
- Do we, the Trust Board, get the right information in relation to adverse incident trends and themes?
- Do we get the right information in relation to SAIs?

What information do you need to have?

- External reports, for example Royal College reports, RQIA reports.
- Independent assurance information (related internal audit reports).
- Quality improvement information including any dashboards for the area; not high-level directorate data.
- Real time data collection, for example almanac heat maps.
- Clinical audit data.
- Risk registers for the area.
- Customer feedback and patient experience information, for example 10,000 voices.
- Complaints and compliments, themes and trends.
- Clinical outcomes data, for example morbidity and mortality.
- Adverse incident data including serious adverse incidents.
- Legal services data including professional or clinical negligence and employers and occupiers liability claims themes and trends.
- Recruitment and retention data.
- Staff absence information.
- Staff survey.

- Related human resource data, for example any trends in bullying and harassment cases.

Case study 2. Systemic failure – patient recall

The Trust has received a complaint from a GP about a 10 year-old girl with congenital phenylketonuria (PKU). People with PKU can't break down the amino acid phenylalanine, which then builds up in the blood and brain. This can lead to brain damage. The patient was diagnosed at five days old and has been on a low-protein diet that completely avoids high-protein foods and has regular monthly blood tests. Despite this regular monitoring that has indicated that all is well, the girl's behaviour has become difficult and school has been reporting a deterioration in her attainment. On reviewing her blood results from the lab the GP has noticed that her results have been **exactly** the same for the last six months, where there would previously have been a little variation but within the normal range. He had asked the lab to check this and has now received information that the last six months' results may have been incorrect. The GP has also stated that he is concerned about patients with PKU whose blood results were also 'normal', particularly a young woman who is pregnant.

The Trust has started to investigate how this might have happened and are planning to recall a number of patients with PKU whose blood tests were also analysed in the same lab.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 3.2.4 Being an effective Board Member
Section 4.5 SAIs (sections 4.5.1 to 4.5.3),
Never events (section 4.5.5)

Early alerts (section 4.5.9)

Lookback processes including patient recall (section 4.5.11)

Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Can we be assured that immediate steps have been taken to prevent any further harm?
- Has a risk assessment of the situation been carried out?
- What is the level of harm to patients?
- How many patients could this potentially impact?
- Does this affect any other Trusts or healthcare providers?
- Has an early alert been submitted?
- Does this constitute an SAI?
- Have we informed the potentially affected patients?
- What is our communication plan?
- How can you reassure service users and the public that the services provided by the Trust are safe?
- Has the laboratory undertaken a recent UKAS accreditation process and were there any significant findings?

What information do you need to have?

- Level of harm/potential harm to patients.
- Numbers of patients potentially affected.

Case study 3. Systemic failure leading to an avoidable SAI-related death[47]

A 54 year-old female patient was admitted for investigation of heart disease. The patient was first on the afternoon list for cardiac angiography. The catheter was successfully placed through the blood vessels into the heart under X-ray guidance. A small amount of dye/contrast medium was injected through the catheter into her

47 This case study is based on Norfolk and Norwich Health Care Trust, which was prosecuted in May 1996 for breaches of health and safety legislation. The judge found that the Trust did not have safe systems of work and the Trust was fined £38,000 plus £17,000 costs.

heart. Moments after the dye was injected into her veins she collapsed and despite attempts to resuscitate her she died. The post-mortem confirmed that she had suffered a fatal air embolism.

The incident was reported as an SAI and the incident team discovered that at the end of the morning session a radiographer commenced a procedure and fitted an uncharged automated syringe, however the procedure was then cancelled. The empty syringe was left in the machine. A different radiographer was allocated for the afternoon list and had made an assumption that the syringe had been charged and had injected air into her heart instead of contrast medium.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3, and 4.5.6.
- Can be we assured that we have systems in place now to prevent recurrence?
- Was it reported as a never event? Has an early alert been submitted?
- What external agencies will be involved, for example Coroner, PSNI, HSENI, RQIA?
- Have we involved the family?
- Are we supporting the staff?
- Are there guidelines in place to prevent this? Were they audited?

- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Never event trend data (local and national).
- Quality improvement data, if applicable.
- Any relevant audits of practice in the clinical area.
- Safety culture data of the clinical area.

Case study 4. Avoidable SAI and systemic failure – retention of a guide wire[48]

A severely ill patient was admitted to the coronary care unit where their condition deteriorated rapidly. The doctor needed to administer emergency drugs by intravenous infusion. Accessing the patient's veins was difficult so the doctor inserted an emergency central line through a vein in the patient's leg using a technique that required a guide wire. The doctor was under pressure due to the patient's condition and wanted to check immediately that the sheath was in the femoral vein, so they quickly aspirated blood and then flushed the sheath ready for use – forgetting to remove the guide wire. The flush pushed the guide wire into the patient's vein and it travelled around their body and lodged near their heart.

The fact that the guide wire had been retained was not noticed until three weeks later when the patient was transferred for heart surgery. The guide wire was removed successfully by a specialist team after two attempts.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.

48 For learning and key contributory factors see, NHS Improvement Surgical Never Events Learning from 38 cases occurring in English hospitals between April 2016 and March 2017, 12 September 2018 accessed via https://improvement.nhs.uk

Section 4.11 Openness and candour

Section 3.2.12 Scrutiny and challenge

Section 4.5.1 SAIs

Section 4.5.5 Never events

Section 4.5.9 Early alerts

What questions do you need to ask?

- How do we prevent this happening again?
- Have the patient/family been informed that it is an SAI and a never event?
- How are we engaging with the patient?
- Have we implemented the World Health Organization (WHO) surgical safety checklist and the five steps to safer surgery? Have we audited compliance?
- Is this an isolated incident for the individual or team?

What information do you need to have?

- Quality improvement data, i.e. WHO surgical safety data
- Trends for never events for retained objects (Trust and national data).

Case study 5. SAI and systemic failure – wrong site surgery

A 47 year-old patient is admitted to have a lymph node removed in her armpit, as part of her treatment for breast cancer. Surgery was performed on the wrong side. The incident was reported as an SAI. The investigation showed the following sequence of events.

The surgeon wrote down the wrong side for the procedure during a busy multidisciplinary team meeting when the laboratory results for both sides were discussed.

The surgeon's notes, including the error, were typed up by the administrator, put in the medical notes and fed into the operating list schedule.

The patient had a benign lump on the opposite side to where surgery was intended. When the patient was examined before the procedure, the surgeon followed what was written in the patient's notes and felt a lump in the 'wrong' side.

The WHO safe surgery checklist was undertaken pre-procedure but the imaging and histology results were not reviewed; only the patient's records were considered.

The error was found when the results of the test on the node removed came back as 'benign'.

The patient was readmitted and the correct procedure undertaken.

The patient makes a formal complaint when she is discharged from the hospital and is informed that the incident is being investigated as an SAI. She had not been informed that this was the case.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.7 Management of HSC complaints
Section 4.5.5 Never events
Section 4.5.9 Early alerts

What questions do you need to ask?

- Consider the generic Broad prompts as per sections above.
- How do we prevent this happening again?
- Has the patient now been informed that it is an SAI and a never event?
- How are we engaging with the patient?

- Have we audited the WHO surgical safety checklist and the five steps to safer surgery following dissemination?
- What is the safety culture of the clinical area?
- Is this an isolated incident for the individual or team?

What information do you need to have?

- Quality improvement data, i.e. WHO surgical safety data.
- Trends for wrong site surgery (Trust and national data).

Case study 6. Avoidable mental health inpatient suicide

Your Board has been presented with a learning report from an SAI on a young man who took his life shortly after admission to one of the Trust mental health in-patient facilities. The report identifies a known ligature point as one of the issues that could have prevented his death and sets out what now needs to be done to prevent further deaths in such a way.

No others learning points are identified in the report.

You are wondering what other learning could have been identified?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.9 Early alerts
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.3 and 4.5.6.
- Can be we assured that we have systems in place now to prevent recurrence? Not just about ligature points but for the identification of individuals known to be at risk?

- Have we involved the family?
- What level of support and engagement are we offering to the family?
- What feedback has there been from the family?
- Are we supporting the staff?
- Are there guidelines in place to prevent this? Were they audited?
- Are there any trends we should be aware of locally (Trust level) or regionally?

What information do you need to have?

- Never event trend data (local and national).
- Quality improvement data, if applicable.
- Any relevant audits of practice in the clinical area.
- Safety culture data of the clinical situation.
- Feedback on experience from families.

Case study 7. Risk assessment of a service reduction/saving proposal

The Trust has a requirement to make a 2% savings in the current financial year for which the executive team has presented a paper for the reduction in domiciliary care services – both those directly provided and those commissioned by the Trust. The proposal has focused on the financial aspects of the service reduction but not the impact on the individuals affected and the unintended consequences of a reduction of service.

You are wondering how to get assurance that these aspects of risk and service user experience have been considered in the proposal.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.13 Internal and external engagement

Section 4.7 Risk management and effective controls

Section 4.3 Quality improvement and measurement

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Have we undertaken an equality impact assessment?
- Have we undertaken required levels of public consultation/stakeholder surveys?
- Can be we assured that we have undertaken risk assessments on patient and client safety? Is the risk adequately described in the Board assurance framework/corporate risk register?
- Have we listened to staff?
- What systems are in place now to prevent recurrence? Not just about ligature points but for the identification of individuals known to be at risk?

What information do you need to have?

- Business proposals including comprehensive risk assessment including patient/client safety risk assessment.
- Equality impact assessment.
- Risk registers.

Case study 8. Performance issues – governance issues on the management of a waiting list and unexplained reduction

Your Trust has been rocked by revelations in the press of a waiting times scandal. It turns out that Trust staff have been offering treatment at hospitals in the Republic of Ireland to patients on its waiting lists at short notice, recording patients as unavailable if they could not travel (no means of transport or other support were offered to patients before or after treatment).

You were aware that Board reports had indicated that the number of patients on the waiting list had reduced quite significantly in the last year (by 2,000 patients) but it

now turns out that this innovative (and technically legal) method was responsible for the successful outcomes.

It is now evident that there has also been a widespread culture of staff bullying (linked to the pressure to deliver on these targets) over the past six years or so and the Trust is in turmoil.

The Chair has stated publicly that the Board was completely unaware of both the waiting times 'scandal' and the culture of staff bullying.

You are wondering whether and how this could have been prevented?

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.8 Financial stewardship
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Has a full investigation been undertaken to establish facts?
- How can we be assured that we have been given candid and accurate performance data in the monthly Board reports? What has the performance reports shown, how is the data presented and could the data be presented better in the future?
- What does our Board assurance framework/principal risk document and corporate risk register say?
- Have we listened to staff? Have we any data from staff surveys?
- Have we completed all the appropriate notification reports, for example has an early alert been completed?

What information do you need to have?

- Service user surveys.

- Staff surveys.
- Complaints data.
- Corporate and directorate risk registers.

Case study 9. Complaints from service users – internal reports versus media coverage

At a recent Board meeting you were presented with a complaints report which showed a low level of reporting and no particular areas of concern. However later at the same meeting the Board received a report on recent media coverage where the Trust was criticised for the placement of older people in same sex wards and for the placement of children and young people in adult wards. The media coverage included direct reports from several patients and their families who stated that they had complained to the Trust but hadn't received a satisfactory response and that they were considering approaching the RQIA and Patient and Client Council to assist them.

You are now concerned that there are opportunities missed in the complaints report to the Board.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.5.7 Management of HSC complaints
Section 4.1 Duty of quality and role of RQIA (section 4.1 and 4.1.1)
Section 4.5 Serious adverse incidents and near miss reporting
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompt questions as per sections above.
- What have service user and staff surveys told us about the clinical area?

What information do you need?

- Any recent thematic reviews by regulators, for example RQIA.
- Service user surveys, for example 10,000 voices campaign.
- Patient safety and quality improvement data including dashboard.
- Risk registers at directorate level.
- Adverse incident reporting data.
- Staff surveys.
- Whistleblowing or raising concerns data.
- Leadership walk-round data.

Case study 10. Whistleblowing by staff

Your Board has a new and inexperienced Chair and a strong Chief Executive. A senior member of staff has highlighted to you that there is significant and serious bullying taking place by the Chief Executive.

You understand that a union-led staff survey is very critical of a bullying culture and that this is being picked up by the press. You have asked for this to be brought to a Board meeting, but this has been refused by the Chief Executive on the grounds that this is an operational matter and not for the Board.

After some discussion the Chair agrees with the Chief Executive, and the staff concerns are not shared with the Board, but many of the concerns are subsequently highlighted by the press.

You and other Board Members ask that this be brought to the Board as a significant and urgent issue, but this is declined. You are now aware that this issue is having a detrimental effect on individual staff and on the performance of the organisation.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.7 Risk management and effective controls

Section 4.7.5 Internal controls – Board assurance framework

What questions do you need to ask?

- How should you deal with this? What options are open to you?
- What are the risks associated with this?
- How would you know when and how to escalate such an issue?
- Where would you get your assurances and evidence and who would you involve?
- What are the outcomes you would wish to see and require from doing something about this?
- How would you determine what is operational and what is open to a Board discussion?
- Who would you aim to protect and how would you ensure this happened?
- What part would effective governance play in resolving this and avoiding any recurrence this in the future?

What information do you need to have?

- Staff surveys.
- Report on issues raised under the organisation's raising concerns or whistleblowing policy.

Case study 11. Concerns about a lone practitioner

Your Board has recently received a report from the Medical Director in respect of the multidisciplinary working of the specialty teams across the Trust and how this safeguards individual practice and improves the diagnoses and treatment of patients. However you also note that there are a number of lone consultant practitioners who are not linked to a relevant team. You are concerned about how

such individuals are able to meet professional standards in light of the experience in your own and other Trusts where such individuals have been practising outside their field of expertise/competency and which has led to large scale reassessments of patients.

At the same Board meeting you have also received a report on an individual (also a lone practitioner) who has been suspended while a review of outcomes for his patient group is undertaken following concerns being raised by another consultant in the Trust.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:
Section 4.11 Openness and candour
Section 3. Roles and responsibilities
Section 3.2.12 Scrutiny and challenge
Section 4.5.11 Lookback processes and patient recall

What questions do you need to ask?

Consider the generic Broad prompts as per the sections above.

- Has a risk assessment been undertaken in respect of lone consultant practitioners who are not aligned to a multidisciplinary team and is this reflected in the directorate or corporate risk register?
- What safeguards or control measures were being implemented in the areas to ensure safe and effective practice? Were any clinical audits undertaken?

In addition, in respect of the clinician who has been suspended the following should also be considered.

- Are there any immediate safety concerns for patients in this potential cohort and what plans are in place to address these?
- Has a risk assessment been completed to determine the size (how many potential patients), complexity and nature of harm/potential harm to patients?

- Do we have a communication plan in place (for patients who are or maybe affected by this, the media and wider public and for staff)?
- What are the business continuity plans for the service area?
- Will this incident necessitate a lookback review process?
- Is the suspension being managed within the parameters of relevant employment law guidance/professional regulation guidance, for example maintaining high professional standards/Trust HR policy and procedure?
- Are staff support mechanisms in place?
- How do we prevent this happening again?

What information do you need to have?

- Clinical coding or other outcomes data for the clinical area.
- Appraisal and revalidation data.
- Complaints and incident data for the area.
- Service user feedback for the area.
- Directorate and corporate risk register.

Case study 12. A case involving cyber security

Board Members have just been briefed about a security issue which has recently emerged.

Some months ago a senior staff member, ‘JB’, received an email telling her about an outstanding invoice. The email contained a very small, illegible thumbnail of the invoice. JB didn't think the invoice was for her but she clicked on the thumbnail to enlarge it, just to check. She didn’t recognise the invoice, but it was similar to others she had received so JB sent the email to the rest of her team to check. A few of JB's team members also clicked on the invoice. It is only six months later that the IT team discover that the email in fact contained malicious software, which was downloaded when JB and the others clicked on the thumbnail. In that time, criminals have been able to steal a large amount of valuable and sensitive information from the Trust, remaining undetected all that time.

By getting JB to click on the thumbnail, the criminals were able to cause significant damage to the organisation through stealing valuable and sensitive data. As a result, the integrity of the whole system has been compromised. Putting this right is likely to be hugely expensive. Phishing emails like this can lead to the loss of business critical information. The story was reported in the media, the organisation suffered reputational damage, and people lost confidence in its ability to protect its assets and the Information Commissioner is likely to take action.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance, and cyber security (4.9.3)
Section 4.7 Risk management and effective controls
Section 4.5.1 Serious adverse incidents and near miss reporting
Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompt questions for the sections above.
- How can we be assured that this could not happen again? Question areas from the SIRO and the data guardian for the organisation.
- What steps had the organisation taken to prevent this? What do we need to do differently?
- What is our communication plan to address the reputational damage?

What information do you need?

- Reports from the SIRO and data guardian and an action plan to prevent recurrence.

Case study 13. Information breach – personal

A 32 year-old female patient is admitted to St Elsewhere HSC Trust for routine surgery. Unfortunately she suffers an unexpected complication that will require prolonged admission for further treatment including antibiotic therapy and further surgery. The prognosis is that she will be left with permanent disability as a result of this incident.

In line with DoH guidance, the Trust reports the incident as a SAI and a team is commissioned to investigate the events using root cause analysis methodology. The team is required to report the findings of the investigation to the Trust Board and the Commissioners within a 12-week period. The lead consultant explains to the patient and her next-of-kin that the incident is being fully investigated and the patient and family agree to be involved in the review and will receive a copy of the investigative report.

The investigation team includes a senior doctor who is required to provide his clinical expertise. Towards the end of the timeframe the doctor becomes ill and will not be able to return to work and participate with the investigation. The Trust is mindful of the potential impact on the family and seek another doctor to assist.

The second doctor is given a copy of the patient's medical records and other relevant documentation including staff rotas, witness statements and policy and procedures. Given the timeframe he takes the information home to examine over the weekend. He stops at a shopping centre on the way home. When he returns to the car the driver's window has been smashed and his briefcase and mobile phone have been stolen. All of the review materials were in this briefcase. He reports the incident to the police and the Trust.

A few hours after the theft a member of the public finds the patient's records and other documentation discarded on a grass verge close to the scene of the crime. She takes the information to the local newspaper and the breach of confidentiality is reported in the press the next day. The local TV station also take-up the story and

the Trust is now required to report this as an additional SAI to the Commissioners and to the Information Governance Commissioner.

In a risk-aware organisation the potential risk of information governance breaches will be considered at service, directorate and corporate levels.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.12 Scrutiny and challenge
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.7 Risk management and effective controls
Section 4.9 Information governance

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Have we informed the family?
- Have we informed the staff who provided witness statements?
- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has an early alert been submitted?
- Are we supporting the staff?
- Are there any control measure in place to prevent this?
- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 14. Information breach – organisational

Your HSC Trust/organisation was involved in a major reorganisation within the last three years that involved the movement of services and transfer of staff, equipment and records.

Following a social media post campaign by an 'urban guerrilla' group, photographs have been posted that show members of the group posing with confidential records which have been stored in a disused Trust building. There is a public outcry, considerable media attention and the Information Commissioner is likely to investigate the matter.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 4.5.1 SAIs
Section 4.5.5 Never events
Section 4.7 Risk management and effective controls
Section 4.9 Information governance
Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has the incident been reported as an SAI?
- Has an early alert been submitted?
- What is the communication plan for potentially affected patients, service users and wider public?
- What is the communication plan for the media?

- Are there any control measure in place to prevent this, for example a decommissioning policy?
- How can we be assured that other buildings are not also vulnerable?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 15. Corporate parenting

A 12 year-old boy, with a history of violent outbursts, is admitted to a Trust children's home after his parents say they can no longer cope with his behaviour. They decided this after he assaulted one of his siblings. The family's situation had deteriorated after an arrangement to provide them with regular respite in a fostering placement broke down due to the boy's behaviour in the placement. The boy is big for his age and could pass for 15 or 16 years of age.

The Trust Board is advised that the boy attacked a 14 year-old resident of the same children's home, biting him in the face. The boy also attacked a female member of staff who came to the assistance of the 14 year-old. Other staff then restrained the 12 year-old. Subsequently, it was discovered that the 12 year-old had a fracture in a bone in his hand.

The family have alleged that the boy sustained this injury when a member of staff deliberately stood on his hand whilst restraining him. Staff believe he sustained the injury to his hand due to the ferocity of his physical attack on the female staff member whom he punched and kicked several times. The 12 year-old boy has been moved to secure care. The female staff member is absent on sick leave and two male members of staff are on precautionary suspension. Police are investigating the assault on the 14 year-old, the assault on the female staff member and the allegation that the 12 year-old was also assaulted by staff.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.6. Social care governance (corporate parenting principles and child protection)

Section 4.5.1 SAIs

What questions do you need to ask?

- Generic Board prompts for the sections above.
- How do we prevent this happening again?
- Is this an isolated incident for the individual or the team?

What information do you need?

- Trend data from the adverse incident/near miss system/complaints and legal services systems.
- Leadership walk-round data for the area.
- Service user/client data.

Case study 16. Police involvement – staff member and drugs charges

A health visitor employed by the Trust has been arrested by police investigating the sale of illegal drugs.

The police have advised that the health visitor had been retrieving unused medications from the homes of deceased clients and stockpiling them. The police suspected that some of these drugs had been sold to a local drug dealer but also suspected that some of the medications may have been sold or provided to other

Trust clients of the health visitor. The health visitor has been suspended by the Trust and police investigations are ongoing.

You are wondering whether and how this could have been prevented and what systems are in place to prevent this happening again?

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.4 Memorandum of Understanding
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Is this an isolated incident?
- How do we prevent this happening again?

What information do you need?

- Updates on internal investigations and related medicines governance action plans.

Case study 17. Unattended fire alarm

The Trust Board are advised of an incident involving a fire alarm going off in one of its hospitals. The alarm continued to sound for 15 minutes.

The incident occurred during visiting hours, and staff, patients and visitors all reported confusion about what to do during the time the alarm was sounding. No evacuation took place and it is reported that staff responded to the alarm by telephoning other wards, porters and management to check if this was a real alarm. The Fire and Rescue Service attended within 10 minutes. A number of staff

communicated to visitors and patients during the incident that they did not know what the Trust's evacuation plan was in the event of a real emergency.

It subsequently emerged that the alarm system had been serviced by a private contractor earlier that day and that the false alarm was as a result of a faulty sensor which had been installed that day.

In a follow-up to the incident the Fire and Rescue Service have advised that it is their assessment that the Trust's preparations and response was inadequate to protect the safety of patients or staff. The Board is now considering this report.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Is this an isolated incident to this part of the Trust?
- How do we prevent this happening again?
- Are there any other issues with this contractor or is this an isolated incident?
- Have we notified all relevant external agencies?

What information do you need?

- Report on fire safety plans and fire risk assessments for the site and other sites/hospitals within the Trust.
- Overview of fire training records.
- Business continuity plans for the site.

Case study 18. A mental health patient absconding and subsequent suicide

The report of a review of a serious adverse incident into a case where a mental health patient had absconded from a mental health unit and shortly after took his life through suicide, reports that only a minority of staff working in the unit and interviewed as part of the review had attended mandatory Trust training on suicide awareness and prevention.

The family allege that their relative had openly told them and Trust staff of his intention to 'get out and kill himself' and that the Trust had not acted on this information.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.9 Early alert

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Can we be assured of compliance with mandatory training?
- Is this an isolated incident to this service area? How do we prevent this happening again?
- Are there any other issues with this contractor or is this an isolated incident?
- What other learning did the SAI review establish and have we disseminated the learning internally? Regionally?

What information do you need?

- Patient/client safety data including risk assessments.
- Clinical and social care audit data for the area and other related units, for example the Emergency Department and Acute Admission units.

- Overview of mandatory training records and any internal or external audit information on this, for example internal audit, RQIA.

Case study 19. Assault of staff in Emergency Department

A male nurse was assaulted in the Trust Emergency Department by two patients who were under the influence of alcohol. The nurse's jaw was fractured and he is now on sick leave after being admitted and treated in the hospital for his injuries. A member of the public who came to the aid of the nurse was also assaulted and suffered cuts and bruises but was able to be released home after treatment.

Staff working in the Emergency Department have complained that porters present in the department at the time of the incident did not come to the assistance of the nurse. Two other Emergency Department staff members present at the time of the assault have gone on sick absence suffering from stress following the incident.

This is the third significant assault on staff in the Emergency Department over the past two years. Trade unions have previously complained at the lack of security in the department and the slow response of police to calls from the Emergency Department when previous incidents have occurred. The two alleged perpetrators were arrested and police investigations are ongoing.

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.1 Adverse incidents, and 4.5.6 Near miss reporting

What questions do you need to ask?

- Generic Board prompts as per the sections above.
- Have we listened to what staff have told us?
- Do we encourage a culture of incident reporting including near misses?

- Do we operate a zero tolerance policy?
- Are security/management of aggression risk assessments undertaken?
- Is training in the management of aggression provided commensurate with the risk assessment? Attendance rates?

What information do you need?

- Trends and themes for incidences of verbal and physical abuse including severity.
- Risk registers at directorate and corporate level.
- Oversight report on management of aggression policy, risk assessment and training.

Case study 20. Information breach and loss of data by Trust staff

The car of a Trust health visitor which was parked outside the house of a client she was visiting has been broken into. The personal records of a number of other clients have been stolen from the car along with a Trust laptop containing personal information and details of other clients.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance
Section 4.5.1 SAIs
Section 4.7 Risk management and effective controls

What questions do you need to ask?

- Generic Board prompts as per sections 4.5.2, 4.5.3 and 4.5.6.
- Have we informed the clients?
- Have we informed the staff who provided witness statements?

- Was it reported as an information governance breach to the Information Governance Commissioner?
- Has an early alert been submitted?
- Are there any control measure in place to prevent this?
- Are there any trends we should be aware about locally (Trust level) or regionally?

What information do you need to have?

- Information governance risk register.
- Media statement.

Case study 21. Allegations of victimisation

A theatre nurse has complained that she is being victimised by a consultant who asked that she should not be scheduled to be in theatre whilst he is operating. He has stated that he has concerns about her professional practice. The nurse states that her problems with the consultant only began after she spoke to him one-to-one about his failure to adhere to the WHO's pre-operative checklist. She now says she has been treated unfairly and that her career and reputation is damaged by this, leading her to feel stressed.

The nurse has subsequently written to the Trust Chair as she further alleges that senior Trust staff have not investigated her concerns because the consultant involved is in a powerful position as he is critical to making certain performance targets and senior managers do not want to upset him.

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from sections as above.

- Do we have a culture where all staff can raise concerns irrespective of their grade/professional background?
- Is this an isolated incident for the nurse and the consultant?
- What is compliance with WHO check list for the area and for the consultant's cases?
- Are there any related patient safety incidents/complaints or claims in the area?

What information do you need?

- Patient/client safety data for the area both outcomes and process compliance rates.
- Staff surveys.
- Leadership walk-round data.

Case study 22. Concerns about a consultant

A nurse has raised concerns through whistleblowing about a consultant who refuses to adhere to hand cleanliness requirements during ward rounds.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Do we have a culture where all staff can raise concerns irrespective of their grade/professional background?
- Is this an isolated incident for the nurse and the consultant?
- What is compliance with WHO check list for the area and for the consultant's cases?
- Are there any related patient safety incidents/complaints or claims in the area?

- Is the alleged incident being managed in line with HR procedures for the investigation of alleged bullying and harassment?

What information do you need?

- Patient/client safety data for the area both outcomes and process compliance rates.
- Staff surveys.
- Leadership walk-round data.

Case study 23. Media concerns about confidentiality

A member of the public has approached the media to report concerns about the confidentiality of information of patients in hospital. The member of the public had been visiting a relative in hospital. The patient in the next bed was a patient who had attempted to commit suicide. During the visit the screening curtain was pulled around the bed of the attempted suicide patient and she was being to spoken to by a doctor. The visitor to the patient in the next bed was able to hear the entire conversation including the detail of the suicide attempt and the factors which led up to the suicide attempt.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.9 Information governance

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Is this an isolated incident? What steps are taken to maintain privacy and dignity in ward areas?
- How can we be assured that this is not happening on a frequent basis?
- What information governance training takes place and does the training apply to all professional staff?

What information do you need to see?

- Information governance risk assessments and action plans.
- Media statement.

Case study 24. Concerns about the individual practice of a consultant gynaecologist

Concerns have been raised by colleagues about the professional practice of a consultant gynaecologist employed by the Trust for the past 12 months. An audit of the records of the diagnosis and treatment of 40 patients seen by the consultant had been undertaken and confirmed that there were concerns. This is the first time information has been shared with the Board.

During the three months of the audit the consultant was under close supervision and following the audit the consultant was now restricted from seeing patients. Consideration is being given to the need for a patient recall.

The consultant had worked in another Northern Ireland Trust for nine months immediately before joining the Trust and had worked as a locum in one other Trust for six months prior to this. The Trust Board is also advised that it they now have information that six years previously, whilst working in England as a senior registrar, concerns had also been raised about his professional practice and an investigation had taken place. The Trust has no information about the outcome of the investigation and the staff member had resigned from that position shortly afterwards.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.10 Professional regulation and standards
Section 4.7.6 Clinical and social care audit
Section 4.5.1 Management of SAIs

Section 4.5.9 Early alerts

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Have we completed the necessary notifications including informing the other Trusts involved? The early alert should indicate to DoH that the issue involved more than one Trust in the region and in England.
- What is the current level of harm to our patients/clients?
- Have we taken the necessary steps to prevent further harm?
- Has a service review been undertaken to assess the extant and severity of the problem?
- Do we have a Directors oversight group in place to manage the potential lookback?
- How can we be assured that our recruitment process are robust and that we don't have another issue that is undetected to date?
- How can we be assured that professional registration and revalidation requirements are robust?
- Have we any concerns with the professional registration checks by the agency?
- Are we investigating the provision of the reference in line with HR policies?

What information do you need?

- Professional report on professional registration and revalidation processes.
- Risk assessment for patient cohort and level of harm or potential level of harm.
- Communication plan for affected patients, potentially affected patients and general public.
- Media communication plan.

Case study 25. Unregistered staff

A recent investigation in a Trust in Scotland has revealed that a radiologist employed by them for the past year, with references from your Trust staff, is

unqualified and unregistered. They are currently undertaking an exercise to re-report every radiological investigation he was involved in, with early indications that there were serious errors in the reporting of complex investigations such as MRI and CT. The review team have contacted the Trust in respect of his practice with your Trust.

A scoping exercise has revealed that the radiologist was employed through a locum agency for nine months in an outlying department that had been difficult to recruit to.

You are concerned about the potential harm to Trust service users and want to understand how he could have been employed without adequate registration checks.

Case study links with:
Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.7 Risk management and effective controls
Section 4.5.1 Adverse incidents and 4.5.6 Near miss reporting

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- Can we be assured that in the short term we have mitigated the risk effectively?
- What is the level of potential harm to our patients in the paediatric wards?
- When was the risk issue added to the directorate risk register?
- Is the issue adequately covered in the directorate and corporate risk register?
- Have we escalated the risk appropriately to DoH and HSCB?
- Are we supporting staff?

What information do you need to see?

- Board assurance framework/corporate risk register with contingency plans.
- Communication plan.

Case study 26. Staffing levels and safe practice

In response to a severe shortage of nursing staff in two paediatric wards (one surgical, one medical) the Trust took steps to call in off duty staff and secure agency staff. However, this was not sufficient and as a consequence three nursing staff without a background or specific training in paediatric nursing were in place. In one of the two wards this was on a supervised basis to undertake a limited risk assessed basis. However in the second ward, it is reported that no such restrictions were applied. Concerns have been raised with the Board by a whistleblower.

The Trust is taking extensive steps to prevent recurrence, including a targeted campaign to recruit more paediatric nurses, and work to look at sickness levels on these wards and improved support and training to ward sisters on both wards.

Case study links with:

Section 4.11 Openness and candour
Section 3.2.4 Being an effective Board Member
Section 3.2.12 Scrutiny and challenge
Section 4.10 Professional regulation and standards
Section 4.5.1 Management of SAIs
Section 4.5.9 Early alerts
Section 4.7.6 Clinical and social care audit

What questions do you need to ask?

- Generic Board prompts from the sections as above.
- What is the current level of harm to our patients/clients?
- Have we taken the necessary steps to prevent further harm?
- Has a service review been undertaken to assess the extant and severity of the problem?

- Will this require a patient recall for this Trust?
- How can we be assured that our recruitment process are robust and that we don't have another issue that is undetected to date?
- How can we be assured that professional registration and revalidation requirements are robust?
- Have we any concerns with the professional registration checks by the agency?
- Are we investigating the provision of the reference in line with HR policies?

What information do you need?

- Professional report on professional registration and revalidation processes.
- Local agency checks.
- Risk assessment for patient cohort and level of harm or potential level of harm.
- Communication plan for affected patients, potentially affected patients and general public.
- Media communication plan.

Case study 27. Letter of complaint to Board by family member

The daughter of an 84 year-old woman admitted to hospital from a nursing home suffering from dehydration has complained to the Trust that the nursing home is refusing to allow her mother to return to the home and insisting her mother be moved to another home. She has now written to every Trust Board Member about her treatment by the Trust and the nursing home.

This is the third nursing home the mother has lived in during the past 18 months. The home manager alleges that the daughter has been persistently abusive and threatening to staff in the home and has also been abusive to other residents and their relatives visiting the home. The daughter is also a client of the Trust in receipt of community mental health services.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.5.7 Management of HSC complaints

What questions do you need to ask?

- Have we established the facts for this case?
- Have we an accurate picture of the standards of care being delivered by the nursing home? RQIA reviews? Complaints data?
- How can we effectively manage a safe discharge for this patient?
- Do we have a duty of care for the daughter? What is the correct course of action for her?

Case study 28. Allegations of theft

The family of an elderly man, who, following a stroke, is in receipt of a domiciliary care package, has alleged that a watch valued at several thousand pounds has been stolen from his house.

A number of Trust staff members were in and out of the house on a regular basis including a community nurse, speech and language therapist and physiotherapist. Domiciliary care workers from a private company contracted by the Trust attend the elderly man twice a day.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.6 Safeguarding vulnerable adults

What questions do you need to ask?

- Generic Board prompts as per the sections above.

- Has it been reported to PSNI?
- Is this an isolated incident?
- How do we prevent this happening again?

Case study 29. Never event and candour

As a Non-Executive Director you hear on the news that your Trust has had a recent outbreak of *Clostridium difficile* (Cdiff) infection as a result of which two elderly patients have died.

Relatives have been interviewed on local television and radio and have said that they had a number of concerns about the cleanliness of the ward in which their relatives had been inpatients and one set of family members stated that they had complained about their mother's bed linen, call bell and bedside locker had been stained with faeces on three visits. One other family when interviewed said that they had no idea that their father was being looked after in a side room because of a potential infection and that they had not been informed that they needed to wear personal protective equipment (gowns or masks). Additionally, three families who have had a recent experience in this ward have provided information about the staff attitude in the ward, saying there was a general lack of cleanliness of the area and that they had noted that staff did not always clean their hands before coming into contact with their relatives. Two of the families had complained locally to the ward manager three months prior to the current events and had been advised to put their concerns into writing. At the time of the press statement these families had only had an acknowledgement of their complaints.

You have not had any prior notice of any of these events and at a recent Board meeting the infection prevention and control performance data for the specialty area did not indicate that there were any problems. The press statement provided by the Trust has stated that this incident has been as a result of exceptional circumstances and that there had been no previous indication that there were any problems with infection control in this area.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

What questions do you need to ask?

- Generic Board prompts from the sections as above

Case study 30. Financial governance issues/conflict of interest

You are on the governing body of the Clinical Commissioning Group, or CCG. One of the hospitals in your region where the CCG makes fixed payments under a guaranteed income contract has had a series of outbreaks of infections in recent months. This has caused a significant number of affected patients to stay in the hospital for longer than expected and some patient deaths may have been linked to the infections.

Some wards have had to be closed for periods of time which, together with the need for patients affected by the infections to stay longer in hospital, has slowed the ability of the hospital to take in new patients.

Following media coverage of these events, the local MP is recommending that the public stay away from the hospital until public health regulators confirm that the risk of further outbreaks of infections has been minimised. The MP is seeking an urgent meeting with the CCG to ascertain its role in these recent events.

Meanwhile patients who had been due to attend the affected hospital are mostly being sent to a neighbouring NHS hospital where the CCG has a payment by results contract and therefore pay according to the level of activity. As well as expecting to be paid standard rates for the further patients being sent to this hospital, the Trust has said it will only take in all the additional patients if the CCG also makes a substantial special payment as recompense for the extra temporary

clinical and nursing staff and managerial time it says it will need to deal with the workload.

Case study links with:

Section 4.11 Openness and candour

Section 3.2.4 Being an effective Board Member

Section 3.2.12 Scrutiny and challenge

Section 4.7 Risk management and effective controls

What information do you need to have?

- Performance reports on Health Care Association infections.
- Patient/client safety data on Health Care Association infections, both outcomes and process measures.

Case study 31. Ambulance service – assessment process

NIAS received a 999 call for a male patient described as having chronic respiratory condition known as COPD, which, during a flare up, can cause shortness of breath and difficulty with breathing. The call was triaged as a category red call requiring an eight-minute response.

A paramedic-led ambulance was dispatched to the call arriving with the patient in three minutes, however they were not informed of the patient's chronic condition prior to arriving. The ambulance crew began to assess the patient which included obtaining a medical history. During this time asthma had been relayed as part of the medical history by the patient's wife. The paramedic began treating the patient for life-threatening asthma as they believed this was the primary cause of the patient's difficulty in breathing. They administered two doses of intra-muscular adrenaline 1:1000 and subsequently the patient developed pain in their chest. A heart tracing was obtained and it was noted that changes had occurred which indicated the patient was having a heart attack. Following admission to the Emergency Department, blood tests were performed and the results indicated that the male patient was having a heart attack. An angiogram was carried out the next day,

which showed no evidence of previous heart disease. Discussion between the receiving hospital clinical lead and the cardiology team resulted in the impression that the patient had suffered a heart attack due to the blood vessels that supply the heart going in to spasm and reducing the flow of blood to the heart secondary to the administration of adrenaline.

Case study links with:

Section 4.12 Being Open

Section 4.11 Scrutiny and Challenge

Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- What early learning have we identified that should be shared internally and with the wider HSC system?
- Has the patient now been informed that it is an adverse incident?
- How are we engaging with the patient (and their family)?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including trend analysis of incident.
- Any relevant clinical audits.

Case study 32. Ambulance service – response to a fall at a care home

NIAS received a 999 call for an elderly male who had an unwitnessed fall in the residential care home where he resided, and had sustained a facial injury. A paramedic-led crew were tasked and on arrival, the crew were met by two carers

who directed them to the patient who was in bed, alert and looking well. The initial assessment of the patient revealed he had a small graze above the left eyebrow which was not actively bleeding. The ambulance crew undertook a range of diagnostic tests and determined the patient had a fast heart rate, low blood pressure and 'skin tenting' (reduced elasticity). In addition carers advised that the patient had not taken his prescribed medications for two to three days and he had not been drinking fluids, which was supported by the fluid chart which the carers had. Based on their observations and the information provided, the paramedic suspected the patient was dehydrated.

In order to treat the suspected dehydration, the paramedic inserted a cannula in the patient's vein and administered sodium chloride solution. The crew continued to monitor the patient and his blood pressure increased slightly, although his blood pressure was still relatively low, the carers advised that this was normal.

The crew informed the patient of their intent to transport him to hospital, to which he refused. The carers informed the crew that they anticipated that the patient would refuse transport. Although having a history of dementia, the crew determined the patient to have the capacity to make the decision to refuse transport to hospital. Prior to leaving the scene, the crew provided the patient and the carers with advice which included contracting the patient's own GP the following morning for follow-up assessment. The carers contacted the patients GP later the same day which resulted in a home visit. The GP assessed the patient and noted that his condition had deteriorated significantly since the attendance of the ambulance. A further ambulance was called and the patient was transported to the Emergency Department. In the Emergency Department the patient was diagnosed with a perforated bowel, however, no surgical intervention was undertaken due to the patient's poor state of health and subsequent low likelihood of successful outcome.

Case study links with:

Section 4.12 Being Open
Section 4.11 Scrutiny and Challenge
Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Have we notified the relevant external stakeholders in line with organisational and regional policies?
- What early learning have we identified that should be shared internally and with the wider HSC system?
- How are we engaging with the patient (and their family)?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including trend analysis of nature and severity of incident.

Case study 33. Ambulance service – adult male refusing to eat

NIAS received 999 call from a care worker for an adult male refusing to eat and who was described as being weak. The call was deemed suitable for the clinical support desk (CSD) and was passed to this area, which is paramedic-led. CSD paramedics utilise a telephone triage and assessment tool called the Manchester Triage System (MTS) as a clinical guide during their telephone consultations. Within the tool, various 'cards' are used dependent upon the patient's presenting complaint. Using MTS as a guide and prompt for clinical questioning the paramedic will clear all 'red flags' in order to rule out any immediately life-threatening conditions. They then have options for either admission to the Emergency Department, referral to primary care or discharging the patient.

Initial discussion regarding the presenting complaint prompted the CSD paramedic to select the 'unwell adult' card. In the subsequent telephone triage/assessment, the caller was advised to contact the patient's GP and/or social worker. The CSD paramedic then closed the call. Later the same day a further emergency call was

received from the patient's stepfather wanting the patient assessed, as he has not been eating for four weeks. A CSD paramedic again assessed the call. During the course of the call, the patient stated that they did not want an ambulance so the CSD paramedic closed the call. The following day an emergency call was received from a care worker who had entered the patient's home to find him deceased.

Case study links with:

Section 4.12 Being Open

Section 4.11 Scrutiny and Challenge

Section 4.5.1 Clinical Governance including SAIs

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Have we notified the relevant external stakeholders in line with regional policy?
- What early learning have we identified that should be shared internally and with the wider HSC system?
- How are we engaging with the patient's family?
- What support has been put in place for the family including advice and counselling? What support has been put in place for the staff members?
- Is this an isolated incident – are there any trends from incident analysis or initial investigation that the Board should be aware of?

What information do you need to have?

- Patient Safety and Quality Improvement Data including adverse incident trend analysis including dealing with patient consent.

Case study 34. Media coverage with complex family dynamics

The father of a severely disabled child has approached the media to allege that the Trust has failed to properly assess his son's needs and to provide an adequate care package.

The father is separated from his son's mother. The son is on the Trust child protection register and the Trust is investigating allegations of physical abuse of the boy made by the boy's mother against the father. The father only has supervised access to his son at the present time although this is not part of his complaint to the media.

Case study links with:

Section 4.11 Culture of openness and duty of candour
Section 3.9 Scrutiny and Challenge
Section 4.6.2 Social Care Governance Safe and Effective Practice
Section 4.6.6 Corporate Parenting
Section 4.6.7 Child Protection

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Are there any immediate care management issues that need to be addressed?
- Have we notified the relevant external stakeholders in line with regional policy?
- What is our media communication plan? Does it comply with relevant Data Protection Legislation and organisational information governance policies and procedures?

What information do you need to have?

- Updates on the emerging situation in respect of any child protection and/or corporate parenting issues.

Case study 35. Media allegations against social workers

A journalist has approached the Trust to state that the parents of a child on its child protection register have approached them to make allegations about named social workers in the Trust's child protection team. The family played to the journalist recordings of conversations which they had surreptitiously recorded with Trust staff including a recording of part of a child protection case conference about their child.

The family had previously made allegations on social media about members of Trust staff and had published personal details of two of these staff including the home address and telephone number of one staff member on social media. Following representations by the Trust these details were removed from the social media page and police are investigating. The family have indicated to the Trust that they intend to publish extracts of the recordings on social media. The parents have three other children who are not on the child protection register.

Case study links with:

Section 4.11 Culture of openness and duty of candour
Section 3.9 Scrutiny and Challenge
Section 4.6.2 Social Care Governance Safe and Effective Practice
Section 4.6.6 Corporate Parenting
Section 4.6.7 Child Protection

What questions do you need to ask?

- Consider the generic Broad Prompts as per Sections above.
- Are there any immediate care management issues that need to be addressed?
- Have we notified the relevant external stakeholders in line with regional policy?
- What is our media communication plan?
- What is our social media policy? What are our organisational information governance policies and procedures?
- What support has been put in place for the staff members?

What information do you need to have?

- High level updates on the emerging situation in respect of any child protection and/or corporate parenting issues.

HSC Board Member Handbook

SECTION 6: Training and development

It is recognised that for ALB Board Members to meet all the requirements set out in summary in this guide considerable training and support is needed, both at the time of engagement and throughout the term of appointment. In practice this means that there are several levels of training and development that need to be addressed. These include but are not limited to:

- Induction;
- Appraisal and identification of individual learning needs;
- Training in core functions, leadership, statutory functions etc.;
- Support and mentorship.

6.1 Induction training

6.1.1 For all ALB Board Members

As a minimum it is expected that a structured checklist of induction materials, resources and training such as the 'On Board' training is used. These include but are not limited to the following.

- Following appointment, and before the first Board meeting, a **one-to-one meeting with the Chair** as a two-way process to both identify the skills and interests of the individual and to set out the expectations in the role as a Board Member.

- A **formal induction session** with other newly appointed Board Members (there may be value in part of this being on a regional basis). As a minimum this should include: a code of conduct for Board Members; declaration of interests; organisational structure and purpose; function and administration of the Board and committees; strategic planning for the organisation; roles of Chief Executive and Accounting Officer; Board role in budget and financial responsibilities; Board role in monitoring openness and duty of candour; performance monitoring of organisation and individual Board Members; governance arrangements including Board role in assuring the annual governance statement.

- **Orientation** to the organisation such as time spent with Executive Officers and other key staff, which may involve shadowing, visits to part of the organisation and/or attendance at meetings.

- Access to key **organisational publications,** including: the latest annual report, accounts and annual quality report, the corporate plan and operational/business plan; and any recent strategy or consultation document the organisation has published.

- Other **information** to be provided for new Board Members should include:
    - Relevant legislation;
    - Budget information;
    - Performance management framework;
    - Quality and safety plan, including the risk register;
    - Standing orders for the conduct of ALBs;
    - Organisation structure;
    - Staff directory and contact information;
    - Biographical and contact details of Board Members;
    - Summary of roles and responsibilities, i.e. the Board, subsidiary committees, Chief Executive/Accounting Officer, senior management team and other senior staff;
    - Forward work programme of Board meetings and other key events (for example conferences);
    - The organisation's code of conduct for Board Members;
    - The organisation's data protection policy and freedom of information policy;
    - Information on corporate governance;
    - Schedule of matters reserved for the decision of the Board and scheme of delegation;
    - Action plan arising from the most recent review of Board effectiveness – Ombudsman or similar complaints handing procedure; and
- Minutes from at least the last four Board and audit committee meetings.

- In preparation for the **first Board meeting** new members should be made aware of the protocols for speaking, presentations and conduct. Formal introductions should be made and the Chair should set time aside before and after the meeting to allow the new Board Member to ask questions or raise concerns.

- **Feedback** from new Board Members on the induction process is essential to ensure that the process remains effective.

6.1.2 Induction training for Board Chairs

When a new Chair is appointed, the Government sponsor body (for example a Government Department) should ensure that an early meeting is arranged with a senior member of the body or, where appropriate, the Minister.

The induction of the Chair should cover all the topics already mentioned. However, there are some topics specific to new Chairs including appraisal, leadership experience and involvement in the recruitment and selection of Board Members.

6.2 Appraisal and ongoing learning and development needs for all Board Members

HSC ALB Board chairs are ministerial appointments; it is therefore the Minister who conducts the appraisal. The Minister can delegate this function to a civil servant no lower than Deputy Secretary level for setting objectives for the Chair and conducting his/her appraisal. The appraisal process encourages critical reflection and provides an evidence base upon which Non-Executives can build for future development. It takes place annually and is the basis on which personal development plans are formed.

In turn the HSC Board Chair is responsible for the appraisal of all Non-Executive Directors while the Chief Executive is responsible for the appraisal of all Executive and Operational Directors.

Formal performance appraisal is a compulsory requirement of the code of practice[49] issued by the Commissioner for Public Appointments Northern Ireland (see Appendix 9).

> *"Departments must have in place performance assessment processes that provide evidence for the consideration of reappointments. A performance assessment should be carried out annually for each Chair and Board Member:*
>
> - *No one can be reappointed unless he or she has performed satisfactorily during his/her current term;*
> - *For audit purposes and for the investigation of complaints, it is essential that all performance assessments are fully documented;*
> - *Performance assessments for the Deputy Chair and the members must be completed by the Chair".*

The Department will issue guidance notes to Chairs on an annual basis, when appraisals are being commissioned. The guidance includes a template with five self-assessment areas for Non-Executive Members to complete in advance of a meeting with the Chair:

1. Making an impact on others – operating as part of a team.
2. Committing to the Non-Executive role.
3. Thinking strategically.
4. Analytical thinking.
5. Learning and self-development.

Board prompts to assist in self-assessment in each of these areas are set out below.

49 CPANI Code of Practice JL2 December 2016 and Appendix A – Statement of Compliance Summary of Codes of Practice in Public Life set out in Appendix 3.

Making an impact on others – operating as part of a team

- How do I operate and contribute to the team environment?
- How did my contribution make the team successful in meeting its aims?
- How do I effectively commit to the team?
- How do I foster good working relationships with both Executive and Non-Executive Board Members?
- How do I take others on and bring them to my point of view?

Committing to the Non-Executive role

- Do I understand corporate governance?
- Do I understand the obligation under the Principles of Public Life?
- Do I commit to decisions that are contrary to my own views?
- Do I have any conflicts of interest I need to declare?

Thinking strategically

- How have I contributed to planning the future focus and activities of the Board?
- Have I collected and reviewed information from the past to analyse what should happen in the future?
- How have I personally assisted the Board in meeting its strategic objectives?
- How have I personally assisted the Board in meeting its financial objectives?

Analytical thinking

- How did I contribute to solutions to problems of dealing with complex information when a decision had to made/solution found by the Board?
- What was my role on the Board at such times?
- How did I go about my analysis to generate options or solutions?

Learning and self-development

- How do I go about developing knowledge or understanding in a relatively short time?
- Have I showed willingness to learn quickly so my confidence and contribution increases?
- Have I gaps in knowledge or skill that I need to develop further?

As part of the appraisal process Non-Executive Directors are expected to provide evidence of their time commitment to the role, identifying any issues or development needs for the following year and declaration of any potential conflicts of interest. Evidence is also sought on the continued adherence to the Principles of Public Life as set out in the Committee for Standards in Public Life 1995 (also known as the Nolan Principles – summarised in Appendix 3).

6.3 Training in core functions for HSC Board Members

6.3.1 Leadership

The role of the Board Member is to provide effective leadership for the organisation. This leadership will include providing strategic direction, ensure effective corporate governance, constructive challenge of fellow Board Members as well as support and guidance to the organisation.

While the training and development needs may be similar for all Board Members, the way in which those needs are met will vary, particularly between Executive Directors who are employed by HSC organisations and Non-Executive Directors who are appointed on a part-time basis by Ministers or the Department. In the case of Executive Directors, they have access to a variety of leadership courses run at a regional level by organisations like the HSC Leadership Centre. The programmes are often modular, requiring eight to 12 days off the job and they have a focus on strategy and policy formulation. It is recommended that Executive Directors and operational directors attend such courses at least once every four years. While

there is no bar on Non-Executive Directors attending such courses the part-time nature of their appointments makes attendance at such courses unrealistic for most.

Non-Executive Directors are typically appointed for an average of three days a month. One of these days will be taken up by the monthly Board meeting, another by committee work and then there are site visits and other duties. However it is essential that time is set aside for Board Member training and that the time that Non-Executive Directors have available is used effectively. There are a variety of methods that can be used to deliver training and development opportunities in these circumstances. Typically, these include:

- One-to-one mentoring and support sessions;
- Short one to two-hour information and discussion sessions held prior to Board Meetings;
- One day seminars to address specific topics;
- Case based learning;
- Web-based interactive sessions; and
- Attendance at conferences, regional or UK wide.

All these methods can be used to enhance the contribution of Non-Executives to the working of their Board. The appraisal process should assist both the individual directors and the Chair to identify and prioritise training and development needs and to enable the organisation to plan to meet the needs.

Part of the leadership role of Non-Executive Board Members is to scrutinise the performance of their Executive Director colleagues particularly in relation to patient/client safety and quality of service.

6.3.2 Organisation and HSC service: functions and relationships

It is essential that directors are familiar with the roles and functions of their organisation. Board Members come to the boardroom with varying degrees of knowledge, skills and experience. The induction process outlined in section 6.1 of

this handbook plays a crucial role in helping directors familiarise themselves with the structures and functions of their organisation. Without such knowledge the effectiveness of a director can be limited. It is the responsibility of the Chair and Chief Executive to ensure that induction training for new Board Members is fit for purpose.

The HSC environment changes over time so it is essential that Board Members are provided with the opportunities to be briefed on policy or structural change. The short one to two-hour briefing sessions that can be held when members are meeting for other purposes are an effective way to update members on change and to facilitate discussion and debate. The Department will often provide information in the form of circulars or policy documents that will assist in disseminating the nature of the changes.

6.3.3 Statutory functions

The Board has ultimate responsibility to ensure that practices within their organisation comply with statutory requirements. This can range from health and safety regulation through to employment legislation. It will include HSC specific regulation and legislation. The Department will from time to time issue guidance in respect of the statutory function of HSC organisations. This may be in response to new legislation or to provide a renewed emphasis on duties in light of experience.

Statutory functions for Boards include:

- Duty of Quality;
- Duty on HSC Trusts in relation to improvement of health and social well-being;
- Duty of Financial Control and Requirement to Break Even;
- Data Protection/GDPR;
- Duty of Equality;
- Duty to Involve and Consult;
- Health and Safety at Work;
- Employment legislation and regulation; and

- Proposed Duty of Candour.

The statutory function of Board Members should be covered at the initial induction. The Executive Directors will play a vital role in ensuring that Non-Executive Directors are kept up to date and briefed about changes to statutory functions. Where a new statutory function is introduced or there are significant changes to existing functions it is essential that special awareness training is provided. Boards need to have an opportunity to consider how such changes might impact on how they provide services.

6.3.4 Openness and a statutory duty of candour

The Inquiry into Hyponatraemia Related Deaths recommended a statutory duty of candour should be enacted in Northern Ireland so that every health care organisation and everyone working for them must be open and honest in all their dealings with patients and the public. If brought into law the intention of this regulation is to ensure that providers of health and social care are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment.

Boards of HSC organisations will have to promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at Board level. Boards should have policies and procedures in place to support a culture of openness and transparency and ensure that all staff follow them. Each Board should have nominated Executive Directors with responsibility for issues of candour.

Boards should also have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered, including the obstruction of another in their professional duty of candour. This is likely to include an investigation and escalation process that may lead to referral to their professional regulator or other relevant body.

The introduction of a statutory duty of candour will provide a challenge to Boards to ensure that there is compliance at all levels of the organisation. There should be the opportunity to be briefed on the requirements of the new legislation (or regulation) and to discuss its wider implications for the organisation. There may be a need to change the culture or values of the organisation and if this is the case such change needs be led from the top. Board Members need to be aware of the requirements that a statutory duty of candour places on the corporate body and on individuals within it and the consequences of failing to adhere to the duty.

6.3.5 Involvement and engagement with service users, carers and families

An effective Board will have direct interactions with the organisation's staff, service users and carers, as well as with the wider public (as set out in sections 4.12 and 4.13).

Non-Executive Directors have a particular responsibility to set the culture of the organisation in being open, transparent and accountable in their dealings. The skills required include the ability to set an involvement and engagement strategy for the organisation and to seek qualitative and quantitative feedback on such engagement.

Board Members need to understand their statutory obligations to involve and consult as well as to embrace the principles of:

- Openness and transparency;
- Dignity, respect and equality;
- Inclusivity, equity and diversity;
- Collaboration and partnership; and
- Communication.

These principles are set out in more detail in section 4.14.

Board Members need to understand the requirements under the Standards for Involvement in Health and Social Care and their responsibility to ensure that service users have been meaningfully involved before any major decision is taken. The five standards for Boards are set out in section 4.14.4 as:

- Standard 1 Leadership
- Standard 2 Governance
- Standard 3 Opportunities and support for involvement
- Standard 4 Knowledge and skills
- Standard 5 Measuring outcomes

6.3.6 Scrutiny and challenge of Executive and Operational Directors in areas of performance and patient/client safety

It is essential that Non-Executive Directors fulfil the role of scrutiny and challenge on a Board. Having a cohesive Board is important and healthy debate and challenge is more likely to be achieved if Board communication is underpinned by a spirit of trust and professional respect. Scrutiny by Non-Executive Directors is greatly enhanced if they have a clear understanding of the structures, and functions of the organisation, hence the importance of the induction process. Other skills that are needed include the capacity to synthesise information, consider options, and seek out alternative perspectives. Added to this is the ability to analysis information that comes to the Board to detect trends or other underlying factors that might give an indication how the organisation is performing.

All Board Members should have an awareness of quality improvement methods. This should enable them to oversee improvements to patient or client experience, the efficiency of the organisation and improvements to population health

6.3.7 Who provides Board-level training and development?

The annual appraisal process will provide the opportunity for the Chair of the Board to reflect with appraisees on their performance and experience at the Board. It also facilitates a discussion about training of development needs. These needs can be brought together into a Board development plan. Some of the needs can be meet

internally by information sessions on seminars to address specific topics. There are a range of providers that the Board can call on to help deliver the Board development plan. These include but are not limited to:

- The HSC Leadership Centre;
- The Northern Ireland Confederation for Health and Social Care (NICON); and
- The 'On Board' training programme and regional or national health or social care conferences.

6.4 Mentorship and support

For all Board Members ongoing support is expected and essential to sustaining effectiveness in the role. This would include regular one-to-one meetings with the Chair, the frequency of which depends on the level of experience and role of the individual on the Board, i.e. that newly appointed Board Members would meet more frequently but for others it may be only be needed on an annual basis, such as at the time of appraisal.

It is also recognised that the availability of a network of support from those in similar roles, both within the organisation and across the sector, is invaluable in providing support through shared experience. A formal mentoring relationship is an extension of this informal arrangement and may be facilitated by a third party.

HSC Board Member Handbook

Appendices

Appendix 1. Acknowledgements

The work was undertaken as part of the planning for the delegated IHRD recommendations undertaken by the ALB Board Effectiveness Group (a sub-group of the Duty of Quality Workstream) who commissioned and oversaw the development of the handbook.

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NISCC
Section 4.6 Social Care Governance, in particular Paul Martin, Anne O'Reilly, Patricia Higgins, Rosalyn Dougherty and Noelle Barton.
Peter McBride, section 4.11 Openness and candour
Alan Weir, section 4.11 Openness and candour
David Bingham, section 6 Training and development
Vivian McConvey, section 5 Case studies
NICON
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- **HSC Trust executive teams and Boards** who met with the Chair of the Board Effectiveness Group and Chair of the Writing Group to provide verbal and written feedback as well as suggestions for improvement.

It is acknowledged that the HSC Board Member Handbook is a combined effort of key stakeholders that will be the key to its success and usefulness to future members of HSC Boards.

Appendix 2. Health and Social Care Trusts

Northern Ireland Ambulance Service

The **Northern Ireland Ambulance Service** (**NIAS**) is an ambulance service that serves the whole of Northern Ireland (approximately 1.8 million people). As with other ambulance services in the United Kingdom, it does not charge its patients directly for its services, but instead receives funding through general taxation. It responds to medical emergencies in Northern Ireland with the 300-plus ambulance vehicles at its disposal. Its fleet includes mini-buses, ambulance officers' cars, support vehicles, RRVs and accident and emergency ambulances.

The Northern Ireland Ambulance Service was formed on 1 April 1995 through the amalgamation of its four predecessors. Its full title is the **Northern Ireland Ambulance Service Health and Social Care Trust.**

Services

The service employs approximately 1,300 staff of which approximately 420 are paramedics, 300 are emergency medical technicians and 100 are control staff, which work shift patterns to ensure the service is operational 24/7. They are based across 46 stations and sub-stations, two control centres (emergency and non-emergency) and a Regional Ambulance Training Centre. It responds to approximately 201,000 emergency (999) calls per year (with the number of 999 calls increasing per year) with a combination of traditional emergency ambulances with two crew members, and rapid response vehicles (RRVs) crewed by a single paramedic. RRVs respond mostly to calls where there is a potential immediate life-threat (Category A) because they can respond more quickly than a conventional ambulance. Double-crew ambulances respond to both emergency and non-

emergency (healthcare professional-initiated urgent) calls as well as providing critical-care transfers between hospitals. The Trust aims to provide at least one paramedic to every emergency call by staffing each double-crew, emergency ambulance with two paramedics or a paramedic and an emergency medical technician and utilising RRVs. The Trust has not adopted the controversial use of emergency care assistants in the way many other UK ambulance services have.

Currently there is no training programme in any Northern Ireland universities to train paramedics.

In addition to the emergency service, NIAS has a fleet of patient care service vehicles which are used for more routine patient transport to/from hospital. Within the Patient Care Service there are both single-crewed 'sitting case' (minibus) vehicles as well as double-crewed 'intermediate care vehicles' which carry a stretcher.

Helicopter Emergency Medical Service

In 2016 NIAS was commissioned to provide a Helicopter Emergency Medical Service (HEMS) for the first time in Northern Ireland which was by then the only region of the UK not to have one. Following a public consultation, they partnered with the charity Air Ambulance Northern Ireland which provides the aircraft and airbase, with the doctors and paramedics provided by NIAS. The service undertook its first live mission in August 2017.

Area covered by Northern Ireland Ambulance Service

Northern Ireland Ambulance Service	
Headquarters	Knockbracken Healthcare Park Saintfield Road Belfast BT8 8SG
Region served	Northern Ireland
Area size	5345 sq. miles
Population	1.8 million
Establishments	46 stations and deployment points
Chair	Nicole Lappin
Chief Executive	Michael Bloomfield
Staff	1,300 (2018/19)
Budget	£70.7 Million
Website	www.nias.hscni.net

Belfast Health and Social Care Trust

The **Belfast Health and Social Care Trust** provides integrated health to the local population in Belfast as well as providing the majority of regional specialist services across the region.

The Trust came into existence on 1 April 2007. It was formed under the Belfast Health and Social Services Trust Establishment Order Northern Ireland 2006 – and is responsible for the services formerly delivered by six Trusts which were merged on 31 March 2007. These Trusts were:

- Royal Group of Hospitals and Dental Hospital Health and Social Services Trust;
- Mater Hospital Health and Social Services Trust;
- North and West Belfast Health and Social Services Trust;
- South and East Belfast Health and Social Services Trust;
- Green Park Health and Social Services Trust; and
- Belfast City Hospital Health and Social Services Trust.

The Belfast Trust employs 20,000 staff. It has responsibility for services to over 340,000 patients, provided at various hospitals including Belfast City Hospital, The Royal Hospitals, the Mater Hospital and Musgrave Park Hospital. With an annual budget of £1.3bn Belfast Trust also comprises the major teaching and training hospitals in Northern Ireland.

Services

Belfast Trust delivers a range of both community and hospital-based care including cardiology, anaesthetics and theatre services, medicine and neurosciences, cancer services, nephrology and transplant services, rheumatology, dermatology and neuro rehabilitation services, adult social and primary care incorporating learning disability, mental health services, services for older people, physical and sensory disability services and psychological services, maternity and women's services, dentistry and child health, trauma and orthopaedics, children's community services, and social services.

Activity

- Adult Emergency Department Services – 135,505 new and unplanned attendances per year.
- 2015/16 delivered 5,961 babies.
- Corporate parent to 740 looked after children in the Belfast Trust of whom 572 (77%) were in fostering placements.
- 10,000 hours of home care support per week is delivered to clients through in-house services.
- Over 6,000 meals per day are produced in Trust canteens.
- 1,800 requests for porters.
- Trust estate of eight million square feet of floor space.
- 35 million lab tests per year.

The area covered by Belfast Health and Social Care Trust has a population of 348,204 residents according to the 2011 Northern Ireland census.

Belfast Health and Social Care Trust	
Type	Health and Social Care Trust
Established	1 April 2007
Headquarters	51 Lisburn Road, Belfast, BT9 7AB
Hospitals	Belfast City Hospital Mater Infirmorum Hospital Musgrave Park Hospital Royal Belfast Hospital for Sick Children

Royal Victoria Hospital	
Chair	Peter McNaney
Chief Executive	Dr Cathy Jack
Staff	19,732 (2018/19)
Budget	£1.3 billion
Website	www.belfasttrust.hscni.net

Northern Health and Social Care Trust

The **Northern Health and Social Care Trust** is a provider of Health and Social Care services across four council areas in Northern Ireland – Antrim and Newtownabbey, Causeway Coast and Glens, Mid and East Antrim and part of Mid-Ulster.

The Trust became operational on 1 April 2007. It has an annual operating budget of around £865m and employs around 12,700 people. Funding is secured from a range of commissioners, the main one of which is the Health and Social Care Board.

Services

The Trust provides acute services through two hospitals – Antrim Area and Causeway – and community-based Health and Social Care services from four localities which together include approximately 300 facilities, including day centres, health centres and residential homes.

Outpatient services are provided from Antrim Area, Causeway, Whiteabbey, Mid-Ulster and Moyle Hospitals and Ballymena Health and Care Centre, as well as from a range of community settings.

Holywell Hospital, a 115-bed psychiatric hospital in Antrim, provides a range of inpatient mental health and addiction services. The Trust also provides 20 acute mental health inpatient beds in the Ross Thompson Unit in Causeway Hospital.

Population profile

Geographically the Northern Trust is the largest Trust in Northern Ireland, covering an area with a population of 463,297 residents, according to the 2011 Northern

Ireland census. It also provides services to Rathlin, the only inhabited island off the coast of Northern Ireland.

The population profile indicates that the Trust has the largest older population and the largest child population, when compared to other HSC Trusts in Northern Ireland. The population is predicted to increase by 3.6% over the next 10 years, with significant increases in the older population over age 85, and a drop in the number of children and working age adults. This demographic change is evidenced through the increase in frail older people presenting to the Trust's Emergency Departments and in increased demand for community services. In addition, the north coast is a popular retirement and holiday venue and this tends to increase the number requiring health and social care in the summer months.

Northern Health and Social Care Trust	
Type	Health and Social Care Trust
Established	2007
Headquarters	Bush Road, Antrim, BT41 2RL
Population	463,297
Staffing	12,687 (Aug 2020)
Budget	£865m
Hospitals	Acute Antrim Area Hospital Causeway Hospital Mental Health Holywell Hospital Community Mid Ulster (Magherafelt) Whiteabbey Moyle (Larne) Robinson (Ballymoney) Dalriada (Ballycastle)
Chair	Bob McCann
Chief Executive	Jennifer Welsh
Website	www.northerntrust.hscni.net

South Eastern Health and Social Care Trust

South Eastern Health and Social Care Trust

The **South Eastern Health and Social Care Trust** is a health organisation in Northern Ireland. Hospitals served by the Trust include Downe Hospital, Lagan Valley Hospital and Ulster Hospital.

The area covered by South Eastern Health and Social Care Trust has a population of 346,911 residents according to the 2011 Northern Ireland census.

The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approximately 345,000 people with an annual budget of £600 million. The Trust employs 12,500 staff.

Services

The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approximately 440,000 people with a budget of over £600 million. The Trust covers an area of 425 square miles and incorporates the Local Government Districts of Ards & North Down, Lisburn & Castlereagh and Newry, Mourne & Down. The main hospital bases are:

- Ards Community Hospital;
- Bangor Community Hospital;
- Downe Hospital, Downshire Hospital;
- Lagan Valley Hospital and the Ulster Hospital; and
- Acute services at the Ulster Hospital, which serve a wider population, including East Belfast.

Community bases are located in many local towns and villages from Moira in the west to Portaferry in the east and from Bangor in the north to Newcastle in the south.

The Trust employs in the region of 12,500 staff across a range of disciplines.

Profile

In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, embracing areas of relative wealth and prosperity as well as pockets of considerable deprivation and need.

South Eastern Health and Social Care Trust	
Type	Health and Social Care Trust
Established	1 April 2007
Headquarters	Upper Newtownards Road, Dundonald, Belfast, BT16 1RH
Population	400,000
Staffing	12,500
Budget	£600 million
Hospitals	Downe Hospital Lagan Valley Hospital Ulster Hospital Ards Community Hospital, Bangor Community Hospital
Chair	Jonathan Patton (Acting)
Chief Executive	Seamus McGorran (Interim)
Website	www.setrust.hscni.net

Southern Health and Social Care Trust

The **Southern Health and Social Care Trust** provides Health and Social Care services in Northern Ireland. It runs Craigavon Area Hospital, Daisy Hill Hospital in Newry, Lurgan Hospital, South Tyrone Hospital, Armagh Community Hospital and St Luke's Hospital in Armagh. St Luke's provides mental health services. Daisy Hill Hospital Emergency Department is under threat because of difficulty in retaining staff. The Trust serves an estimated population of 380,312 (June 2017 estimates).

The Trust was established on 1 April 2007 when the Health and Social Services Trusts in the five Local Government Districts of Newry & Mourne, Banbridge, Armagh, Craigavon and Dungannon were dissolved under the Dissolution Orders 2007.

The Trusts in the Southern Health and Social Services Board Area that were merged were:

- Craigavon Area (Lurgan/Portadown) Hospitals Trust;
- Craigavon and Banbridge Health and Social Services Trust;
- Armagh and Dungannon Health and Social Services Trust; and
- Newry & Mourne Health and Social Services Trust.

Services

The Trust employs approximately 13,000 staff and spends £532 million annually in the delivery of Health and Social Care Services.

The Trust delivers services from a number of hospitals, community-based settings and in some cases directly in individuals' homes. A comprehensive range of services is provided through the following directorates:

- Acute services;

- Adult mental health and disability services;
- Older people's and primary care services; and
- Children and young people's services.

Activity

- 50,000 inpatients
- 120,000 Emergency Department patients
- 190,000 outpatients

Profile

- The second largest resident population compared to other Trusts in Northern Ireland at 365,712 (20% of population).
- 9% growth in population between 2000 and 2013, compared to Northern Ireland average of 8.7% with projected growth of a further 25% by 2023, compared to the Northern Ireland average of 10%.
- The largest increase in births since 2001 at 17%, compared to Northern Ireland average of 10%. An 11.3% growth in 0–17 population is expected between 2012 and 2037, compared to a decrease in Northern Ireland of 3.3%.
- The highest projected growth in the over 65 population between 2012 and 2037 of 95%, compared to Northern Ireland average of 79%.
- Central and Eastern European migration accounts for 4.2% of the Trust population, compared to the Northern Ireland average of 2.2%.

Southern Health and Social Care Trust

Type	Health and Social Care Trust
Established	2007
Headquarters	Southern College of Nursing, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Population	365,712
Budget	£532m

Hospitals	Craigavon Area Hospital Daisy Hill Hospital South Tyrone Hospital
Staff	13,000
Chair	Roberta Brownlee
Chief Executive	Shane Devlin
Website	www.southerntrust.hscni.net

Western Health and Social Care Trust

The **Western Health and Social Care Trust** is a health organisation in Northern Ireland. Hospitals served by the Trust include Altnagelvin Area Hospital, Tyrone and Fermanagh Hospital, Omagh Hospital and Primary Care Complex and the South West Acute Hospital.

The Western Health and Social Care Trust became operational on 1 April 2007 following the amalgamation of three separate Trusts: Altnagelvin, Foyle and Sperrin Lakeland Trusts and Westcare Business Services.

The area covered by Western Health and Social Care Trust has a population of 294,417 residents according to the 2011 Northern Ireland census.

The Western Health and Social Care Trust provides Health and Social Care Services across the super council areas of Strabane and Derry City, Fermanagh and Omagh District and a portion of the Causeway Coast and Glens Borough Council area.
The Western Trust employs approximately 12,500 staff and spends £588 million annually in the delivery of Health and Social Care Services.

Our aim is: “to provide high-quality patient and client-focused Health and Social Care services through well trained staff with high morale”.

The Trust provides services across 4,842 sq. km of landmass and delivers services from a number of hospitals, community-based settings and in some cases directly in individuals’ homes. These comprehensive range of services are provided through the following directorates:

- Primary care and older people’s services (including nursing services);
- Women and children’s services (includes social work services);

- Adult mental and health and learning disability services; and
- Acute services.

Western Health and Social Care Trust	
Type	Health and Social Care Trust
Established	2007
Headquarters	MDEC Building Altnagelvin Area Hospital Glenshane Road Londonderry BT47 6SB
Population	294,417
Staffing	12,500
Budget	£588 million
Establishments	Altnagelvin Area Hospital Tyrone and Fermanagh Hospital Omagh Hospital and Primary Care Complex South West Acute Hospital
Chair	Sam Pollock
Chief Executive	Dr Anne Kilgallen
Website	http://www.westerntrust.hscni.net/index.htm

Appendix 3. Nolan Principles for Public Life

The **Committee on Standards in Public Life** is an advisory Non-Departmental Public Body of the United Kingdom Government, established in 1994 to advise the Prime Minister on ethical standards of public life. It promotes a code of conduct called the Seven Principles of Public Life.

The Seven Principles of Public life

- Selflessness – Holders of public office should act solely in terms of the public interest.
- Integrity – Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- Objectivity – Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- Accountability – Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- Openness – Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- Honesty – Holders of public office should be truthful.
- Leadership – Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

These seven principles apply to anyone who works as a public office holder including:

- Those elected or appointed to public office, nationally or locally;

- Those appointed to work in the civil service, local government, the police, courts and probation services, Non-Departmental Public Bodies, and in the health, education, social and care services; and
- Those in the private sector delivering public services.

Appendix 4. Template for HSC Board cover papers

Sections

- Title of paper
- Author(s) of paper
- Purpose of paper
- Key issues
- Organisational implications (implications specific to the core business)
- Financial implications
- Which key areas of the strategic plan does this align to?
- Impact on quality
- Key risks and proposals to mitigate the risks
- Equality and diversity impact
- Communications issues
- Recommendations (including discussion, decision, approval, or noting, in some circumstances).

The author of each Board paper should be required to complete all sections of the cover paper template. If the author believes that N/A is the correct response in any section, he/she should explain why this is the appropriate response.

Appendix 5. (i) DAO (DoF) 06/19 – Guidance on Proportionate Autonomy for Arm's Length Bodies

Partnership working: proportionate autonomy for ALBs

Introduction/Background

As laid out in The Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice (the code), there are around 120 ALBs delivering public services in Northern Ireland, and they account for roughly 70% of the Northern Ireland Executive's departmental expenditure limit budget. The partnerships/relationships between these ALBs and Departments are therefore critical to the delivery of high-quality public services.

While ALBs should all operate with a level of autonomy in order to deliver their services/business, Departments will always be responsible to the Northern Ireland Assembly for the funding granted to them. As reflected in Managing Public Money NI, the Accounting Officer of a Department should make arrangements to satisfy themselves that the ALB Accounting Officer is carrying out his or her responsibilities, and that their organisation, or any organisation funded by the ALB operates effectively and to a high standard of probity. It follows therefore that there will always be a certain level of engagement and assurance required from ALBs.

As partnerships and the nature of relationships between Departments and ALBs will vary according to the purpose, size, structure and public interest in the ALB, so too will the level of autonomy with which an ALB operates at any one point in time, i.e. not one size fits all, all of the time. It is also important to remember that the level of autonomy may also depend on the judgement of Ministers concerning the degree of risk that they may be prepared to bear as well as the accountability that is required.

Partnership agreements

Partnership agreements set out the overall governance framework within which ALBs should operate, including the framework through which the necessary assurances are provided to stakeholders in order to satisfy accountability

requirements. The various roles/responsibilities of partners within the overall governance framework are also outlined.

Delivering public services in partnership

Good public policy requires a focus on outcomes rather than on outputs, processes or inputs. An outcomes delivery plan has been developed as a basis for delivering public services in as effective and co-ordinated manner as possible. Based on the framework of outcomes prepared by the Northern Ireland Executive formed after the election in May 2016, the aim is to build ways of working within the Northern Ireland Civil Service and wider public sector that are outcomes-based and are characterised by focus on impact through collaboration with others. For this system to work well and achieve good outcomes, it is essential that relationships between Departments and ALBs are based on trust, shared values and outcomes, transparency and clear lines of accountability and responsibility.

In this system the focus of engagement between Departments and ALBs will be on strategic issues and delivery of outcomes.

Partnership working

As reflected in the partnership agreement template, there should be strategic alignment between the aims, objectives and expected outcomes and results of the ALB and Department concerned. Departments and ALBs should be clear about the outcomes they are seeking to achieve, and when planning and discussing performance focus on what high-level outcomes the ALB is required to achieve.

Important features of partnership working to help achieve these outcomes are shared values and vision; open, transparent and honest two-way communication – there should be no surprises to either party; shared and agreed understanding of risk and increased co-operation and collaboration. In order to achieve better outcomes and more collaborative working, Departments and ALBs need to embed a co-working partnership approach recognising they are part of one eco-system. This should lead to a better understanding of the delivery of our public services on an

outcomes-based approach, and the ability to identify and understand emerging risks and trends.

Partnership working may require more strategic engagement at a senior level (primarily Executive but also Non-Executive) with the onus on the ALB Board for the delivery of agreed outcomes.

What is 'proportionate autonomy'?

The concept of proportionate autonomy is about the level of independence and autonomy with which an ALB can operate from its Department, and relates to the extent and nature of engagement and assurance required between a Department and an ALB. Essentially, it is about trust, and the basis for it. It is however flexible, and will be subject to individual circumstances – i.e. not one size fits all, all of the time.

In practice, therefore, this should mean that ALBs that deliver their agreed outcomes on an ongoing basis, and provide sound and reliable assurances should be able to operate with a high degree of autonomy from their Department in recognition of that level of trust that has been established and consistently demonstrated through evidence of good standards of governance, good financial management, compliance with relevant guidance and provision of reliable and accurate information.

Where ALBs are not yet in this position the interactions necessary will be reflected in the engagement plan. In some instances specific issues may have arisen, in which case the extent and nature of engagement may need to change for a period of time until they are resolved.

How to assess proportionate autonomy

Due to the differing nature of ALBs, it is difficult to be prescriptive about what proportionate autonomy should look like. While there will be some commonality, each case will be unique and as stated above, not one size fits all, all of the time. In

general as partnerships mature, trust will grow and as confidence increases in the efficacy of systems, so too will the level of autonomy.

In practice, ALBs should all be operating with a certain level of independence/autonomy in order to deliver their services/business, and where they achieve their agreed outcomes in line with any policy set, this should be taken into consideration as part of the overall assessment to determine the appropriate level of autonomy.

Further areas for consideration include an assessment of the effectiveness of the ALB's governance procedures, systems of internal control and assurance mechanisms, together with any relevant risk issues, quality of financial management and general compliance with guidance. All of these, together with an assessment of the relevant assurances provided, will help assess what is an appropriate level of autonomy, and set the tone for the relationship. It is important that Departments rely on assurances from ALBs as appropriate, and do not carry out excessive checking of information/returns provided by ALBs or duplicate administrative functions of ALB staff.

It should also be recognised, that the level of autonomy with which an ALB operates can change. Where things do go wrong however, any response by Departments should be proportionate to the risk posed.

The engagement plan annex within the partnership agreement allows flexibility for an ALB and a Department to specify and agree the nature and extent of engagement between them, and will reflect the level of ALB autonomy. This should be considered on an annual basis, and in conjunction with the principles laid out in the code.

Annex A, set out in Appendix 5 (ii), provides a summary of assurances/indicators that Departments and ALBs should consider when establishing their engagement plans. Engagement plans will reflect the appropriate level of ALB autonomy based

on assurances/indicators of good governance and the maturity of the partnership/relationship.

Benefits of a higher degree of autonomy

Potential benefits though from a practical point of view may include the following:

- Reduced bureaucracy and burden of duplicate checking/compliance/assurance processes for both ALBs and Departments;
- Streamlining of processes – information should only be provided once;
- Increased delegated levels of expenditure for ALBs;
- Better use of resources; and
- Potential efficiency savings.

It is important to remember that the pace of movement towards higher degrees of autonomy will differ and the end point may also vary depending on the nature and structure of the ALB and Department.

Review

Departments and ALBs should consider and review the nature of their relationship (as part of the review of the engagement plan within the partnership agreement) either on an annual basis as part of existing governance processes, or in the case of any specific event that has the potential to change the relationship and the level and nature of engagement that may be necessary.

It is also important to emphasise the need for Departments to be careful not to introduce disproportionate measures in response to specific governance events or failings. Departments should review on a periodic basis (at least every three years) the extent to which its practices adhere to the principle of proportionality so as to ensure that excessive processes have not been introduced over time.

Developing/sharing best practice

In taking forward the transition to partnership working, it will be beneficial to share lessons learned and best practice between Departments to help embed the new arrangements and to build contacts through a more formalised network. This may

include some common training, events around common issues and problems as well as a repository of best practice available on the accountability and financial management section of the DoF website. The Departmental Implementation Group, set up to help implement the new approach, will remain as a forum for Departments to meet and share experience and will also be a forum to develop knowledge and expertise around partnership working with ALBs through peer-led learning.

Appendix 5. (ii) Annex A

Assurances/Indicators to consider in determining proportionate autonomy and establishing engagement plans.

Guide for Departments and ALBs

A qualitative overall assessment of the effectiveness of available assurances should be carried out.

1. Board effectiveness

Assurance sources

Most recent internal and independent Board effectiveness review.

Considerations

- What were the results of the last Board effectiveness review?
- What actions were planned as a result?
- Did the review highlight significant issues to be addressed?
- If so what progress has been made in implementing these?
- What are the results of the most recent Chair and Board Member appraisals?
- What are the results of the most recent Board Chair peer review?
- Are there any indications of ineffective Board relationships?
- Are there any other indications that the Board may not be operating effectively or in accordance with its role and code of conduct?

2. Independent audit opinions – internal audit

Assurance source

Head of Internal Audit (HIA) annual report and opinion.

Considerations

- What overall opinion has been provided by the HIA?
- What areas of concern/limited assurance have been referred to in the HIA's annual opinion and report?
- Does the report indicate concern in relation to the timely implementation of audit recommendations?
- What was the result of the most recent external quality assessment of the internal audit function?

3. Independent audit opinions – external audit

Assurance sources

Annual external audit opinion – annual report and accounts.

Annual report to those charged with governance.

Considerations

- Is the external audit opinion 'clean' or qualified?
- If qualified what actions are in place to address the qualification matters?
- Are there any regularity or other matters referred to in the opinion?
- What matters are raised within the report to those charged with governance?
- What plans are in place to address matters raised within the report to those charged with governance?

4. Risk management

Assurance source

Risk management framework

Considerations

- Has the organisation a risk management framework in place integrated with the business and strategic planning process?
- Have shared risks been identified and evaluated through shared understanding on strategic alignment?

5. Annual governance statement

Assurance source

Governance statement – annual report and accounts.

Considerations

- Are there any significant internal control weaknesses referred to in the governance statement?
- If weaknesses are identified what actions are in place to address the identified weaknesses?
- What is the Board's recorded assessment of compliance with its corporate governance code of good practice?

6. ALB assurance statements

Assurance source

In-year ALB assurance statements.

Considerations

- Are the ALB assurance statements signed by the Accounting Officer (considered by the ALB audit committee and provided to the Board where possible) and agreed by the Chair or Board before submission to the relevant Department, in line with the process set out in the partnership agreement?
- What issues have been identified within the statements?

7. Other assurance sources

Assurance sources

- **Outcomes delivery/performance targets**
- **Financial performance**
- **Annual ALB Accounting Officer declaration of Fitness to Carry Out the Accounting Officer Role**

- **Robustness of expenditure decisions in business cases/economic appraisals**
- **Other Departmental returns**

Considerations

- Has the ALB consistently demonstrated a sound track record of delivery against required outcomes and performance targets?
- Has the ALB consistently demonstrated the ability to deliver within budget?
- Has the ALB Accounting Officer provided annual declaration of Fitness to Carry Out the Accounting Officer Role?
- Where business cases/economic appraisals are presented to the relevant Department for approval are these compliant with the Northern Ireland Guide to Expenditure Appraisal and Evaluation and Managing Public Money NI requirements and provide a robust case for the proposed expenditure?
- Are returns provided to the Department by the ALB of good quality with minimal need for revision following review?

Appendix 6. Information management assurance checklist

In conjunction with the organisation's SIRO and personal data guardian, as Chief Executive of [*insert name of organisation*], I hereby give an assurance that a systematic and planned approach to the governance of information is in place that ensures the organisation can maintain information in a manner that effectively services its needs and those of its stakeholders in line with appropriate legislation.

I can confirm that:

YES/NO

1. INFORMATION GOVERNANCE FRAMEWORK

i) My organisation has in place an information governance management framework which is supported by policies, strategies and improvement plans.

ii) My organisation has in place information governance awareness and mandatory training procedures and staff are appropriately trained.

iii) The information governance agenda in my organisation is supported by adequate information quality and records management skills, knowledge and experience.

iv) My organisation's SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy.

v) My organisation has documented and agreed procedures in place to ensure compliance with the requirements of the General Data Protection Regulation.

2. FOI/EIR

i) My organisation has documented and publicly available procedures in place to ensure compliance with the Freedom of Information (FOI) Act 2000 and Environmental Information Regulations 2004 (EIR).

3. DATA PROTECTION AND CONFIDENTIALITY

i) All staff in my organisation are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users.

ii) Information governance in my organisation is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs.

iii) In my organisation there are appropriate procedures in place for recognising and responding to individuals' requests for access to their personal data.

iv) Individuals are informed about the proposed uses of their personal information which is held by my organisation.

v) Processing outside the UK of person identifiable data held by my organisation complies with the General Data Protection Regulation and Department of Health (NI) guidelines.

vi) The processes for all transfers of hardcopy and digital person identifiable and sensitive information held by my organisation have been identified, mapped and risk assessed, and technical and organisational measures adequately secure these transfers.

vii) The confidentiality of service user information held by my organisation is protected through use of pseudonymisation and anonymisation techniques where appropriate.

4. THIRD PARTIES

i) My organisation has contractual arrangements in place with all contractors, support organisations and individuals carrying out work on behalf of the organisation which include compliance with information governance and relevant legislative requirements.

ii) In situations where the use of personal information held by my organisation does not directly contribute to the delivery of care services such information is only processed where there is a lawful basis to do so and objections to the disclosure of confidential personal information are appropriately respected.

iii) Where required, protocols governing the sharing of personal information by my organisation have been agreed with the other organisation.

5. MANAGEMENT OF CLINICAL RECORDS

i) In my organisation there is consistent and comprehensive use of the Health + Care Number (HCN) in line with the Department's best practice guidance.

ii) Procedures are in place in my organisation to ensure the accuracy of service user information on all systems and/or records that support the provision of care.

iii) A multi-professional audit of clinical and social care records across all specialties has been undertaken in my organisation.

iv) Procedures are in place within my organisation for monitoring the availability of paper health/care records and tracing missing records.

v) In my organisation national data definitions, standards and validation programmes are incorporated within key systems and local documentation is updated as standards develop.

vi) External data quality reports are used for monitoring and improving data quality within my organisation.

vii) In my organisation audits of clinical coding, based on national standards, have been undertaken by a NHS Classifications Service approved clinical coding auditor within the last 12 months.

viii) A documented procedure and a regular audit cycle for accuracy checks on service user data is in place within my organisation.

ix) In my organisation clinical/care staff are involved in validating information derived from the recording of clinical/care activity.

x) In my organisation training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards.

6. MANAGEMENT OF CORPORATE RECORDS

i) Documented and implemented procedures are in place for the effective management of corporate records in my organisation.

ii) As part of the information lifecycle management strategy, an audit of corporate records held by my organisation has been undertaken and an information asset register is maintained.

If you are unable to provide any of these assurances, please explain what the current circumstances are on a separate page and detail what action is being taken to resolve the issues including timeframes.

This information should be returned to the Department.

Signed:

Chief Executive

Organisation:

Date:

Appendix 7. Information governance management framework

DoH Amended Guidance 2019

Organisations are expected to assure their Department that they have an information governance management framework in place which is supported by policies, strategies and improvement plans.

Robust information governance requires clear and effective management and accountability structures, governance processes, documented policies and procedures, trained staff and adequate resources. The way that an organisation chooses to deliver against these requirements is referred to as the organisation's information governance management framework.

Requirement

The information governance management framework must be documented, approved at senior management level and reviewed annually.

Key governance bodies must be established, comprehensive information governance policies must be communicated to staff and strategies/improvement plans must be in place.

In-year reports and briefings on information governance arrangements, implementation of strategies and improvement plans must be provided to, and considered by, senior management in the organisation, who must annually approve any necessary improvements to existing arrangements.

The information governance management framework may be described in a single one page stand-alone document or incorporated within an overarching information governance policy or strategy, but it must provide a summary/overview of how an organisation is addressing the information governance agenda.

Guidance

Example of an information governance management framework.

INFORMATION GOVERNANCE MANAGEMENT FRAMEWORK		
Heading	**Requirement**	**Notes**
Senior roles	• IG lead • Senior information risk owner (SIRO) • Personal data guardian	These roles should be at Board or the most senior leadership team level.
Key policies	• Overarching information governance policy • Data Protection Act/confidentiality policy • Organisation security policy • Information lifecycle management (records management) policy • Corporate governance policy • Freedom of information policy • Risk management • Information quality	This documentation should consist of an overarching high-level information governance policy (which is a statement of the organisation's intentions and approach to fulfilling its statutory and organisational responsibilities) supported by corporate policies, strategies and plans covering the key areas of information governance. An information governance strategy or improvement plan may cover several years and should identify how the corresponding information governance policy will be delivered.
Key governance bodies	IG Board/Forum/Steering Group	A group, or groups, with appropriate authority should have responsibility for the IG agenda.
Resources	Details of key staff roles and dedicated budgets	The key staff involved in the information governance agenda should be identified with a description of their roles and responsibilities. Any dedicated budgets and high-level plans for expenditure in-year should also be identified, including outsourcing to external resources or

		contractors.
Governance framework	Details of how responsibility and accountability for information governance is cascaded through the organisation	This should include staff contracts, contracts with third parties, information asset owner arrangements, departmental leads on aspects of information governance etc.
Training and guidance	Training for all staff Training for specialist information governance roles	Staff need clear guidelines on expected working practices and on the consequences of failing to follow policies and procedures. The approach to ensuring that all staff receives training appropriate to their roles should be detailed.
Incident management	Documented procedures and staff awareness	Clear guidance on incident management procedures should be documented and staff should be made aware of their existence, where to find them and how to implement them.

Organisations are expected to assure their Department that mandatory information governance awareness and training procedures are in place and staff are appropriately trained.

To ensure compliance with legal requirements and central guidelines relating to information governance staff must receive appropriate training. Information governance training is therefore mandatory for all staff and training needs must be routinely assessed, monitored and adequately provided for.

Requirement

An information governance training programme must be developed that includes training needs analyses and induction for new entrants. Training needs must be regularly reviewed and re-evaluated. **It is expected that at least 95% of all staff**

should have completed their information governance training in the period 1 April to 31 March.

All staff must receive information governance training and continue to receive it every three years. Action must be taken to test and follow up staff understanding of information governance and additional support provided where need is identified.

Training material must be reviewed regularly for equivalence to best practice and updated in line with legal requirements, corporate and/or Department of Health policy, or any major changes which may impact on the information governance agenda, at a local or national level.

Guidance

The HSC Leadership Centre has developed an e-learning suite of programmes for information governance. The suite of programmes includes freedom of information, data protection, ICT security, records management and confidentiality and is available regionally to all HSC organisations through the HSC Leadership Centre.

Organisations are expected to assure their Department that information governance is supported by adequate information quality and records management skills, knowledge and experience.

Information quality and records management are key elements of information governance. An information quality and records management assurance framework should be in place around healthcare and corporate records across the whole organisation.

Requirement

Skilled information quality and records managers/officers must be in place along with documented information quality and records management strategies, approved by senior management/committee, which form part of the broader information lifecycle policy.

There must be an information quality and records management framework in place with adequate skills, knowledge and experience to successfully co-ordinate and implement the information quality and records management action plan.

Information quality and records management arrangements must be co-ordinated by the lead manager/officers and incorporated within broader information governance arrangements.

Guidance

Information quality and records managers/officers

Organisations must ensure they have individuals with clear responsibility for the quality of service user, staff and corporate data across all systems.

Organisations must ensure there are individuals with clear responsibility for the management of records within the organisation.

Awareness and training

The organisation must assess (and annually review) its legal obligations and associated risks to determine the resources, awareness and training needed to establish and maintain the level of assurance required for managing records and dealing with any requests. Appropriate training must be provided according to staff job roles, level of access to person identifiable information and responsibilities for processing/managing records.

The HSC Leadership Centre has developed an e-learning suite of programmes for IG. The suite of programmes includes freedom of information, data protection, ICT security, records management and confidentiality and is available regionally to all HSC organisations through the HSC Leadership Centre.

Strategies

There must be documented strategies in place, signed off by senior management, to support the information quality and records management work programme which:

- Identify key individuals, and the reporting structure across the organisation, to lead on information quality and records management;
- Outline key aspects of the work programme;
- Identify the support needed to ensure the work is completed; and
- Form part of the broader information lifecycle policy.

These must be supported by an improvement plan which clearly identifies work/actions, responsible individuals and timescales for completion.

There must be adequate arrangements in place to assure senior management that the organisation complies with current information governance standards. Senior management should be kept informed of changes and risks which need to be considered and addressed.

Organisations are expected to assure their Department that the senior information risk owner or SIRO is effectively supported and takes ownership of the organisation's information risk policy and management strategy.

Organisations must ensure an appropriate senior individual is allocated responsibility for owning information risk. In HSC organisations this role is referred to as the SIRO. The SIRO should be familiar with information risks, and the organisation's response to risk, to ensure they can provide the necessary input and support to the Board and to the Accounting Officer.

Requirement

The SIRO must have an effective support infrastructure and adequate information risk skills, knowledge and experience to successfully co-ordinate and implement information risk management.

The SIRO and the supporting information risk management leads (information asset owners and supporting staff) must be appropriately trained and conduct regular risk reviews for all key assets.

The arrangements for information risk management must be regularly reviewed to ensure they remain current and effective.

The SIRO must successfully complete strategic information risk management training followed by annual refresher training.

Guidance

Information risk – responsibilities and accountability

Information risk should be managed in a robust way within all work areas and not be perceived as the sole responsibility of IT or information governance staff. Assurances need to be provided in a consistent manner through the development of an information governance framework.

This structured approach relies upon the identification of information assets and assigning ownership of assets to senior accountable staff.

Accountability and performance

Senior level ownership of information risk is a key factor in successfully raising the profile of information risks and embedding information risk management into the overall risk management culture of the organisation.

Roles

The role of the Accounting Officer

In HSC organisations, the Chief Executive is the Accounting Officer and has overall accountability and responsibility for information governance. They are required to provide assurance, through a statement of internal controls, that all risks to the organisation, including those relating to information, are effectively managed and mitigated.

The role of the SIRO

The SIRO, who should be an Executive Director or other senior member of the Board familiar with information risks, is the focus for management of information risk at Board level. They should not be the personal data guardian as the SIRO should be part of the organisation's management hierarchy rather than having an advisory role.

As the SIRO will be expected to understand how the strategic business goals of the organisation may be impacted by information risks it may therefore be logical for this role to be assigned to a Board Member already leading on risk management or information governance.

The role of the information asset owner

Information asset owners (IAOs) are directly accountable to the SIRO and will provide assurance that information risk is being managed effectively for their assigned information assets.

The role of the IAO is to understand what information is held, what is added and what is removed, how information is moved, who has access to it and why. As a result they should be able to understand and address risks to the information and ensure that it is fully used within the law for the public good. The IAO will also be responsible for providing or informing regular written reports to the SIRO, a minimum of annually, on the assurance and usage of their asset.

**** It is important that ownership of information assets is linked to a post, rather than a named individual, to ensure that responsibilities for the asset are passed on, should the individual leave the organisation or change jobs within it.**

Information assets

Information assets are identifiable and definable assets owned or contracted by an organisation which are valuable to the business of that organisation. Information assets include computer systems and network hardware and software.

Information assets include information which is of value to the organisation, is not easily replaced, supports delivery of business outcomes and if lost could seriously impact on business delivery and organisational reputation.

Information asset register

It is very important that all organisations ensure their information assets are identified and assigned to an information asset owner (or equivalent). Information assets should be documented in a register. The SIRO (or equivalent), should oversee a review of the organisation's asset register to ensure it is complete and robust.

In order to establish corporate coherence it should be possible for a single asset register to be created for the organisation. As a priority, it is essential that all critical information assets are identified and included in this asset register, together with details of business criticality, the information asset owner (or equivalent), and risk reviews carried out. To improve its usability and maintainability, the information asset register may be organised by service, rather than location.

With the introduction of the General Data Protection Regulation there is a requirement to identify what information is held in an organisation, in particular, all personal and sensitive information assets to ensure full compliance with the new regulations. GDPR requires that the lawful basis for processing activities is established and documented in an information asset register. GDPR introduces a new accountability and governance principle, which requires organisations to maintain internal records of their processing of personal data. Formally documenting assets and any associated risks to information in an information asset register will help demonstrate compliance with this principle.

Organisations are expected to assure their Department that documented and agreed procedures are in place to ensure compliance with the requirements of the General Data Protection Regulation.

From 25 May 2018 organisations have a statutory duty to comply with the requirements of the GDPR. Compliance includes knowing what personal data is held, how and why it is processed, who has access to it, and with whom it is shared.

Failure to comply with the requirements of the GDPR can carry a penalty of up to €20million or 4% of global turnover.

Requirement

There must be documented and agreed procedures in place to ensure compliance with the requirements of the GDPR, including the allocation of appropriate resources and the provision of ongoing staff training and awareness.

Guidance

Data protection key actions

The key actions of the data protection work are to:

- Ensure compliance with all aspects of the GDPR and related provisions and provide reports to the senior level of management in the organisation;
- Draft and/or maintain a data protection policy;
- Promote awareness throughout the organisation about the requirements of the GDPR by organising training and providing written procedures that are widely disseminated and available to all staff;
- Ensure service users are provided with information on their rights under data protection legislation;
- Maintain a record of, and monitor for GDPR compliance all data processing undertaken by the organisation, for example in an information asset register;
- Manage an audit programme of data protection and health checks to monitor and ensure GDPR compliance. Implement and report on action plans that derive from compliance activities;
- Co-ordinate a risk management and compliance framework for privacy including working with IT leads to ensure systems are GDPR compliant;

- Assess the risks associated with data processing operations and ensure internal controls are in place to mitigate these risks. Privacy impact assessments must be carried out on all new projects/policy that involve the processing of personal or sensitive personal data and for any changes to current policies/procedures/processes that similarly involve the processing of personal or sensitive personal data;
- Advise the organisation on whether or not a data protection impact assessments should be undertaken, the methodology it should use, safeguards, monitoring of performance and whether its conclusions comply with the GDPR;
- Maintain and forward the organisation's notification to the ICO;
- Oversee the breach management process; and
- Lead on the resolution of complaints from data subjects, staff and the general public.

The Information Commissioner's Office, the regulator, publishes GDPR-related guidance which can be accessed on the Information Commissioner's Office website.

Appendix 8 (i) Summary of the Human Rights Act 1998

Article 2 Right to life

For health and social care this means that nobody, including the Government, can act to end a life and must take steps to protect it if an individual's life is at risk. Public bodies have to consider an individual's right to life when making decisions that might put them in danger or that affect their life expectancy.

Article 3 Freedom from torture and inhuman or degrading treatment

For health and social care this means that no individual should be subject to inhuman or degrading treatment or punishment. Public bodies must not inflict such treatment and must act to protect the individual if others are treating the individual in this way. Inhuman treatment is defined as treatment that causes intense physical or mental suffering.

Article 6 Right to a fair trial

For health and social care this relates to a public authority making a decision that has an impact on an individual's civil rights or freedoms. Although not directly relevant it has been argued that decisions in health care should also follow the requirements for impartiality, openness and transparency and that the consent process allows for the individual to be given sufficient information to make an autonomous decision.

Article 8 Respect for your private and family life, home and correspondence

For health and social care this relates to the confidentiality and privacy of family life and has been interpreted by the court as covering sexual orientation, lifestyle and how an individual dresses. It also includes who sees and touches another person's body, so that permission (through the consent process as required) is needed for such activities. Article 8 also covers the right to enjoy family relationships without interference, including the right to live with your family and to have regular contact.

Article 14 Protection from discrimination in respect of these rights and freedoms

For health and social care this means when a person is treated less favourably than others in a similar situation and this treatment cannot be objectively and reasonably justified. Discrimination can also occur if an individual is disadvantaged by being treated the same as another person when the circumstances are different. These rights are also covered by the Northern Ireland Act 1998.

Appendix 8 (ii) Equality legislation

The Northern Ireland Act 1998 (the Act)[50] is set out to change the practices of Government and public bodies so that equality of opportunity and good relations are central to policy making and service delivery.

Section 75 of the Act requires public bodies (including Health and Social Care organisations) to comply with the *Equality of Opportunity duty* in promoting equality of opportunity between nine equality categories*:*

- Religious beliefs;
- Political opinion;
- Racial group;
- Age;
- Marital status;
- Sexual orientation;
- Gender;
- Disability; and
- Persons with dependents and persons without.

A second *Good Relations duty* requires public bodies to promote good relations between persons of different religious belief, political opinion and racial group.

For health and social care this means that every HSC organisation has to have an *Equality Scheme* in place as a public statement of the organisation's commitment to fulfilling its Section 75 responsibilities including procedures for measuring performance which is scrutinised by the Equality Commission (now the Equality and Human Rights Commission).

50 https://www.equalityni.org

Appendix 8 (iii) Disability Discrimination Act 1995[51]

The Equality Commission has responsibility for enforcing the Disability Discrimination Act 1995 (DDA), as amended, in Northern Ireland. It also has a legal duty to work towards the elimination of discrimination against disabled people, to promote the equalisation of opportunities for disabled people, and to keep under review the working of the DDA.

Disability discrimination law in Northern Ireland – a short guide

The following is an extract from the short form guidance provided by the Equality Commission for Northern Ireland as it relates to the **provision of services and employment.** Further information is available from the Commission's enquiry line and on the website.

The Equality Commission for Northern Ireland

The Equality Commission has responsibility for enforcing the Disability Discrimination Act 1995, as amended, in Northern Ireland. It also has a legal duty to work towards the elimination of discrimination against disabled people, to promote the equalisation of opportunities for disabled people, and to keep under review the working of the Disability Discrimination Act 1995.

The law

The Disability Discrimination Act introduced, over a period of time, new laws and measures aimed at ending the discrimination faced by many disabled people. It gives disabled people rights in:

- Employment;
- Access to goods, facilities and services, including transport;
- The management, buying or renting of property; and
- Education.

The DDA only protects people who meet its definition of disability.

51 Equality Commission, Short Form Guidance on the Disability Discrimination Act 1995.

The DDA defines disability as “a **physical** or **mental** impairment which has a **substantial** and **long-term adverse effect** on a person’s ability to carry out **normal day-to-day activities**”.

Physical impairment – this includes, for instance, a weakening of part of the body (eyes, ears, limbs, internal organs) caused through illness, by accident or from birth. Examples are blindness, deafness, paralysis of a leg or heart disease.

Mental impairment – this includes mental ill health and what is commonly known as learning disability.

Substantial – put simply, this means that the effect of the physical or mental impairment on ability to carry out normal day-to-day activities is more than minor or trivial. It does not have to be a severe effect.

Long-term adverse effect – the effect has to have lasted, or be likely to last, overall for at least 12 months and the effect must be a detrimental one. People who are diagnosed with cancer, HIV and multiple sclerosis are deemed to be disabled from the point of diagnosis rather than from the point when the condition has some adverse effect on their ability to carry out normal day-to-day activities.

A **normal day-to-day activity** is something which is carried out by most people on a fairly regular and frequent basis, such as washing, eating, catching a bus or turning on a television. It does not mean something as individual as playing a musical instrument to a professional standard or doing everything involved in a particular job.

To meet the definition, a person must be affected in at least one of the respects listed in the DDA:

- Mobility;
- Manual dexterity;
- Physical co-ordination;
- Continence;

- Ability to lift, carry or otherwise move everyday objects;
- Speech, hearing or eyesight;
- Memory or ability to concentrate, learn or understand; or
- Perception of risk of physical danger.

People who satisfy the definition of 'disability' are covered by the DDA. This includes people who have had a disability in the past.

Discrimination in employment

Under the DDA, discrimination in employment occurs when:

- A disabled person is **treated less favourably** than someone else on the grounds of his/her disability (direct discrimination);
- A disabled person is **treated less favourably** than someone else and the treatment is for a **reason relating to the person's disability**, and this treatment **cannot be justified** (disability related discrimination);
- There is a **failure to make a reasonable adjustment** for a disabled person; or
- **Victimisation** occurs if a disabled person is subjected to **harassment** for a reason which relates to their disability.

Provision of goods, facilities and services

Those who provide goods, facilities and services to the public, or a section of the public, cannot discriminate against a disabled person. Under the DDA, discrimination in the provision of goods, facilities and services occurs when:

- A disabled person is **treated less favourably** than someone else and the treatment is for a **reason relating to the person's disability**, and this treatment **cannot be justified;** or when
- There is a **failure to make a reasonable adjustment** for a disabled person.

Education

A separate piece of legislation deals with disability discrimination in education. Under the Special Educational Needs and Disability (NI) Order, discrimination in education occurs when:

- A disabled pupil or student or prospective pupil or student is **treated less favourably** than someone else and the treatment is for a **reason relating to the pupil's or student's disability**; and this treatment **cannot be justified.**
- There is a failure to make a **reasonable adjustment** for a disabled pupil or student; and when
- **Victimisation** or **harassment** occurs.

Reasonable adjustments by service providers

Service providers who offer services to the public must make reasonable adjustments. In order to make a reasonable adjustment, a service provider may have to:

- Change a **practice, policy or procedure** which makes it impossible or unreasonably difficult for disabled people to use their services, for example, amending a 'no dogs' policy to allow a disabled person accompanied by a guide dog to enter their premises;
- Provide an **auxiliary** aid or service if it would make it easier for disabled people to make use of their services, for example, the provision of information in alternative formats such as audio tape, Braille or large print; or
- Provide a reasonable **alternative method** of making services available to disabled people where a **physical feature** makes it impossible or unreasonably difficult for disabled people to make use of them, for example, providing staff assistance to disabled customers who cannot access goods due to their disability when shopping.

Service providers have to make reasonable adjustments to the physical features of their premises to overcome physical barriers to access. A physical feature includes:

- Any feature arising from the design or construction of a building on the premises occupied by the service provider;
- Any feature on those premises or any approach to, exit from or access to such a building; and
- Any fixtures, fittings, furnishings, furniture, equipment or materials on such premises, including steps, kerbs, internal and external doors, toilet and washing facilities, lighting, signs and furniture.

All features are covered whether temporary or permanent. A building means an erection or structure of any kind.

Can a service provider treat a disabled customer less favourably or not make reasonable adjustments?

A service provider can justify treating a disabled customer less favourably or refusing to make reasonable adjustments in the following circumstances.

- Where the treatment is necessary in order to avoid endangering the health and safety of any person.
- Where the disabled person is incapable of entering into a legally enforceable agreement or of giving informed consent.
- If they would otherwise be unable to provide the service to the disabled person or other members of the public.
- When greater expense is involved in providing a special service for a disabled customer.
- When an adjustment would fundamentally alter the nature of a business or service.

The service provider must believe that one or more of the above conditions exist and it must be reasonable to hold that belief.

Is there anything to stop a disabled person being given more favourable treatment?

A service provider may treat a disabled person more favourably than others. For example, a theatre manager can offer people who are hard of hearing front stall seats at rear stall prices; football clubs can reserve pitch-side places for wheelchair users; and historic houses can offer concessionary prices for disabled people.

Appendix 9. Code of Practice for Ministerial public appointments in Northern Ireland

Version JL2 December 2016

Extract, section 4

Performance assessment

4.5 Departments must have in place performance assessment processes that provide evidence for the consideration of reappointments. A performance assessment should be carried out annually for each Chair and Board Member.

- No one can be reappointed unless he or she has performed satisfactorily during his/her current term.
- For audit purposes and for the investigation of complaints, it is essential that all performance assessments are fully documented.
- Performance assessments for the Deputy Chair and the members must be completed by the Chair.

Number of terms served

4.6 Appointments for the same position are restricted to two terms. Those who have served two appointment terms, of whatever length, on a Board are ineligible to apply for the same position.

- The length of appointment terms will be determined by statute, or be a matter for decision by Ministers.
- Notwithstanding the length of individual appointment terms, the maximum period in a post must not exceed 10 years.

Appendix 10. References and further reading

Statute (including Statutory Instruments[52] and Rules)[53]

The following can be accessed here (unless otherwise indicated)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1972 S.I.1972/1265 (N.I.14)

Statutory Instrument: Sex Discrimination (Northern Ireland) Order 1976 SI 1976 No 1042 (NI15)

Statutory Instruments: The Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 S.I.1990/247 (N.I.3)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1991 SI 1991/194 (N.I. 1)

Statutory Instruments: The Health and Personal Social Services (Northern Ireland) Order 1994 SI 1994 No 429 (NI 2)

Statutory Instruments: The Health and Social Care (Reform) Act (Northern Ireland) 2009

Statutory Instruments: The Health and Social Care (Amendment) Act (Northern Ireland) 2014

United Kingdom Act (1995): Disability Discrimination Act 1995 (1995 c.50). The Stationery Office, Statutory Instrument: Race Relations (Northern Ireland) Order 1997 SI 1997 No 869 (NI6)

United Kingdom Act (1998): Human Rights Act 1998 (1998 c.42). The Stationery Office, London

United Kingdom Act (1998): Northern Ireland Act 1998, Section 75 (1998 c.47). The Stationery Office, London

Statutory Instruments: The Public Interest Disclosure (Northern Ireland) Order 1998 SI 1998 No 1763 (NI 17)

52 Statutory Instruments also known as SIs, are a form of legislation which allows the provisions of an Act of Parliament to be subsequently brought into force or altered without Parliament having to pass a new Act. They are also referred to as secondary, delegated or subordinate legislation.
53 Statutory Rules are made under the Statutory Rules (Northern Ireland) Order 1979. They replaced statutory rules and orders made under the Rules Publication Act (Northern Ireland) 1925 and are comparable with SIs in the rest of the UK.

Statutory Instrument: Fair Employment and Treatment (Northern Ireland) Order 1998 SI 1998 No.3162 (N.I.21)) London

United Kingdom Act (2000): The Freedom of Information Act 2000 (2000 c.36). The Stationery Office, London

Statutory Instrument: Equality (Disability, etc.) (Northern Ireland) Order 2000 SI 2000 No. 1110 (N.I.2)) http://www.legislation.gov.uk/nisi/2000/1110/contents

Acts of the Northern Ireland Assembly: The Health and Personal Social Services Act (The Health and Personal Social Services Act (N.I.) 2001) 2001 (2001 c.3)

Statutory Instruments: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003 No 431 (NI 9) http://www.legislation.gov.uk/nisi/2003/431/contents

Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994 SR 1994 No 63

Statutory Rules: The Northern Ireland Blood Transfusion Service (Special Agency) (Establishment and Constitution) Order (Northern Ireland) 1994 SR 1994 No 175

Statutory Rules: The Northern Ireland Guardian Ad Litem Agency (Establishment and Constitution) Order (Northern Ireland) 1995 SR 1995 No 397

Statutory Rules: The Northern Ireland Medical and Dental Training Agency (Establishment and Constitution) Order (Northern Ireland) 2004 SR 2004 No 62

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

Statutory Rules: The Patient and Client Council (Membership and Procedure) regulations (Northern Ireland) 2009 SR 2009 No 98

Statutory Rules: The Regional Health and Social Care Board (Membership) Regulations (Northern Ireland) 2009 SR 2009 No 95

Statutory Rules: The Regional agency for Public Health and Social Well-being (Membership) regulations (Northern Ireland) 2009 SR 2009 No 93 & No 97

Statutory Rules: The Northern Ireland Practice and Education Council for Nursing and Midwifery (appointments and procedure) regulations (Northern Ireland) 2002 SR 2002 No 386

Statutory Rules: The Northern Ireland Social Care Council (Appointments and Procedure) regulations (Northern Ireland) 2001 SR 2001 No 313

Statutory Instrument: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003 No 431 (N.I. 9)

Guidance and codes

Committee on Standards in Public Life Reports

ISO 3100: 2009 – Risk Management

Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies July 2012

Code of Conduct and Code of Accountability for Board Members of Northern Ireland Fire and Rescue Service February 2013

Board Governance Self-Assessment Tool January 2013

NAO Audit Committee Self-Assessment Checklist

HMT Audit Committee Handbook

NHS Internal Audit Manual

An Assurance Framework: a Practical Guide for Boards of DHSSPS Arm's Length Bodies

Managing Public Money NI A3.1: Governance Statement –Managing Public Money NI - Chapter 3 and associated annex | Department of Finance (finance-ni.gov.uk)

Circulars

Archived circulars can be accessed via DoH website using the link to archived DHSSPS unless otherwise indicated.

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation

Circular HSS (PPM) 8/2002 – Risk Management in the HPSS

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management

Circular HSS(SM) 4/2003 – Code of Conduct for HPSS Managers, Department of Health, Social Services and Public Safety (2003): Code of Conduct for HPSS Managers

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls Assurance Standards – update

Circular HSS (PPM) 4/2005 – AS/NZS 4360: 2004 – Risk Management

Circular HSC (SQSD) 22/2009 – Learning from Adverse Incidents and Near Misses Reported by HSC organisations and Family Practitioner Services

Circular HSC (SQSD) 5/2010 – Handling Clinical and Social Care Negligence and Personal Injury Claims

Other relevant publications

Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in Health and Social Care

The Quality Standards for Health and Social Care

Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS

HM Treasury (2004) Management of Risk: Principles and Concepts

Health & Safety Executive (2003): 'Interventions to control stress at work in hospital staff'. The Health & Safety Executive, London

Department of Health, Social Services and Public Safety (2004) Embracing Diversity – Understanding and valuing ethnic diversity in the HPSS

Safety First: a Framework for Sustainable Improvement in the HPSS

Integrated Governance Handbook (DH, 2006)

National Audit Office: Managing Risks in Government 2011

National Audit Office: Managing Risks to Improve Public Services 2004

Equality Commission NI 2005: Guide to Statutory Duties Arising from Section 75

Programme for Government Outcomes Framework

Appendix 11. Abbreviations

ALB – Arm's Length Body

BHSCT – Belfast Health and Social Care Trust

BSO – Business Services Organisation

CAMHS – Children and Adolescent Mental Health Service

CCG – Clinical Commissioning Group

COPD – chronic obstructive pulmonary disease

CQUIN – Commissioning for Quality and Innovation

CSD – clinical support desk

CT – computerised tomography

DHSSPS – Department of Health, Social Services and Public Safety (Northern Ireland) - now known as DoH

DoH – Department of Health (Northern Ireland)

GDPR – General Data Protection Regulation

HSC – Health and Social Care

HSCB – Health and Social Care Board

HSENI – Health and Safety Executive for Northern Ireland

IAO – information asset owner

IHRD – Inquiry into Hyponatraemia-Related Deaths

MOU – Memorandum of Understanding

MRI – magnetic resonance imaging

MTS – Manchester Triage System

NDPB – Non-Departmental Public Body

NHS – National Health Service

NHSCT – Northern Health and Social Care Trust

NIAS – Northern Ireland Ambulance Service

NICON – Northern Ireland Confederation for Health and Social Care

NIPSO – Northern Ireland Public Services Ombudsman

NISCC – Northern Ireland Social Care Council

PCC – Patient and Client Council

PDSA – Plan-Do-Study-Act

PfG – Programme for Government

PHA – Public Health Agency
PKU – phenylketonuria
PPI – personal and public involvement
PSA – Professional Standards Authority
PSNI – Police Service of Northern Ireland
QI – Quality Improvement
RQIA – Regulation and Quality Improvement Authority
SAI – serious adverse incident
SEA – significant event audit
SEHSCT – South Eastern Health and Social Care Trust
SHSCT – Southern Health and Social Care Trust
SIRO – senior information risk owner
UKAS – United Kingdom Accreditation Service
WHSCT – Western Health and Social Care Trust
WHO – World Health Organization

Appendix 12. Examples, policies, procedures and legislation relevant to openness at each level

LEVEL	POLICIES AND PRODECURES		LEGISLATION
	ORGANISATIONAL	**INDIVIDUAL**	
1 – OPEN CULTURE	• Performance reporting and monitoring • Information management policies • Freedom of information policies • Consent policies • Confidentiality policies • Staff welfare • Schwartz Rounds/Balint Groups • NICE Guideline 138 • Shared decision-making • The Sanctuary Model • Caring to Change • PPI	• Training, undergraduate and postgraduate • Leadership • Being Open guidance • Staff support groups	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016
2 – OPENNESS TO PROMOTE IMPROVEMENT	• Service user Feedback/Compliments • Staff feedback • Complaints policy • Quality improvement	• Training, undergraduate and postgraduate • Leadership • Being Open guidance	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of

	ORGANISATIONAL	INDIVIDUAL	
	Initiatives • Clinical audit • Cultural assessment tools • Early alerts • Whistle blowing • Near miss reporting	• Peer review • Professional development opportunities • Support for quality improvement research	Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016
3 – OPENNESS WHEN THINGS GO WRONG	• Complaints policy • A just culture • Adverse incident reporting procedures • Serious adverse incident review procedures • Morbidity and mortality Reviews • Referrals to the Coroner • Early alerts • Independent oversight or review of incidents • Signs of Safety • Contracts of employment • Joint protocols with PSNI • Being Open – Saying sorry when things go wrong (January 2020)	• Training, undergraduate and postgraduate • Leadership • Guidance, including how to make an apology • Access to expert advice, including legal support and protections • Counselling • Occupational health and independent support • Being Open – Saying sorry when things go wrong (January 2020)	• The Health and Social Care Reform Act (Northern Ireland) 2009 • Freedom of Information Act 2000 • Mental Capacity (Northern Ireland) Act 2016